"WHEN LOVE AND SKILL WORK TOGETHER:" WORK, SKILL AND THE OCCUPATIONAL CULTURE OF MENTAL NURSES AT THE BRANDON HOSPITAL FOR MENTAL DISEASES, 1919 - 1946

by

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A Thesis
Submitted to the Faculty of Graduate Studies
In Partial Fulfilment of the Requirements
For the Degree of:

MASTER OF ARTS

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Winnipeg, Manitoba

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Abstract

The Brandon Hospital for Mental Diseases became, in 1921, the first mental institution in Western Canada to establish a training school for female nursing attendants. The founding of this school must be seen primarily to have served the psychiatric community, and it conveyed minimal advantage upon its graduates. With limited opportunities for advancement or future employment, mental nurses at the hospital in the 1920s evolved a culture of resistance to the long hours, poor working conditions and restrictive regulations of the training school.

By the late 1930s, the Depression had dramatically altered the labour market in Manitoba, and the Hospital was able to exercise a preference for hiring native-born women of higher social class and educational attainment. Unlike the nurses of the 1920s, many of these women saw their affiliation as impermanent and their credential to advantage them in their future career advancement. They were consequently more disposed to subscribe to the ideology of the training school.

In response to ongoing marginalization by the general nursing community, the mental nurses of the 1930s differentiated the work that they did from that of general nurses on a conceptual level. They developed a hierarchy of caring that privileged their "caring care" over the more prescriptive clinical care of the general hospital nurse. In so doing they created the intellectual basis for a discrete occupational identity. This identity may have played a pivotal role in the creation of the Western Canadian system of freestanding training schools for psychiatric nurses.

Introduction

This work is concerned with the occupational culture of the mental nurses at the Brandon Hospital for Mental Diseases between 1919 and 1950. It concentrates on the changes that were made at the hospital in these decades, the impact that these changes had on the day to day lives of the women who worked there, and on the way in which these changes altered the perception that these women had of their work.

The selection of the Brandon Hospital for Mental Diseases is at once arbitrary and deliberate. Practical considerations like the proximity of the community of Brandon and the existence of an established archives at the institution influenced the selection however. Brandon is appropriate on several other counts. The Brandon Hospital for Mental Diseases was at the time of its construction the largest and most modern mental hospital in Canada. It will be argued that it represented the pinnacle of nineteenth century asylum design, and for this reason was singled out by the Canadian National Committee for Mental Hygiene for critical treatment in its highly political survey of custodial institutions in 1919.

On the heels of the CNCMH Report, the Norris government resolved to remedy the problems of the mental health service and put in place an institutional structure which set the stage for aggressive, doctor-driven reforms to the institutional care for the insane. In 1921, the hospital became the first in Western Canada to establish a School of Mental Nursing. Although beyond the scope of the present paper, it is argued that the evolution of this hospital through the peculiar circumstances of the Depression created the context for the emergence of the separate system of psychiatric nurses' training that was to prevail in the western provinces from the 1950s to the 1990s.

This work draws on four distinct bodies of historical scholarship. Labour history provides a framework for understanding the labour process and the evolution of occupational cultures. It also provides models for understanding the strategies employed by mental nurses to alter the conditions of their labour and to contest the way in which power and privilege were allocated within the hospital community. From women's history comes an understanding of the function of gender in shaping identity and occupational culture. It provides a context for understanding the dichotomy that divided the male work of curing from the female service of caring that mental nurses inherited from the general hospital system. From the history of psychiatry comes an understanding of the genesis of change in the North American mental health system in the early twentieth century, including an understanding of the rise of the therapeutic mental hospital, the emergence of medical psychiatry as the dominant clinical paradigm, and of the role of the First World War and the emergence of the Mental Hygiene movement in re-casting the care of the mentally ill.

The present work owes its greatest debt to the proliferation of scholarly works devoted to the fourth approach, the understanding of general nursing. Reacting against the whiggish preoccupations with nursing élites and heroic portrayals of nurses which had dominated the field before the 1970s, scholars like Barbara Melosh and Susan Reverby in the United States and Kathryn McPherson and JoAnn Magda Whittaker in Canada have begun to create a theoretical context for understanding the lives and work of ordinary nurses. Drawing on feminist interpretations of labour history, they have explored the structural limits to professionalism, the dominant ideologies of inter-war nursing and the role of gender in the cultural negotiations of the hospital workplace.

The work is divided into five chapters. The first provides a brief narrative history of the care of the mentally ill in the Canadian Northwest and the founding of the Brandon Asylum for the Insane in 1891, and it contextualizes the opening of the new asylum with the latter nineteenth century emphasis on the moral treatment of the mentally ill. After the Brandon Asylum burned to the ground in 1910, it was reconstructed as the Brandon Hospital for the Insane and renamed in 1919 the Brandon Hospital for Mental Diseases. These name changes reflected changes in the dominant aetiology of mental illness and the ambitions of the psychiatrists to integrate themselves into the broader medical community.

It is argued that this change was driven by two concomitant phenomena. The first was the Mental Hygiene movement which, drawing on the tactics and ideology of the public health movement, sought ways to improve society by identifying and eliminating moral and intellectual defect. The second was a paradigm shift from moral treatment to medical intervention, driven by a new and ambitious corps of psychiatrists whose techniques had been validated by the imperative to confront Shell Shock during the First World War.

The second chapter shifts in emphasis away from Brandon and mental nursing to look at the social, political and intellectual context of general hospital nursing in Canada in the first three decades of this century. It does so to provide a political context for the formation of the School of Mental Nursing. It argues that by the 1920s, the gatekeepers of the discipline of nursing were the powerful superintendents of the general hospitals, and it explores the ideological and practical devices that these élites employed to assert their hegemony. Similarly, this chapter provides an intellectual framework for understanding nursing work, specifically the interplay of science, skill, ideology and femininity as they

related to the formation of occupational culture in hospital nursing.

The third chapter carries the narrative through the superintendency of Charles Baragar in the 1920s. It traces the efforts to establish the Brandon hospital as a centre for the delivery of modern, scientific care for the mentally ill. The linchpin of this new model was the school of nursing, intended to equip the hospital with a corps of highly skilled, scientifically trained mental nurses that were equal in training and respectability to those found in large urban general hospitals. It is argued, however, that what emerged over the course of the decade was a doctor-driven system that was primarily designed to serve the needs of the psychiatric community by creating the outward appearance of a hospital. At the end of the 1920s, the hospital remained a fundamentally custodial institution, and the limited technical demands of the work contributed little to the nurses' sense of the scientific nature of their work.

By the end of the decade, reform at the hospital had more or less ground to a halt and the labour atmosphere was poisoned. While the medical community had been able to replicate the form of the general hospital training school, it could not deliver on the intangibles. Nurses, not psychiatrists, were the gatekeepers of the general nursing system, and at a time when the élites of the general nursing community were consolidating their authority by actively excluding marginal practitioners from the discipline of general nursing, mental nurses were shut out. Without the promise of future employability and mobility, nurses at Brandon evolved a culture of resistance to the long hours, poor working conditions and restrictive regulations of the nursing service.

The fourth chapter takes this chronology into the 1930s. In this decade the school

of nursing succeeded, where previously it had failed, in cultivating an affiliation in its female staff to the ideology of nursing. This is attributed to two principal factors. First, as the decade progressed, new and innovative therapies were devised for the aggressive medical treatment of mental illness, and although custodial modes of care persisted for the vast majority of the patients at the hospital, and although domestic chores still constituted the majority of their work, mental nurses had a stronger basis for the perception of the skilled, scientific nature of their work. The second factor is demographic. Widespread unemployment during the Depression had dramatically altered the labour market in Manitoba, and the Hospital, which had long been an employer of last resort, was able to exercise a preference for hiring native-born women of higher educational attainment and higher social class. Unlike the women of the 1920s, they saw their affiliation with the hospital as impermanent. They planned further employment and advancement in careers. Many saw their future in general nursing, and they were consequently more disposed to subscribe to the ideology of the training school and more inclined to tolerate the poor working conditions because they could perceive future benefit to inhere in so doing.

The nurses of the 1930s were still, however, marginalized by the general nursing community. One of the ways in which they were able to cope with this marginalization was by differentiating on a conceptual level mental from general nursing. Extending the cure/care dichotomy that had long divided nurses and doctors, mental nurses developed a hierarchy of caring where they separated the "caring care" that they delivered from the more prescriptive clinical care of the general hospital nurse. By invoking their superior ability to care and their learned capacity to function in the often unpredictable environment of the

mental hospital, they elevated the custodial care that they gave to a higher echelon than the one assigned to it by the general nursing community. In so doing they created for themselves the basis for a distinct occupational culture.

The fifth and final chapter briefly examines the persistence of this culture into the 1940s. By 1939, the Canadian economy shifted to a wartime footing and the worst of the Depression was over. The demographic changes of the 1930s proved impermanent. Women who had worked at the hospital in the 1930s left to take their general training, to pursue mental nursing at other institutions, to marry, or to take work in other sectors. The hospital found itself once more unable to attract sufficient staff to meet its most basic requirements. Male wards were staffed with conscientious objectors on Selective Service and the female wards were filled with volunteers, mostly married women, with little training or experience.

What was not entirely impermanent was the cultural change that had been effected by the trained mental nurses of the 1930s. Some of these women did remain in the service of the hospital, while others returned as instructresses and administrators following general training. Those who returned brought with them an ethos which combined the ideology of general nursing with that of mental nursing. Although further research is required, preliminary evidence, some of it testimonials from these nursing administrators themselves, suggests that this dual affiliation played a role in the creation of the Western Canadian system of freestanding training schools for mental nurses that persisted into the 1990s.

Chapter 1 - Mental Health Care in Manitoba Before 1919.

It has become a cliché in Canadian medical history to complain that scholars have been too preoccupied with the asylum, and that this preoccupation has impaired the development of an historiography of the general hospital.[1] The irony of such a statement is that while the asylums of the nineteenth century have certainly been given a great deal of attention, the corpus of scholarship on the early twentieth century, a period in which the social understandings of mental illness and the paradigms of care changed dramatically, is limited. Furthermore, many of the existing histories have tended to confine themselves to debates about the social function of the mental institution. Few historians have attempted to understand how the mental institution functioned as a community of patients and workers.

The social relations of any institution are conditioned by its history, and in the case of the Brandon Hospital for Mental Diseases, this is particularly evident. Its history, location, and very architecture conditioned the experience of the staff throughout the twentieth century. These same factors combined to bring it under intense public scrutiny in 1919 and forced a dramatic series of changes in the operation and administration of the Hospital. Any history of the hospital in the inter-war period must begin with this context.

Before 1880, there was no formal provision for the care of the mentally ill in Manitoba, and individual cases were dealt with spontaneously and at the discretion of local magistrates. While many remained with their families or were left to fend for themselves, the more troublesome were often deported to their country of origin or to the established

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[1]See S.E.D. Shortt, "The Canadian Hospital in the Nineteenth Century: An Historiographic Lament," *Journal of Canadian Studies*, 18:4 (Winter, 1983), 3-14.

asylums of Central and Maritime Canada.[2] Those who were perceived to pose an immediate peril to themselves or the community were incarcerated in the common jails, and it is probably fair to accept the assertion of one history which suggests that some were "disposed of in ways reminiscent of the Old West."[3] Formal, institutional treatment of the insane was a luxury that the government of the underdeveloped province was unwilling to bear, but by the late 1870s, as the population of the west began to mature, a provincial asylum became both affordable and necessary.[4]

Under the British North America Act, the care of the insane was the precinct of the provinces. For the first decade, mentally ill Manitobans remained in the custody of federal officials at provincial expense, first in the makeshift gaol at the Lower Fort, and after 1877 at the Federal Penitentiary at Stony Mountain. By 1880, however, Stony Mountain was desperately overcrowded (being responsible for the federal prisoners not just of Manitoba, but the whole northwest), and the federal government began to apply pressure upon the Province to construct an asylum.[5] In 1883, the Provincial government authorized the construction of a fifty-four bed facility at Selkirk, which was ultimately to be the east wing

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[2]Cornelia Johnson, "A History of Mental Health Care in Manitoba: A Local Manifestation of an International Social Movement," (Unpublished M.A. Thesis, University of Manitoba, 1980.), 4.

[3]BMHCA SB1 F3, Peter Adamski, "A History of the Brandon Mental Health Centre," (Unpublished History, 1976), 2.

[4]Cornelia Johnson notes that the federal funding to the provinces doubled in 1881, and that after this the federal government was increasingly anxious to cast off Manitoba, which to that point had been largely a dependent territory. Cornelia Johnson, "A History of Mental Health Care in Manitoba," 30.

[5]Ibid, 31.

of a multi-part edifice which, when completed, would accommodate five times that many.[6] The completion of this structure was hastened the following year when the Dominion Inspector of Public Institutions pronounced the basement cells occupied by the insane at Stony Mountain "inhumane and unfit for habitation," as they had been contaminated by sewage from the adjacent cesspool. He demanded the immediate removal of the patients to another facility. All but the few who were considered too violent were transferred to a modified warehouse at the Lower Fort where they remained until the following summer, when they were transferred to the nearly-completed facility at Selkirk.[7] Here, for the first time, they were under the supervision and care of a medical doctor.[8]

The asylum at Selkirk was filled to capacity from the time that it opened, and the provincial government was forced very soon thereafter to consider the erection of another institution.[9] The selection of the town of Brandon was influenced by several factors. Brandon was a rapidly growing prairie metropolis which promised to develop into a major

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[6]Ibid.

[7]Ibid, 32.

[8]The asylum at the Lower Fort was superintended by David Young. Dr. Young's journal remains to this day instructive about the ascendent nineteenth century practices of moral treatment. The infrequency and brevity of the entries, and the eventual abandonment of the journal after six months suggest the extent to which administrative responsibilities precluded any real treatment. PAM, P2184-A F11, "1885 Journal of David Young."

[9]Joseph Workman, Superintendent of the Toronto Asylum noted, "No State in the Union and no Province in the British Colonies has ever built a new asylum where there has not been waiting at least three times as many lunatics as would fit it." The day Selkirk opened, 59 patients were transferred to the 54-bed facility. Cited in Cornelia Johnson, "A History of Health Care in Manitoba," 39.

regional transportation centre. As such, it was an area in which the incumbent provincial government wished to strengthen its political presence.[10] An asylum at Brandon would create a kind of regional balance, situated as it was well distant from the other facility at Selkirk.[11] Additionally, the proximity of Brandon to the Territories would facilitate the treatment of Dominion wards from the Northwest Territories, a service which the provincial government anticipated would offset the costs of maintenance.[12]

The principal factor which militated in favour of the selection of Brandon, however, was the existence of a suitable structure already owned by the provincial government. The Brandon Reformatory had been completed in 1890 at a cost of over $30,000. It was constructed to accommodate forty-five young offenders of nine and ten years of age, and it was superintended by J.W. Sifton, father of Clifford Sifton, who was Attorney General of Manitoba, and a politician of growing influence.[13] The Reformatory, however, had become a source of increasing embarrassment for the government as the blatant patronage surrounding its erection became apparent. The number of offenders in the narrow age band for which the Reformatory was constructed was small, and the government steadfastly refused to broaden the mandate, preferring as was the custom, to confine children in the

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[10]BMHCA SB1 F3, Joyce Oishi, "An Urban Formation Analysis," (Unpublished Paper, 1976), 3.

[11]Ibid, 4.

[12]BMHCA SB1 F3, T. A. Pincock, "The Care of the Insane in Manitoba," (Unpublished Manuscript, 1933), 2.

[13]Kurtland Refvik, *A History of the Brandon Mental Health Centre*, (Brandon: Brandon Mental Health Centre Historical Society, 1991), 1.

common jail after their eleventh birthday. In the end, the Brandon Reformatory for Boys had only one occupant, nine year old Billy Mulligan who was sentenced to five years for stealing from a mailbox. Mulligan was attended by a staff of 6 who came to be known as the "Mulligan Guard." The whole operation cost $3000 *per annum*, and the government was soon looking for a way to divest itself of this political white elephant.[14]

In 1891 (on the eve of the nomination of James Smart, the incumbent Minister of Public Works to the seat of Brandon South), it was announced that the Reformatory would be converted into an Asylum to confine the insane of Manitoba and the Territories, and later that year, the Brandon Asylum, still staffed principally by members of the old Mulligan Guard, received its first inmates.[15] Twenty-five patients were transferred from the severely overcrowded facility at Selkirk, and several others from jails around the province where they had been held awaiting accommodation.[16] The Brandon Asylum was full almost from the day it opened, and within a year, the government announced that it was commissioning a large addition.[17] Overcrowding, however, would continue to be a dominant concern for most of the next century, and one which would shape the lives of those who lived and worked there.

While the location of the Asylum at Brandon was an accident of political fortune, the

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[14]Ibid, 2.

[15]BMHCA SB1aF3, Robert McGarva, "From Prison to Community: The Development of Care and Treatment at the Brandon Mental Hospital, 1918 to the late 1950s," (Unpublished Paper, 1986), 7.

[16]Cornelia Johnson, "A History of Mental Health Care in Manitoba," 41.

[17]Robert McGarva, "From Prison to Community," 13.

campus on which it was located was not inconsistent with the requirements made by the ascendent theories of care for the mentally ill. The philosophy of William Tuke, who founded The York Retreat in 1796, remained to the end of the nineteenth century a dominant construct in the care of the mentally ill.[18] The Retreat was a model Quaker community for the insane where, through the application of what Tuke called "moral treatment" it was anticipated that the insane would recognize and correct their own deviant behaviour.[19]

Tuke theorized that the insane had in some way lost control of the inhibitions which defined their humanity. The barbaric treatment of the insane which often left them unclothed and chained in filthy circumstances in no way served to assist them in the recovery of this humanity. Instead, he argued that the insane should be immersed in an environment which emphasised the self-discipline that they lacked. Reduced to its most basic level, his was a pragmatic approach aimed at minimizing external physical coercion.[20] A combination of authoritarian firmness tempered with individual attention and kindness delivered in an environment free of the stresses and anxieties of daily life would allow the

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[18]Tuke's grandson, Samuel Tuke, recorded many of his father's theories in the 1813 *Description of the Retreat,* which became a benchmark for many later treatises on insanity and its causes and cures. Many insightful critiques of the Tuke model and its successors have followed Michèl Foucault's 1962 *Madness and Civilization: A History of Insanity in the Age of Reason*, Richard Harvard, translator, (New York: Pantheon Books, 1965). See for example, David Rothman, *Discovery of the Asylum*, (Tank: Little Brown and Co., 1971) and Andrew Scull, *Museums of Madness*, (London: Allen Lane, 1979).

[19]It is not the precinct of this paper to evaluate the social meanings which have been ascribed to the interpretations of insanity in the nineteenth century, except where the historical and sociological debates help to illumine the functions of the asylum as a community.

[20]Andrew Scull, *Museums of Madness*, 68.

insane to come to terms with their own humanity and impose from within the necessary restraint and self-discipline to again become productive members of society.[21]

The template for this environment was the Quaker family, with its strong emphasis on paternal authority. Asylum superintendents were to become father figures, administering benevolent discipline to their wards as they would children, until such time as the internal mechanisms for discipline were recovered or refined enough for this discipline to spring from within.[22] This environment was to be strictly regulated, governed by a rigid routine, and characterized by the strict separation of the sexes. Within these parameters it was to provide opportunities for rest, recreation, structured interaction, and personal attention from the medical superintendent. Andrew Scull notes:

> [Moral treatment] was not 'kindness for kindness' sake.' From its architecture to its domestic arrangements, the Retreat was designed to encourage the individual's own efforts to reassert his powers of self-control. For instead of merely resting content with controlling those who were no longer quite human... moral treatment sought to actively *transform* the lunatic, to remodel him to something approximating the bourgeois ideal of a rational individual.[23]

In the end, only Tuke's emphasis on taxonomy and discipline was incorporated into the system of asylums across Western Europe and North America which provided for the

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[21]Daniel Francis, "The Development of the Lunatic Asylum in the Maritime Provinces," *Acadiensis*, VI:2 (Spring 1977), 28.

[22]Michèl Foucault observed that Tuke's principal contribution was the introduction not of a science but a personality -- the medical personage, "at once father and judge, family and law" -- to the care of the insane. Michèl Foucault, *Madness and Civilization*, 269.

[23]Andrew Scull, *Museums of Madness*, 69.

mass custodial care of the insane.[24] Ironically, the fervour for moral treatment which spread across late nineteenth century North America, fuelled by the efforts of reformers such as Dorothea Dix and Samuel Kirkbride, contributed to the construction of massive and outwardly impressive public edifices which as a function of their scale, were utterly incapable of delivering any but the most basic of custodial care.[25]

Geography and milieu figured prominently in prescriptions for the moral treatment of the mentally ill. Tuke and his disciples stressed that it was improbable for an insane person to recover while still exposed to the stresses of the environment which had precipitated the insanity. Asylums, therefore were to provide shelter especially from the pressures of an industrial or urban existence, and they were ideally to be located at some distance from the metropolis in a secluded, pastoral, or park-like setting.[26] The spatial separation of the asylum from the metropolis allowed it to serve its function of removing the mentally ill from the community at the same time as furthering its curative ends. If, furthermore, the asylum was so located as to be visible from the centre of the metropolis, it could serve yet another function. It could be a visible reminder of the consequence of deviant behaviour. As Daniel Francis observes, this last function was one which was often accompanied by a statement of bourgeois righteousness and self-adulation: "As examples

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[24]This is the central contention of Gerald Grob's *Mental Institutions in America: Social Policy to 1875*, (New York: The Free Press, 1973).

[25]Olga Maranjian Church, "From Custody to Community in Psychiatric Nursing," *Nursing Research*, 36:1 (January 1987), 50.

[26]Daniel Francis, "The Development of the Lunatic Asylum in the Maritime Provinces," 29.

of the charitable disposition of the populace, they were trophies to be displayed."[27]

Despite the accidents of its location, the site of the Brandon Asylum satisfied all three of these requirements. While the city of Brandon was located on the south bank of the Assiniboine River, the Asylum was situated approximately two miles to the north of town, perched on the valley rim overlooking the city. In 1913, Superintendent J. J. McFadden alluded to the advantages of location in his Annual Report:

> [The Hospital] is situated on the north bank of the Assiniboine River and commands a most extensive view of the valley of the river, of the surrounding country, and of the city of Brandon. The site is well chosen, and I doubt that it is equalled by any place between the Great Lakes in the east and the Rocky Mountains in the west.[28]

The structure remains to the present a dominant feature of the northern skyline of the city of Brandon. While the land around it was principally agricultural, the Asylum grounds were themselves treed and parklike, creating the kind of pastoral preserve prescribed by moral treatment models.

Geographic separation from the community whose name it bore was to be a key factor in shaping the lives of those who lived and worked at the Brandon Asylum. Until the turn of the century, when space constraints made it necessary to permit some of the male staff to live out, all employees lived at the institution.[29] At just over two miles from Brandon, the asylum was distant enough before the advent of motorcars so as to make a daily trek to

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[27]Ibid, 30.

[28]PAM, Brandon Hospital for Mental Diseases, "Brandon Hospital for the Insane, Annual Report for 1913," (manuscript version).

[29]Joyce Oishi, "An Urban Formation Analysis," 3.

and from the institution daunting, and long working days and early curfews limited the opportunities for the staff to venture into town. In the winter, the wind funnelled down the Assiniboine River Valley, piling up drifts which frequently left the institution out of contact with the broader community for days at a time.[30] Furthermore, both asylum philosophy and a limited budget necessitated that the institution be largely self-sufficient. Even before it opened, the asylum operated a large farm which met many of its staple needs.[31] The river-bottom soil type on the south end of the property facilitated the growing of vegetables, and the hospital kept large dairy and swine herds. Linens, uniforms, and other goods were made and laundered in-house, and the asylum was equipped early in the century with its own steam plant, complete with electrical generation and water-pumping capacity.[32] This level of self-sufficiency heightened the sense of isolation and separation from the city of Brandon and limited the intercourse between asylum employees and the residents of the broader community.[33]

From 1882 to 1910, daily routines at Brandon Asylum changed little. Overcrowding and the lack of adequate staff were persistent problems, and although a series of additions

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[30]Ibid, 4

[31]The first *Annual Report* makes mention of the success of the asylum farm, in spite of the fact that the asylum was unoccupied during the planting season, and thus provided no patient labour. BMHCA SB1 F4, *First Annual Report of the Brandon Asylum for the Insane*, (1891). Reports of the activities of the farm figured prominently in this and all other annual reports.

[32]Kurtland Refvik, *A History of the Brandon Mental Health Centre*, 25.

[33]Barry Edginton, "Moral Treatment to Monolith: The Institutional Treatment of the Insane in Manitoba, 1871-1919," *Canadian Bulletin of Medical History*, 5:2 (Winter, 1988), 177.

were built to the original Reformatory, they generally met only immediate needs, and were usually overcrowded from the time they were opened.[34] The care offered was of a purely custodial nature, and although the annual reports and correspondence are filled with the rhetoric of moral treatment, the ratio of medical staff to patients precluded the individual attention necessary to such practices.[35] Although the asylum was always superintended by a physician, his time was generally so occupied with the care of the physically ill and with administrative matters that little attention was given to the mental health of the patients.[36] In essence, it was a purely custodial facility and provided for only the barest physical needs of its inmates.

Throughout the period, the asylum staff possessed limited experience and training. Moreover, the staff members were highly transient. In 1897, for example no single female attendant remained at the institution for more than a year.[37] The tenure of the male staff was generally longer, but these individuals were similarly untrained, being principally farm

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[34]For example, J.J. McFadden complained that the large addition to the original Reformatory commissioned in 1903 would be insufficient to meet the needs of the growing population by the time it was occupied in 1905. "Brandon Asylum for the Insane, Annual Report for 1904."

[35]It was not until 1907 that the Hospital employed a second medical officer, and there was frequently only one doctor on the staff even as late as 1918. PAM, Brandon Asylum for the Insane, *Annual Reports, passim.*

[36]C.K. Clarke and C.M. Hincks lamented in the report to the Public Welfare Commission on the conditions of the hospital that the medical superintendent was "too busy filling out death certificates" to attend to the most basic needs of the patients. MLL :"Report of the National Committee on Mental Hygiene," published in the "Second Interim Report of the Public Welfare Commission of Manitoba," February, 1919.

[37]PAM, Brandon Asylum for the Insane. *Annual Report for 1897.*

labourers, and there are several instances recorded where attendants moved over to the employ of the asylum farm when presented with the opportunity.[38]

After 1910, a Chief Attendant was hired who had some formal training in asylum management in Scotland, but with this exception, not a single member of the staff had any training until the opening of the school of nursing in 1921.[39] Although after 1916 the female staff wore a nurses' uniform consisting of a striped dress and a white apron and cap, they were provided with no formal training and they were principally domestics responsible for keeping order, cleaning the wards and answering the telephones.[40] For male staff, the principal qualification for employment was political loyalty, and although the work carried little prestige and paid poorly, most of the appointments were through political patronage. In the first decade of the century, this patronage was administered by Dr. McInnis, the MLA for Brandon South, who selected all new employees from lists supplied by the hospital, and on a number of occasions petitioned directly to the hospital for the creation of a new

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[38]PAM RG 18 A4, Box 5, File "Correspondence from the Superintendent [of the Brandon Asylum]," *passim*. Mick Carpenter observes that in Great Britain geography and class considerations prescribed that asylum attendants and farm labourers were often seen to come from the same families, and often moved between these jobs depending upon the strength of the farm economy. There is evidence that similar patterns operated at Brandon, and the Annual Reports indicate that many attendants resigned "to go to farming," and a number more were promoted from "inside attendants" to "outside attendants" or farm supervisors. Mick Carpenter, "Asylum Nursing before 1914: A Chapter in the History of Labour," in Celia Davies, ed., *Rewriting Nursing History*, (London: Croom Helm, 1980), 132.

[39]MLL, "Second Interim Report of the Public Welfare Commission of Manitoba," February, 1919.

[40]BMHCA SB6 F1, Val Graham, "A History of the School of Nursing" (Unpublished Paper, 1980), 3.

position for a constituent in need of a job.[41]

Patronage seems to have played a lesser role in the employment of female staff. Evidence gleaned from an oral history project conducted at the asylum's successor, the Brandon Mental Health Centre, in 1973 suggests that the greater part of the female staff were recent Irish or Scottish immigrants, and that many had been domestic servants prior to their engagement by the hospital. The reliance on immigrants signifies the hospital's status as an employer of last resort in the community, and indeed the hospital was seldom able to fill its service with native-born women. For this reason, it often relied on the ties of existing staff to the Old Country for recruitment. Margaret (Halley) Carter, for example, recalls that she came from Scotland to a ready job as the third sister to work at the hospital. [42]

November of 1910 marked a fundamental turning point for the Asylum. In 1909 the government had commissioned major renovations to the large addition that had been completed in 1905. The institution was desperately overcrowded, with patients sleeping on stair-landings and in hallways. By opening the attics and converting the superintendent's apartment to dormitory space, it was hoped to increase the capacity of the facility by twenty percent.[43] On 4 November 1910, days before the completion of a fully modern fire-fighting system, and after the existing system had been disconnected, the Brandon Asylum burned

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[41]There are numerous examples in the correspondence files of the Deputy Minister of Public Works, 1901-1906. PAM RG18 A4 Box 5.

[42]See BMHCA SB2 F6, Richard Crofton, interview with Valerie Heppner, 26 March 1973; SB2 F18, Alexander McBain, 9 March 1973; SB2 F26, Mrs. Frank Roberts (Miss Margaret Pue), 19 February 1973; and SB2 F3 Margaret (Halley) Carter, 8 March 1973.

[43]"Brandon Asylum for the Insane, *Annual Report for 1910.*"

to the ground. Only two lives were lost (both patients who escaped and were later found frozen to death), but the fire left some seven hundred patients and staff homeless. The province quickly made arrangements for the patients to be housed at the Brandon Winter Fair Grounds. For two years the Brandon Asylum operated there while a new facility was completed on the site of the original building.[44]

While the original Brandon Asylum made use of an existing structure with a miscellany of annexes and additions, its replacement was purpose-built, and it was at the time of its completion the largest asylum in Canada. From this point on, its architecture became one of its defining features.[45] The new structure was built on what is called the "linear" or "corridor" model, a corruption of the asylum design advanced in the middle of the nineteenth century by the prominent American reformer Samuel Kirkbride, superintendent of the Pennsylvania Hospital for the Insane and a founding officer of the Association of Medical Superintendents of American Institutions for the Insane.[46]

Kirkbride, who published *On the Construction, Organization and General Arrangement of Hospitals for the Insane* in 1854, gave the moral treatment models developed by William Tuke and his followers architectural expression. For Kirkbride, the asylum was not a neutral structure, but an instrument of therapy. Kirkbride argued that the order and discipline of the Victorian family should inform not just the social organization

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[44]Ibid.

[45]Barry Edginton, "Moral Treatment to Monolith," 179.

[46]For a discussion of Kirkbride's influence, see Gerald Grob, *Mental Institutions in America*, 143.

of the asylum, but its physical organization as well.[47] He designed asylums which had large centre blocks with grand entrances and foyers. These centre blocks were to contain the apartments of the medical superintendent, and were therefore to represent the centralized authority and power of the patriarch. From this centre block emanated two wings of dormitories, clearly interposing the superintendent between the male and the female wards. These wings were to be further subdivided to allow for the ready classification and taxonomy of the patients, separating them in such a way as to facilitate care and to prevent the more agitated patients from coming into contact with quieter ones, and separating the recovering from the chronic and incurable cases. Large, open-pattern dormitories were to keep the patients under the easy purview of the superintendent and his attendants.[48]

Kirkbride, sensitive to the economics of running a state hospital, designed his asylums to accommodate no more than 250 individuals, feeling this to be an adequate compromise between the need for individual attention that defined moral treatment and the political economy of the public institution.[49] The advantages of the Kirkbride or "Pennsylvania" design soon became apparent to the designers of public asylums. The Kirkbride model, with its emphasis on taxonomy and classification, and on large open dormitories was scaled-up, sometimes to handle up to a thousand patients. Ultimately the same architectural expedients which were intended to maximize the contact of the patients

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[47]Ibid, 170.

[48]Gerald Grob, *Mental Institutions in America*, 171.

[49]Nancy Tomes, "A Generous Confidence: Thomas Storey Kirkbride's Philosophy of Asylum Design," in Andrew Scull, ed., *Madhouses, Mad Doctors and Madmen*, (London: Allen Lane, 1981), 147.

with the staff, were to facilitate the supervision of the maximum number of patients with a minimum of attendants.[50]

This corruption of the Kirkbride model satisfied all of the imperatives which faced the planners of public asylums in the latter half of the nineteenth century. Situated in the country, they removed the contagion of mental disease from the visible urban context. Designed to accommodate a maximum of patients with a minimum of staff, they satisfied the economic requirements of a public institution. That their curative function was utterly lost in the process is evidence of the extent to which economic considerations eclipsed all others in their construction and design. Tom Brown asserts that:

> Nowhere can the validity of Grob's perspective on the history of the nineteenth century asylum be more readily demonstrated than by examining the way in which the architecture of the asylum itself eventually served to undermine the therapeutic goals of the institution.[51]

Patients in these asylums were frequently consigned to a vacuous existence, languishing in the corridors and day rooms, shepherded like livestock and subject to restraint as the dominant form of control and discipline.

The structure completed at Brandon in 1913 represented the zenith of such institutional architecture. As the largest and newest asylum in North America, it boasted a

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[50]Gerald Grob provides an insightful critique of the social control models of Scull, Rothman and Foucault, arguing that they have been largely blinded by the equation of outcome and motive, and that the development of the custodial asylum was an economic expedient which pushed the Kirkbride model beyond its capacity to provide individualized and curative care to the patient. See also Gerald Grob, "Rediscovering Asylums: The Unhistorical History of the Mental Hospital," in M.J. Vogel and C.E. Rosenberg, eds, *The Therapeutic Revolution: Essays in the Social History of American Medicine*, (Philadelphia: University of Pennsylvania Press, 1979).

[51]Thomas Brown, "Architecture as Therapy," *Archivaria*, 10, (Summer, 1980), 107.

nominal capacity of one thousand. The institution incorporated all of the latest innovations in institutional design, from sanitary terrazzo flooring to forced air heating and dumb waiters for the transport of food from the kitchen to the widely separated dining rooms. It was equipped with a fully modern operating theatre and pathology laboratory, and it offered for the first time a continuous bath and hydrotherapy room for the treatment of excited patients.[52]

The irony of the construction of this facility is that it was built in utter contradiction to the preferences of psychiatric specialists. By 1910, a forceful public critique of the large custodial asylums had emerged in the United States and was being felt strongly in Canada. Custodial care was recognized to be ineffectual and expensive, and the harshness of institutional life was becoming a matter of growing public concern.[53] Many of the prominent advocates of moral treatment recognized the impossibility of its application in the large corridor asylums, and were calling for asylums built on the "cottage" or "colony" model. The cottage system sought to recapture the original intent behind the Kirkbride asylum. Its advocates wanted asylums to be constructed as a series of discrete, small buildings which would be self-contained and under the supervision of a trained psychiatrist. In this way, the individualized attention pivotal to the success of moral treatment could be restored to the system.[54]

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[52]"Brandon Hospital for the Insane, Annual Report for 1913."

[53]Barry Edginton, "Moral Treatment to Monolith," 172.

[54]Thomas Brown, "Architecture as Therapy," 112; Gerald Grob, *Mental Institutions in America*, 326.

In his correspondence with the Minister, J.J. McFadden, superintendent at Brandon, repeatedly called for the institution of the cottage system, as did the prominent and politically influential Winnipeg doctor Gordon Bell, who had been the first medical superintendent at Brandon.[55] This advice was not heeded, and instead, the government, with what Joyce Oishi called its "penchant for monumental form" built an asylum that in scale and form took the custodial monolith to new heights. Oishi observes:

> It is a comment on the Manitoba Government and architecture of the time that the second building, designed specifically as an asylum by the provincial architect, Sam Hooper, was minimal in its response to the [therapeutic] function of the institution... [but] lent itself to more monumental façades.[56]

McFadden, although he never abandoned the call for the cottage system, recognized the political and economic advantages offered by the new structure, and in his Annual Report of 1913, he proudly declared that the Brandon Hospital for the Insane, as it was re-named in 1913, was accommodating like numbers of patient to those that he had visited in Eastern Canada but required less than half the staff.[57]

Although the new structure was considered a marvel at the time of its construction, and the government paraded a number of prominent visitors through its hallways in its first year, its deficiencies soon became all too apparent.[58] The heating, laundry and kitchen were inadequate, the dumb waiters never worked, and the much vaunted terrazzo floors proved

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[55]"Brandon Asylum for the Insane, Annual Report for 1902."

[56]Joyce Oishi, "An Urban Formation Analysis," 8.

[57]"Brandon Hospital for the Insane, Annual Report for 1913."

[58]Ibid. The annual report contains a long list of dignitaries and distinguished visitors.

much too hard and slippery for the aging population of the hospital.[59] Every year several patients, principally older women, sustained severe fractures after slipping on the floors, and "considering the floors" became a common preface for the report on injuries in the Annual Reports of the 1920s.[60]

There were no real recreational opportunities for the patients, and those who were unable to work on the farm (which included all of the patients in the female service) were consigned to a daily routine of passing time without diversion in the long, windowless main corridors which doubled as day-rooms, provided only with hard wooden benches (to which they were often shackled).[61] The dormitories were too large to allow for the adequate classification of patients, and placing so many patients in a single room proved explosive and sometime perilous to staff. Consequently, on some wards, restraint was applied almost continuously.[62] In 1933, T.A. Pincock, superintendent, commented with exasperation:

> In view of the report by Dr. McFadden in 1902 in which he recommended the provision for single room care and stressed the comfort, welfare, and treatment of the patients, it seems doubly surprising that ten years later a building project of such magnitude should have been carried out without provision for one private room, with excessively large wards, lack of facilities for proper classification and segregation, poor lighting, absence of infirmary sections, and many other deplorable defects.

What in its first year had attracted visitors from all over the continent Pincock declared

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[59]A litany of problems are exposed in the Deputy Minister of Public Works' Correspondence with the Hospital in the 1920s. See PAM RG 18 B2, Boxes 2-4.

[60]For example see BMHCA SB23a F4 *Brandon Hospital for Mental Diseases, Annual Report, 1926.*

[61]Robert McGarva, "From Prison to Community," 10.

[62]T. A. Pincock, "The Care of the Insane in Manitoba," 3.

"obsolete by 1919."[63]

By 1919, changes in the political and social climate had caused the public criticism of the asylum system to build to critical levels. In 1908, Clifford Whittingham Beers published *A Mind That Found Itself.* Beers was a graduate of Yale University and of a prominent New England family. After a psychotic episode, Beers spent two years in several private asylums in Connecticut, and on his release published an autobiography in which he related the abuses that he suffered while incarcerated.[64] Beers' book became a best-seller and went through several editions in the first years after its initial publication. His story fed the already growing criticism of the asylum system, and helped to turn the attention of social reformers to the plight of the mentally ill. In 1909, he became the primary spokesman for the newly-formed National Committee on Mental Hygiene.[65] The NCMH came to be at the centre of the mental hygiene movement, a movement which shifted the plight of the mentally ill into the spotlight of mainstream politics and played a strong role in ensuring the professional hegemony of psychiatrists in the administration of mental health care.[66]

The First World War magnified the concerns raised by the mental hygienists. Just as the Boer War had raised alarms in Great Britain over the physical fitness of the British

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[63]T. A. Pincock, "The Care of the Insane in Manitoba," 3.

[64]Clifford Whittingham Beers, *A Mind That Found Itself*, Fortieth Anniversary Edition, (Philadelphia: Doubleday, Doran and Co., 1948).

[65]Albert Deutsch, *The Mentally Ill in America*, Second Edition (New York, 1949), 300-302.

[66]David MacLennan, "Beyond the Asylum: Professionalization and the Mental Hygiene Movement in Canada, 1914-1928," *Canadian Bulletin of Medical History*, 4:1 (1987), 13.

soldiery, the First World War raised the same questions about its mental fitness. The phenomenon of Shell Shock in particular was a cause for great concern, as in addition to creating alarm about the mental fitness of the soldiers in the trenches, it posed an immediate and pressing challenge to the officers prosecuting the War. The inability or refusal to fight, and the appearance of a variety of ailments, such as the inability to see, speak, taste or hear; which showed no connection to a physical trauma, created a dilemma for the military just as the abandonment of the trenches by numbers of apparently uninjured soldiers created significant problems of morale for those who remained. The imperative that they gave to the medical men in the field hospital, therefore, was to return the shell-shocked to the lines as expeditiously as possible.[67]

This imperative freed the Royal Army Medical Corps, and with it the Canadian Army Medical Corps, to experiment freely with new therapeutic techniques. Traditional methods of moral treatment and milieu therapy were time consuming and too "soft" to be politically acceptable. Necessity legitimated a number of therapeutic practices which had theretofore been regarded with disdain and mistrust. Intrusive therapies, ranging from the more innocuous application of hot and cold compresses to the "quick cure," a euphemistic term used to describe torture with electrostatic shocks, were legitimated in their application to Shell Shock victims and became part of the repertoire of the doctors and psychiatrists who would assume prominent positions at the civilian mental hospitals after the war.[68]

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[67]Tom Brown, "Shell Shock and the Canadian Expeditionary Force, 1914-1918," in Charles G. Roland, ed., *Health, Disease and Canadian Medicine* (Toronto: The Hannah Institute for the History of Medicine, 1984), 317.

[68]Ibid, 323-4.

Shell Shock also fuelled public support for the mental hygiene movement. Since it was commonly interpreted to be a manifestation of a latent moral or mental defect which was simply revealed by the stresses of the War, the incidence of Shell Shock became all the more alarming when extrapolated to suggest an even more disturbing incidence of mental defect in the general population.[69] Public sympathies were mobilized in favour of preventive mental health care, and together with the message of mental hygiene came the call for asylum reform.

The coalescence of these social forces was felt particularly deeply at the Brandon Hospital for the Insane. In 1918, Clarence M. Hincks and C. Kitson Clarke, Professors of Medicine at the University of Toronto, founded the Canadian National Committee for Mental Hygiene on the model of its American counterpart. The CNCMH was founded in the belief that: "a group of professional and lay citizens could materially strengthen the hand of [those] agencies [dealing with the mentally ill] by impartially surveying the problems of mental abnormality in Canada."[70] One of the first actions of the CNCMH was to undertake an audit of public institutions across Canada. The first stop on this tour, at the request of Thomas Johnson, Attorney General and Chief Commissioner of the newly created Public Welfare Commission, was Manitoba. [71] Clarke and Hincks were generally critical of the

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[69]Albert Deutsch, *The Mentally Ill in America*, 313-15.

[70]John Heagarty, *Four Centuries of Medical History in Canada*, (Toronto: McMillan, 1928), 13.

[71]For a discussion of the broader ramifications of this tour, see David MacLennan, "Beyond the Asylum: Professionalization and the Mental Hygiene Movement in Canada, 1914-1928."

state of the mentally ill in Canada, but they singled out the Brandon Mental Hospital for particular vitriol. Their report began:

> The hospitals for the insane in Manitoba... have neither the staff nor the equipment to make them any more than custodial institutions...

The report went on to describe the patients as arrayed on hard wooden benches, many in manacles, looking "like caged animals" and showing signs of abuse. They complained of the "herd" treatment of the insane, and noted that there were no diversions to combat the "deadly apathy of a most distressing character" they found throughout. They laid the blame not at the feet of the superintendent, whom they found to be diligent, if preoccupied with administrative matters, but squarely at the feet of the province. The report concluded with a call for a Royal Commission into the custodial treatment of the insane in Manitoba.[72]

Hincks and Clark were not alone in this criticism. The Brandon Hospital for the Insane was in 1919 a very troubled institution. There were numerous accusations of mismanagement and corruption, and the Inspector of Public Institutions had reported in 1918 that the institution "was a place of utter futility and idleness with patients looking to death for their freedom."[73] A similar report by the Canadian Military had been scathing in its assessment of the facility, and the military had insisted that all Dominion War Veterans be housed at the Selkirk facility instead of at Brandon:

> We have the honour to report that as a hospital for the insane, we were very

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[72]MLL, C.K. Clark and C.M. Hincks, "Report of the National Committee on Mental Hygiene," published in "Second Interim Report of the Public Welfare Commission of Manitoba," February, 1919.

[73]Cited in Doug Smith *et al.*, *Lives In the Public Service: A History of the Manitoba Government Employees Union*, (Winnipeg, 1994), 19.

> infavourably [sic] impressed with it, and we are of the opinion that under the present regime it is not a desirable institution to send military patients to.... [We have] had considerable experience in asylums, but seldom in one with such an internal atmosphere of medievalism or one filled with such depression.[74]

Moreover, in 1919, labour problems erupted at the hospital, and the male attendants formed the Manitoba Provincial Sanatorium Employees Union to protest the poor wages, the persistence of blatant political patronage, the poor living conditions, and the government's unwillingness to apply the principle of one days' rest in seven to the Civil Service.[75] The publication of the Hincks report in 1919 brought all of these troubles into the public eye, and Hincks' call for a Royal Commission was repeated in the press.[76]

The Norris Liberal government was sensitive to the volatility of the issue of mental health care, and it responded quickly to the Hincks Report. The office of the Provincial Psychiatrist was created, and it was given superintendence over the Winnipeg Psychopathic Hospital, a new facility which would specialize in the acute care of curable patients and would act as the admitting hospital for the mental hospitals in the eastern half of the province.[77] The Provincial Psychiatrist was also appointed *ex officio* senior non-resident officer of the Brandon and Selkirk hospitals, and in addition to being responsible to the Department of Public Works, reported also to the Public Welfare Commission, which had

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[74]PAM, RG18 B2 Box , Major General Guy Fiset to Provincial Secretary (unnamed), 24 June 1918.

[75]Doug Smith *et al.*, *Lives In the Public Service*, 20.

[76]Barry Edginton, "Moral Treatment to Monolith," 181.

[77]Ibid.

been created in 1918 to act as ombudsman for all wards of the province. New directors were appointed at the province's two mental hospitals, and the 1919 "Act Respecting the Care and Treatment of Mentally Diseased Persons," in addition to making long overdue changes to the 1877 Lunacy Act, renamed the facilities "Hospitals for Mental Diseases" in an attempt to emphasize their new curative roles and the pathological nature of mental illness.[78]

The two new officers at the Brandon Hospital for Mental Diseases were mental hygienists of note, and both were strongly influenced by their experiences as military psychiatrists. The government secured early discharge from the Royal Army Medical Corps for Captain Richmond Goulden, who took over from J.B. Chambers as acting superintendent in 1919.[79] Concurrently, Major Charles A. Baragar was appointed permanent Superintendent, and granted an immediate leave of absence to do post-graduate work in Mental Hygiene and Psychiatry in Boston.[80] Baragar, although trained at sanatoria before the war, had acted as a psychiatrist in the Canadian Army Medical Corps, and had had direct exposure to the

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[78]"Act to Amend the Insane Asylums Act," RSM, 1920, Chapter 30.

[79]PAM RG18 B2 Box 2, Oxton to Acting Director of Medical Services, 3 May 1919. Chambers' appointment was very much a temporary one. Chambers was over sixty-five years old, and had just retired as superintendent at Selkirk. His retirement was delayed by the creation of a vacancy at Brandon by the resignation of H.E. Hicks. Hicks had been in place for only a year, and was himself an acting superintendent following the resignation of J.J. McFadden. It is presumed that McFadden's resignation was requested. A loyal servant of the Roblin Government, McFadden was held responsible for many of the failings of the hospital and resigned amid accusations of corruption. Hicks, it seems, was merely incompetent, and no doubt Chambers was brought out of retirement on the understanding that his presence would help to avert scandal while a new director was found.

[80]RG18 B2 Box 2. Carbon copy of "Order in Council Appointing Charles A. Baragar Superintendent of the Brandon Hospital for Mental Diseases" (date illegible, [May 1919]).

treatment of Shell Shock while in Flanders.[81] The political astuteness of these appointments is evident. There was no Royal Commission.

Baragar was to preside over the Brandon Hospital for Mental Diseases for ten years, and in this period, the transformation from asylum to hospital became more than simply nominal. Baragar pressed his political supervisors for the material trappings of a modern hospital: a school of nursing and trained ward nurses, a pathology laboratory, electrotherapy and hydrotherapy equipment, an x-ray machine, and most importantly, a freestanding psychopathic hospital entirely separate from the chronic service.

Over the course of this decade, many of these requests were honoured, although the Hospital remained predominantly a custodial institution. Baragar would lobby aggressively for the creation of a trained nursing service of equal calibre to that found in any general hospital. The creation of such a service, however, served primarily the ambitions of the psychiatrists who felt that the presence of the accoutrements of the hospital would help to validate the medical dimensions of their work in the eyes of the broader community. That the general nursing community under the control of the powerful general hospital superintendents was in a period of retrenchment and actively seeking to exclude marginal practitioners from nursing ultimately limited the success of this program.

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[81]BMHCA, Unsorted materials, Sidney J. C. Pierce, "Obituary for Charles Baragar," carbon copy of original typescript (1937).

Chapter 2 - Establishing An Historical and Theoretical Context For Mental and General Nursing

This chapter concentrates on a specific sub-category of the practitioners who were called nurses. It excludes those with whom the broader study is concerned, mental nurses. It does so in order to establish a base-line or norm against which the work and occupational identity of mental nurses can be assessed. The emphasis here is on "trained" nurses of the first half of this century, that is to say those who participated in a specific program of instruction and apprenticeship at a general hospital.

Beginning in the last decades of the nineteenth century, hospital trained nurses began to distinguish themselves from untrained or informal practitioners ("proclaimed" nurses in the lexicon of the day), and through their organizations, struggled to establish clear guidelines for training and apprenticeship. This process was intended to serve two purposes. The first was to enhance the general reputation of nursing as an appropriate pursuit for respectable women, and the second was to disqualify not only untrained practitioners, but also many who had received lesser training, especially those who had graduated from the training schools of smaller, less respected hospitals. Numbered among those so disqualified were nurses trained at mental hospitals

This section uses the terms "graduate" and "registered" nurse interchangeably. In the language of the day, "graduate" denoted one who had completed a two, and later three, year apprenticeship at a recognized hospital training school, and "registered" was used to distinguish one who had used this status to register herself with the sanctioned regional nursing authority. It should be noted that not all graduate nurses were "registered." The

registry was a venue for announcing one's availability for work, and for some it was the source of a credential that substantiated one's skill in response to the inquiries of private clients. Registration, therefore, conferred specific advantages upon nurses in private practice that did not necessarily pertain in other nursing contexts. Not all graduate nurses who remained in the hospital system as staff nurses, supervisors or superintendents or who branched out into industrial or public health nursing sought registration. Even in private practice, in the absence of any legislated requirement to do so, many inter-war graduate nurses declined to register themselves.[1]

The importance of an understanding of general nursing in a study of mental nursing is underscored by the cultural associations of the word "nurse". For most of the twentieth century, the female attendants in mental hospitals have been called "nurses". This appellation, however, has almost always been qualified by a preceding "mental" (and more recently "psychiatric"). The value statement implicit in this qualification is at the very heart of social and historical assumptions about the nature of nursing. In the introduction to his article "Asylum Nursing Before 1914: A Chapter in the History of Labour," British historian Mick Carpenter laments that: "When we say "nurse",... everyone knows that general hospital

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[1]The failure, despite considerable efforts by the nursing élite, to obtain mandatory registration, and the continued prevalence of untrained nurses and of nurses trained in hospitals whose training schools did not meet the standards of the regional registry, may be seen as a reflection of the subordination of the demands of the nurses to those of hospitals, that required an ongoing source of cheap labour, and to those of the medical profession, which may have perceived a threat inherent in the professionalization of nursing. See JoAnn Magda Whittaker, "A Chronicle of Failure: Gender, Professionalism and the Graduate Nurses' Association of British Columbia, 1912-1935," (MA, University of Victoria, 1990).

nursing is signified." [2] This tendency speaks to two trends, one of which reflects practice and the other social, political and economic conditions of nursing in the first half of the century. Historical writing has tended to exclude the experiences of the various practitioners who were called nurses, or to collapse the diversity of experiences and skills into a single, exclusive category. The nurses' context reflects the outcome of a long campaign by the élites in the general nursing community to define narrow parameters of nursing practice and to exclude practitioners who did not fall within this circumference.[3]

By the 1920s, the greater portion of the female workforce in many Canadian mental institutions consisted of students or apprentices at a school of mental nursing. In most external aspects, these schools differed little from their counterparts in the general hospitals. Young women generally enroled for two to three years for a course of instruction, and they lived on-site for the duration of their apprenticeship. During training, nursing apprentices received some instruction on the theory and practice of nursing, but the greater portion of their time was spent on the wards training "on the job." Generally, the students received only a nominal stipend and "bartered" their labour at the hospital for their training and their

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[2]Mick Carpenter, "Asylum Nursing Before 1914: A Chapter in the History of Labour," in Celia Davies, ed., *Rewriting Nursing History* (London: Croom Helm, 1980), 124.

[3]A third observation might be that the internalist tendencies of nursing historiography have tended to create a body of scholarship alienated from the broader context of social history. This has facilitated the acceptance of the prescriptive literature of the nursing élites and the historiographic marginalization of peripheral practitioners. See Charlotte Moran, "From Vocation to Profession: the Intellectual Transformation of English-Canadian Nursing Education, 1875-1936," (Unpublished MA, University of Calgary, 1989).

board.[4] These mental hospital schools adopted many of the rituals and symbols of the general hospitals. Nurses wore uniforms modelled on those of their hospital counterparts, and these uniforms often provided visible reminders of the nurse's progress in her training and her status within the hospital hierarchy. Often, these schools were supervised by a graduate nurse with hospital training. These similarities, however, often disguised a fundamental political tension: throughout the first half of the twentieth century, efforts by mental hospitals to emulate their hospital counterparts were met with resistance from the élites within the general nursing community. Indeed, the powerful nursing superintendents, through their client organizations, consistently attempted to differentiate the two approaches to the discipline, with the aim of ranking "medical" nursing above "mental" nursing.

Debates within the nursing community in the first half of the century often focused on who was entitled to claim the title of "nurse" and who was not. Numerically weak, carrying the stigma of the mentally ill, and often excluded from the sanctioned nursing organizations, mental nurses were marginal players in these debates. The necessity of qualifying their title speaks to the contingency of their claim and underscores the success

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[4]Charles Rosenberg argues that barter was the basis of the economic relationship between student and hospital:

> Education, and the credentials that it legitimated, had become both inducement and part payment for a key segment of the hospital's labour force. This was an economic logic too compelling to be ignored. Both hospitals and prospective nurses were capital poor; it was only natural for the two parties to barter: work for diplomas.

Charles Rosenberg, *The Care of Strangers: the Rise of the American Hospital System*, (New York: Science History Publications, 1979). Mental hospital stipends were generally higher than those offered to general nursing apprentices, reflecting in part the undesirability of mental hospital work and the uncertain employment outcomes that followed training.

of the élites in the nursing community in establishing general hospital nursing as the normative standard against which the skills of other practitioners were measured.[5] It will be argued that mental nurses' own occupational identity was largely predicated upon their relationship to the general nursing community. Therefore, an understanding of the occupational culture of mental nurses must begin with an understanding of the emergence of general nursing and the occupational culture of general hospital trained nurses.

Canadian historian Kathryn McPherson employs a generational model to explore how social and economic relations shaped the work and lives of graduate nurses in Canada after 1870. She argues that this provides a basis for assessing the changes in circumstances that influenced the work done by nurses and how these changes influenced the way in which they conceptualized their work. She defines five generations spanning the years between 1874, when the first hospital school of nursing was established in Canada, and the present.[6] This study accepts the general utility of the generational model and the periodization that McPherson maps. It proposes that an examination of the activities and struggles of the nurses of the first and second generations, nurses trained in English Canada between 1870

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[5]It may be argued that mental nurses were doubly penalized in this regard. Not only were their patients politically marginalized and unable to aid them, but so too were the psychiatrists. Indeed, the psychiatric community were often champions of trained nursing, perceiving that the presence of hospital nurses would bolster the claim of the asylum to hospital status and advance their own sometimes marginal position within the medical community. See Chapter 3.

[6]Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990,* (Toronto: Oxford University Press, 1996), 18-25. The generational analysis is the basis for her earlier work on second and third generation nurses in "Skilled Service and Women's Work: Canadian Nursing, 1920-1939," (Unpublished PhD, Simon Fraser University, 1989).

and 1900, and between 1900 and 1920, serves as a useful basis for understanding the political and social context into which mental nurses were introduced when the Brandon Hospital for Mental Diseases School of Nursing was opened in 1921.[7]

The limitations of a generational model are acknowledged, especially as a measure of something so intangible as occupational identity. Individuals do not always fit neatly into a generational category, and certainly individual practitioners encountered circumstances common to different generations. Nonetheless, a generational model does serve as a rough guide to the particular set of social, economic and political dynamics that together constituted the cultural context in which nurses worked.[8]

Contact between the generations created a context in which a self-conscious occupational culture was created, sustained, revised, re-interpreted and communicated through networks and between generations.[9] In the training school, much of the supervision and instruction was provided by nurses of the preceding generation. Outside the hospital,

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[7]While the term "Canadian" is used throughout the present work, it does not accommodate the specific set of circumstances that pertained in Québec. Nursing services in Québec have historically been dominated by the Catholic Church. Between 1850 and 1950, the steady growth in female religious orders provided a ready supply of nurses. The peculiar conditions which prevailed in the hospitals which were owned and administered by religious orders created a very different experience for all Québécois nurses, including laywomen. For an introduction to Québec Nursing, see Clio Collective, *Quebec Women: A History*, (Toronto: Women's Press, 1987), especially 218-22.

[8]Kathryn McPherson, *Bedside Matters*, 19.

[9]American historian Barbara Melosh usefully distinguished "work culture," the adaptation to constraints within the workplace, and "occupational culture," the ideology which governs workers' identification with their conditions and the collective intellectual understanding of the work that is the arbiter of autonomy and control over the means of production. Barbara Melosh, *"The Physician's Hand," Work, Culture, and Conflict in American Nursing*, (Philadelphia: Temple University Press, 1982), 7.

younger nurses found mentors and patrons within the organizations that ran the registries and the various other nursing organizations. The role of the second generation is particularly important. It will be argued that shifts in the aetiology of disease established a discursive context which limited the lasting influence of the first generation. The second generation secured its dominance through the creation of a self-conscious élite which was aware of the importance of employing its version of nursing history as a mechanism for the transmission of values from one generation to the next. This self-conscious creation of a legitimizing literature served this élite's aspirations for professional recognition and ensured that nurses were conscious of the generational context in the development of their occupational identity.[10] This chapter will explore three aspects of what McPherson identifies as that second generation of Canadian nurses. It will look briefly at the apprenticeship system in which they were trained, the work they performed, and the institutions and organizations that they founded to promote their interests. These three elements together comprise the framework on which a distinctive occupational identity depended.

In the last quarter of the nineteenth century, a new type of nurse began to appear on the wards of the hospitals in Canada. Unlike the traditional female ward attendants, who might have been married women, widows, or even former patients of the hospital, these women were young and unmarried, and they were titulary students or apprentices. The hospital schools of nursing in which these apprentices worked generally called themselves "Nightingale Schools," and, when first established, were generally put under the control of

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[10]Kathryn McPherson, *Bedside Matters*, 19-20; see also Susan Reverby, *Ordered to Care: The Dilemma of American Nursing*, (New York: Cambridge University Press, 1987), 67.

a British trained "Nightingale Nurse."

The allusion is to Florence Nightingale, the middle class crusader and sanitarian who was an acclaimed correspondent and nurse during the Crimean War. Nightingale, on her return to England, situated herself at the head of a hospital reform movement that sought to improve the standard of training and care in England's charity hospitals. She established her program at London's St. Thomas' Hospital in the 1860s. Her model called for a training school for nurses, independent of the other administrative structures of the hospital, and it became the model on which most North American hospital nursing schools were nominally organized. Nightingale's philosophy was founded on the essentialist axiom that opened her treatise on nursing *Notes on Nursing*: "Every woman is a nurse."[11] This book, published in 1859, became required reading for all nursing students until after the Second World War. In it, Nightingale expanded a vision of nursing founded on strict moral training emphasising punctuality, trustworthiness, personal neatness and cleanliness, and ward management delivered in an autonomous, nurse-administered hospital training school.[12]

The success of the Nightingale model can be attributed at least in part to its self-conscious emphasis on its own propagation and reproduction. St. Thomas' graduates were

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[11]Florence Nightingale, *Notes on Nursing*, (Philadelphia: J.B. Lippincott, 1929) 1.

[12]For a more recent narrative on Nightingale and her contributions, see Monica Baly, *Florence Nightingale and the Nursing Legacy*, (London: Croom Helm, 1986). For a brief intellectual biography of Nightingale, see Charlotte Moran, "From Vocation to Profession: The Intellectual Transformation of English Canadian Nursing Education: 1875-1936," (Unpublished MA, University of Calgary, 1989), especially Chapter 2; and Charles Rosenberg, "Florence Nightingale on Contagion: The Hospital as Moral Universe," in *Healing and History: Essays for George Rosen*, Charles Rosenberg, ed. (New York: Science History Publications, 1979).

indentured to their school for three years after graduation. These graduates were often "loaned" to other institutions where they played pivotal roles in the founding of training schools. In some instances, their salaries were paid out of the "Nightingale Fund," a philanthropic trust administered by an independent board in London.[13] The hospital reserved the right to recall these graduates if the newly established schools failed to conform to Nightingale's prescriptions for curriculum, philosophy and discipline.[14] Given the international reputation of Nightingale among laypersons, and the socially precarious position of turn of the century hospitals, these sanctions must have carried considerable weight.

The Nightingale model was exported to North America in 1873 with the opening of schools of nursing under the supervision of London graduates in Boston, New Haven and New York. One year later, Theliopolis Mack's General and Marine Hospital in St. Catharine's became the first Canadian institution to establish a Nightingale School. Other schools followed quickly thereafter, and by 1900, there were there were two dozen such hospital schools in Canada. The first such school on the prairies was opened at Winnipeg

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[13]The "Nightingale Fund" loomed large in many early histories of nursing, but mentions of it are largely absent from more recent works. See, for example, Lavinia Dock, *A History of Nursing: From Earliest Times to the Present Day with Specific Reference to the Work of the Past Thirty Years*, Volume 3, (New York: G.P. Putnam and Sons, 1912), 10.

[14]Specific discussions of the St. Thomas' legacy are found in Charlotte Moran, "From Vocation to Profession," 38; and in Celia Davies, "A Constant Casualty: Nurse Education in Great Britain and the United States of America to 1939," in Celia Davies, ed., *Rewriting Nursing History*, (London: Croom Helm, 1980), 104.

General Hospital in 1887.[15]

Much has been made in traditional histories of the import of these early training schools, but their role in the reform of patient care has probably been exaggerated. The tales of the "old style of nurse" a *leitmotif* in histories written by advocates of nurse training, must be taken in that historiographic context. These tales are generally repeated by authors of a more liberal tradition who are firmly wedded to the "march of technology" school of medical history and have tended to denigrate the contributions of scientifically untrained nurses. Since a plurality of these histories has been written by and for nurses, one might argue that the remembrances of the untrained nurse, while perhaps unreliable for what they tell us about these practitioners, tell us a great deal about the occupational identity and aspirations of the nursing community.

The literary image inevitably invoked is that of Sarah Gamp, the drunken charwoman who served as a night attendant in a hospital in Dickens' *Martin Chuzzlewit*. While the Gamp caricature may have been over-played by the early advocates of nurse training, she did capture the class affiliation of the nurses of her era. Before the institution of trained nurses, with the exception of the middle and upper class "visitors," ward attendants were almost exclusively drawn from the working classes. Many were older women, often widowed, while others were domestics or charwomen who worked as hospital attendants to supplement other wage work or who sought the affordable lodging that accompanied the

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[15]JoAnn Magda Whittaker, "A Chronicle of Failure," 18-19; and Kathryn McPherson, *Bedside Matters*, 31. For a detailed narrative on the establishment of training programs, see Dorothy Kergin, "Nursing as a Profession" in Mary Q. Innis ed., *Nursing Education in a Changing Society*, (Toronto: University of Toronto Press, 1970), 46-63.

work.[16] Another category of ward attendants was drawn from patients who, nearing the end of their convalescence, found a ready job on the wards and in some instances a means of working off an unpaid account at the hospital.[17]

Characterizations of these "old-style" nurses reflected middle class attitudes towards working people. Many scholars have observed that these nurses tended to have values more in common with the working-class patients whom they served than the middle class doctors, hospital administrators and nursing superintendents who were inclined to label them as shiftless and dissolute. There is little question that many of these women provided competent and conscientious care, although this was at best grudgingly acknowledged by their contemporaries.[18] It is this moral characterization of the "old-style" nurse which reveals most about the first generation of nurses and the movement which created them. Nightingale and her allies must be seen as moral reformers as much as they were medical

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[16]Assessing the demographics of "old-style" nurses is very difficult due to the paucity of records. Susan Reverby provides some demographic information based on the study of retired nurses at one Boston Hospital. Susan Reverby, *Ordered to Care*, Chapter 1.

[17]This last condition may have been more prevalent in the American system than in Canada. It is referred to in a number of U.S. sources, but seldom in the Canadian ones. See Susan Reverby, *Ordered to Care*, 27.

[18]Kathryn McPherson cites a speech to nursing graduates by Sir William Osler recalling his internship at Montréal General in 1868:

> They were generally ward servants who had evolved from the kitchen or from the backstairs to the wards... Many of them were of the old type so well described by Dickens, and there are some of the senior medical men present who remember the misery that was necessary in connection with that old-fashioned type of nurse.

but later in the same speech, Osler acknowledged that many of the "Dickensian" nurses "in behaviour and devotion and in capability [were] equal to the best I had ever met." Kathryn McPherson, *Bedside Matters*, 28.

ones, and their goal was to impose a middle class standard of morality and respectability upon the hospitals. Most telling in this regard, Nightingale, a sanitarian, never accepted the aetiology of disease that accompanied the scientific revolution of the latter nineteenth century. Germ theory was morally neutral, and was thus irreconcilable with her class conditioned understanding of the role of nurses.[19] The embrace of aseptic theory by the second generation of trained nurses therefore created a discursive context which allowed the latter to set themselves apart from their predecessors, a process that cemented their place as the dominant cultural influence on later generations.

By the 1890s, there was an apparent consensus at hospitals across the continent that the new style of nurse was to prevail. Certainly part of that change is rooted in changes in the dominant paradigms of medical care. In the late nineteenth century, advances in science and medicine had equipped doctors with a new aetiology of disease and a new range of therapeutic techniques. Many of these techniques, especially those involving surgery, required very specialized after-care, equipment or facilities that were beyond the means of the average physician. Physicians therefore turned to the hospitals, which represented a means of pooling capital resources, giving them access to the tools of these new therapies. The success of these therapies demanded a highly competent corps of bedside attendants who would ensure the rapid and safe recovery of their patients. In order to attract the class of patient who could afford such capital intensive features, hospitals turned away from the charity cases that had previously been their mainstay. One of the keys to attracting the

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[19]Reverby, *Ordered to Care*, 23. Reverby's argument is premised in part on that made by George Rosenberg in *Florence Nightingale on Contagion*.

middling classes to the hospitals was a reputation for respectability. Trained nurses, attuned to middle class mores and sensibilities and possessing specific competence in the delivery of patient care were a part of this equation.[20]

The context for the emergence of the trained nurse was therefore a dramatic shift in the political economy of the hospital. Significant in shaping this change was the seemingly incompatible need of the hospital for a highly skilled, yet low-cost, workforce. This incompatibility was reconciled through the almost exclusive employment of apprentices. Student nurses represented a flexible, subordinate and respectable workforce whose work patterns could be readily adjusted to meet institutional needs. Furthermore, underemployment among women, especially after 1930, and the narrow range of non-industrial forms of women's paid work ensured an inexpensive labour force which would do the work of the hospital uncomplainingly and cheaply.[21]

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[20]The dramatic changes witnessed in North American hospitals in this period are beyond the scope of the present work. For a discussion of hospitals in the U.S., see David Rosner, *A Once Charitable Enterprise*, (New York: Science and History Publications, 1988); Morris Vogel, *The Invention of the Modern Hospital*, (Chicago: University of Chicago Press, 1979); and Charles Rosenberg, *The Care of Strangers*. The Canadian historiography is not as extensive. See David Coburn and C. Lesley Biggs, "Limits to Medical Dominance: The Case of Chiropractic," in *Social Science and Medicine*, 22:10 (1986), 1035-1046; Colin D. Howell, "Reform and the Monopolistic Impulse: The Professionalization of Medicine in the Maritimes," *Acadiensis*. XI:1 (Autumn, 1981), 51-68; S.E.D. Shortt, "Physicians, Science, and Status: The Professionalization of Anglo-American Medicine in the Nineteenth Century," *Medical History*. 27:1 (1983), 51-68; and David Gagan, "For Patients of Moderate Means: the Transformation of Ontario's Public General Hospital, 1880-1950," *Canadian Historical Review*, LXX:2 (June 1989), 151-179.

[21]See George M. Torrance, "Hospitals as Health Factories," in David Coburn, Carl D'Arcy, Peter New and George Torrance, eds., *Health and Canadian Society: Sociological Perspectives*, (Don Mills: Fitzhenry and Whiteside, 1981); and David Wagner, "The Proletarianization of Nursing in the United States, 1932-1946,"

The use of apprentices must be seen foremost to serve the economic needs of the hospital. In inter-war Canada, students were generally paid nominal stipends, with deductions made for uniforms, room and board, and "breakages."[22] They were generally employed for a period of three years, after which time they were recommended by the hospital to write the registered nurses' exam, after which time it was assumed that they would move into private practice. In this respect, North American hospitals differed markedly from their British counterparts. In Great Britain, nurses tended to remain on the staff of their *alma mater* after graduation, whereas in North America, hospitals minimized the presence of staff nurses and sometimes relied entirely on apprentices to fill all but the most senior positions. The economic position of these hospitals was often marginal, and their capacity to employ domestic staff limited.[23] They required not just model nurses, but workers prepared to undertake manual labour, and they tended to recruit among the better educated working classes.[24] Most North American training schools were founded by hospital boards, not by social reformers. Thus, the training school model, originally

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International Journal of Health Services, 10:2 (1980). This argument is germane to Kathryn McPherson's *Bedside Matters*. See especially Chapter 4; and Susan Reverby, *Ordered to Care*.

[22]Detail about the fees, tuition and wages of apprentice nurses across Canada prior to 1930 can be found in George Weir, *Survey of Nursing Education in Canada*, (Toronto: University of Toronto Press, 1932), especially Chapters IX and XIII.

[23]Charles Rosenberg, *The Care of Strangers*, 221.

[24]Charlotte Moran, "From Vocation to Profession," 42-44. For an account of the collision of the British nursing ideal with the demands of the North American hospital, which were conditioned by economic need more than ideology, see Nancy Tomes, "Little World of our Own': The Pennsylvania Hospital Training School for Nurses, 1895-1907," *Journal of Medicine and Allied Sciences*, 33 (1978), 507-530.

constructed as a mechanism for middle class evangelism, was vitiated; instead, hospital administrators and trustees co-opted young trainee nurses as a source of cheap labour.[25]

The hierarchical structure and strict discipline of the training school had both practical and ideological dimensions. By their intermediate year, apprentice nurses often found themselves in charge of a ward by themselves, and in their senior year, they were often placed in supervisory positions. Codes of conduct, enforced by the fear of sanction, ensured that the apprentices comprised a workforce capable of working with minimal supervision. This discipline limited the number of staff nurses that the hospital was compelled to hire. Furthermore, hierarchy and discipline ensured an ordered workforce that would not register collective objection to onerous routines, enabling hospitals to reduce their total workforce.[26] The training school in this period functioned, therefore, as guarantor both of employee discipline and of a small payroll. This discipline was also justified on medical grounds. Before the invention of antibiotics, controlling the spread of disease was a matter of observing ritual cleanliness: Nursing "technique" was a highly ritualized form of behaviour which was designed to protect nurse and patient alike from disease and which secured the reputation of the hospital.[27]

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[25]Barbara Melosh, *The Physician's Hand*, 3; Susan Reverby, "A Caring Dilemma: Womanhood and Nursing in Historical Perspective," *Nursing Research*, 36:1 (January/February, 1987), 7. See also Christopher Maggs, *The Origins of General Nursing*, (London: Croom Helm, 1986), for a perspective on the political economy of the British hospital.

[26]Marjorie Adams Amirault, "The Historical Evolution of Nursing Education in a Diploma Small School," (Unpublished MN, Dalhousie, 1991)61. See also Charles Rosenberg, *The Care of Strangers: The Rise of the American Hospital System*, 221.

[27]Kathryn McPherson, *Bedside Matters*, 90.

Ideologically, the observance of strict discipline and rituals of deference contributed to the creation of a nurse who conformed to contemporary expectations of respectable femininity. In this way, the discipline applied to the apprentices helped to secure the reputation of the hospital as a respectable and credible institution. Many scholars have observed that specific training in comportment was particularly important given the class background of many of the apprentices. Although contemporary literature emphasised their middle class background, many nurses were in fact of rural or working class background, and the rituals of the training school equipped them with the tools that they required to function in bourgeois society both on the wards and later in private practice.[28]

Another ideological dimension of the ritual discipline of nursing technique related to the need to resolve certain contradictions represented by the work of nursing. Mary Poovey argues that this was accomplished, at least in part, by the strict observance of the dichotomy between the male role of curing and the female task of caring, which represented a compromise based on normative female roles in the home. Of Florence Nightingale, she writes:

> ...she was able to take up her calling without arousing religious controversy... [or] antagonizing medical men. Neither a mother nor a professional, she was able to nurture her wards and to supervise sanitary conditions; she was in short, able to make the hospital a home...[29]

Shared experiences were reinforced by uniform procedure and uniform dress.

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[28]For demographic data, see George Weir, *Survey of Nursing Education in Canada*; and Kathryn McPherson, *Bedside Matters*, Chapter 2. For an American context, see Barbara Melosh, *The Physician's Hand.*

[29]Mary Poovey, *Uneven Developments: The Ideological Work of Gender in Victorian England*, (Chicago: University of Chicago Press, 1988), 14.

Nursing uniforms were the most visible outward expression of this quest for respectability. Historians of costume have noted that the dress employed by nurses, much as that employed by nuns, was deliberately anachronistic. These uniforms, modelled on the type worn by domestic servants, at once distinguished the trained nurse from her untrained predecessors and symbolized her subordinate relationship as servant to the patient, the physician and the hospital.[30] Uniforms were also used as a means of signifying and reinforcing the internal hierarchies of the training school. Changes in uniform, like the presence of a cap, the colour of the stockings or the style of the collar or cuffs denoted the progress of the nurse through her training and her place within the internal hierarchy of the hospital much in the fashion of a military uniform.[31]

The uniform as privilege was also used to reinforce the relationships of subordination. One of the most frequently cited sanctions that was applied against a nurse for inadequate performance or transgression of hospital rules was the loss of the cap, a

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[30]Discussions of uniforms form a part of nearly every nursing history, suggesting the place that they occupied in the culture of nursing. Irene Poplin argues for the centrality of uniform to the strategies of hospital reformers. Irene Poplin, "Nursing Uniforms: Romantic Idea, Functional Attire or Instruments of Social Change?, *Nursing History Review*, 2 (1994).

[31]Kathryn McPherson locates the importance of uniform and hierarchy with an amusing anecdote about a physician at Vancouver General Hospital who would not be attended by an apprentice:

> At night we didn't have that many Graduates on, you see, they'd be students on, so our Supervisor always kept white stockings up there and when any of us had to scrub for this man we took off our black stockings and shoes and she gave us white stockings, because he always looked down to see. If he saw white stockings, that was fine and he'd go and scrub...

Kathryn McPherson, *Bedside Matters*, 104.

symbolic demotion to probationer status. This punishment reflected a reality of the power structure within the hospital. Apprentices were in effect indentured to the hospital. If they were expelled or forced to resign their position, they would be unable to claim the right to call themselves nurses or to be listed in the registry. The loss of the cap was a reminder that the hospital was the final arbiter in all matters, and that two or three years of effort would be lost if the nurse did not respect her subordinate role.[32] It was also a punishment that only marginally disrupted the routines of the hospital and the nurses' training. Historians who have tracked dismissals and resignations at hospitals have noted that most occurred early in the training process, suggesting that hospital administrators recognized the skill and value that their senior apprentices represented.[33] From that point on, while undoubtedly those who were less able or less disposed to handle the routine had been eliminated, hospital administrators would have been less willing to terminate an apprentice over a minor transgression, and certainly the nursing histories have been filled with the tales of the exploits of nurses bending the rules while their superintendents chose to look the other way.[34]

The shared experience of apprenticeship relates only partially to the experience of the wards. One of the hallmarks of the Nightingale model was that nurses were required to live in residence. Life in residence was governed by the same rigour and discipline as life

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[32]Marjorie Amirault, "The Historical Evolution of Nursing Education in a Small Diploma School," 40.

[33]Kathryn McPherson, *Bedside Matters*, 43.

[34]Ibid, Chapter 5.

on the wards. Off the wards nurses were expected to maintain high standards of decorum and conduct and were subject to stringent regulations, early curfews, limited access to the outside world, and limited privacy. This highly structured life approached what American sociologist Erving Goffman called the "total institution" where residents work, play and sleep under a single, pervasive authority. Like Goffman's asylum, the archetype of the total institution, nursing schools attempted to forge a uniform work culture.[35]

The totality of the training school experience and the presence of strict internal hierarchies retarded collective resistance to the often oppressive conditions that prevailed within hospital nursing services. Training school, however, is seldom recalled by its graduates as a negative experience. Oral testimonials have tended to show that apprentices recall training as a passage from fear to mastery and pride.[36] The shared experience and isolation of the school of nursing may be argued to have strengthened what Carol Smith-Rosenberg calls homosocial networks within a class of nurses based on a common identification with gender and work.[37] This shared experience may in turn be seen as primary in the constitution of the occupational identity of inter-war nurses that was reinforced by nursing organizations in the private duty world.

The political economy of the hospital made little allowance for the employment of graduate nurses on the wards, especially in North America. It was not until after the Second

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[35]See Erving Goffmann, *Asylums: Essays on the Social Situations of Mental Hospital Patients and Inmates*, (New York; Doubleday, 1961).

[36]Barbara Melosh, *The Physician's Hand*, 49.

[37]Caroll Smith-Rosenberg, *Disorderly Conduct: Visions of Gender in Victorian America*, (New York: A.A. Knopf, 1985).

World War that graduate nurses were well-represented on the wards of the general hospital. After graduation, about one in five nurses remained in the hospital system, generally in a supervisory capacity. Of the eighty percent of graduates who did not continue in an institutional setting, some found industrial or public health work, but most made their way into the freelance market, working as private duty nurses.[38] One of the major preoccupations of the freelance nurse was finding enough work to survive.[39] Although second generation nurses fared better in this regard than their successors, nurses would sometimes go days or even weeks between cases. Money was a perpetual problem. Even when living in the home of a patient, they were required to keep a residence of some sort, often in a rooming house populated by other nurses. Competition between nurses was always a factor, but early in the century, before there was a dramatic over-supply of graduate nurses, the greater competition came from untrained practitioners. Throughout the first quarter of the century, untrained and informally trained women continued to claim the title of nurse, and there was no clear legislative authority or licensing procedure that would distinguish one who had a hospital credential from one who did not.[40] It was around this issue that graduate nurses first coalesced to form regional and provincial nursing organizations to represent their interests. These organizations provided collegial relations in an otherwise isolating occupational experience, united women behind shared occupational interests, and represented a

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[38]Fairly precise details about the composition of the nursing workforce in the 1920s can be found in George Weir, *Survey of Nursing Education in Canada.*

[39]See Barbara Keddy, "Private Duty Nursing Days in the 1920s and 1930s in Canada," *Canadian Women's Studies,* 7:3 (1984), 99-102.

[40]JoAnn Magda Whittaker, *A Chronicle of Failure,* 18-19.

significant means by which this legacy was transmitted to future generations.

Historians of nursing have devoted considerable space to celebrating and assessing the efforts of the early nursing organizations to secure professional standing, but have given comparably little attention to the devices and organizational structures that enabled them to mount their campaigns. Those who have undertaken such an examination have concluded that in order to attract and retain membership, nursing organizations often adopted techniques more familiar to trade unions than professional organizations. This included the provision of services which reflected the fragile economic position of the constituency, such as sick benefits and superannuation funds. Through their registry offices these organizations became the central clearinghouses through which nurses could get jobs and publicize their availability and credentials.

Critics of nursing organizations have often observed that they were dominated by a narrow élite of the graduate nursing population, and indeed it was to serve the interests of this élite that the first such organizations were formed. Although some Canadian hospital administrators had affiliated with the American Society for the Superintendents of Training Schools for Nurses when it was founded at a conference on public health at the Chicago World's Fair (1893), the first wholly Canadian organization was its outgrowth, the Canadian Society for the Superintendents of Training Schools for Nurses, which was formed in 1907, and was to become better known under its later name, the Canadian Association of Nursing Education (CANE). The Canadian National Association of Trained Nurses was founded in 1908 to represent primarily the interests of working nurses. All three of these organizations merged in 1920 to create the Canadian Nurses' Association (CNA), which would endure as

the most prominent and powerful body representing the interests of the nursing community.[41] While the CNA and its predecessors provided a level of affiliation that was national in scope, the more active organization was to be found at the local level, either in the provincial nursing groups or in the alumnae associations of the various training schools.

Membership in a hospital alumnae association provided a variety of advantages and opportunities for gradate nurses. As a social venue, it mitigated the sense of isolation that was often a feature of private practice. Alumnae associations sponsored lecture series and seminars that allowed nurses to stay abreast of the latest changes in medical and nursing practice, and the associations were the locus of charity work and political activity. Many of the alumnae and regional associations also assumed the function of benevolent societies. In a time when graduate nurses seldom had the means to provide for their own medical care or to buy insurance against other calamity, the associations offered group sick-benefits and hospital insurance, and they sold low-cost superannuation funds, a working woman's only protection against the inevitable poverty of old age.[42] Given the geographic dispersion of the nursing community and the nature of the work which frequently precluded attendance at meetings, the nursing associations relied heavily on the mail, and a variety of alumnae

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[41]Kathryn McPherson, *Bedside Matters*, 63. JoAnn Magda Whittaker provides a useful narrative on the formation of the various nursing organizations. JoAnn Magda Whittaker, "A Chronicle of Failure." For a more immediate and detailed account of the formation of these organizations, see John Gibbon and Mary Mathewson, *Three Centuries of Canadian Nursing*, (Toronto: MacMillan Company of Canada, 1947).

[42]On the similarity between trade and fraternal organizations and nursing organizations, see Kathryn McPherson, *Bedside Matters*, 68-70. See also Marie Campbell, "Sexism in British Columbia Trade Unions," in D. Cobourn *et. al.* eds., *Health and Canadian Society Sociological Perspectives*, (Don Mills: Fitzhenry and Whiteside, 1987).

journals as communication tools. One of these alumnae journals, the Toronto General Hospital *Journal* grew to such a circulation that in 1907 it was re-cast as the national periodical *Canadian Nurse*, which was to become the primary organ of the national communications strategy of the CNA.[43]

The work rhythms of the freelance nurse were also reflected in their comparative under-representation in the leadership of those organizations. Although membership was generally open to any trained nurse, these organizations were generally led by members of nursing's own élite. Often, executive positions were held by women who were either in administrative positions at hospitals or who had left active nursing and were living a comfortably middle class married existence.[44] Although married women were generally precluded from the active practice of nursing they were not excluded from those organizations, and married women were frequently active volunteers in the nursing organizations. In this way, some have argued, the nursing association became the dominion of the superintendents and middle class reformers, creating a divide between working nurses and the élite who were directing and structuring the occupation both in and outside of the hospital schools.[45]

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[43]Kathryn McPherson, *Bedside Matters*, 64.

[44]Barbara Melosh, *The Physician's Hand*, 38. See also Kathryn McPherson for observations on the connection between "first wave feminism" and nursing organizations. She observes that their structure and activities reflected that they were born in the parlour rather than the union hall, and that they were infused with the sense of optimism and progress that characterized the pre-war and inter-war feminists. Kathryn McPherson, *Bedside Matters*, 69-71.

[45]Barbara Melosh asserts that a large number of nurses did register an approval of professionalization, but that this was impossible given their gender and given their

One of the primary activities of these organizations was to secure legislative recognition and definition for the nursing "profession." They promoted models of professionalization primarily to address the problem of marginally trained nurses who graduated from the small schools. Nursing leaders pressed for regulation which would ensure a uniform standard for graduate nurses.[46] This was accomplished in some measure by the early 1920s, by which time all nine provinces had established acts which recognized the authority of the nursing associations. The Manitoba R.N. Act which was passed in 1913, gave Manitoba Association of Graduate Nurses the right to set educational standards, representing a significant gain by the nurses. That the act required that a hospital have only five beds to be recognized as a training institution, however, vitiated the potential efficacy of the act in advancing the cause of professionalization. Without mandated standards for training schools, small hospitals continued to employ apprentices as the only economical source of labour. Many schools simply ignored the legislated requirements for prior educational attainment and prescribed curriculum, and many non-certified schools continued to pump out graduates.[47]

It should be noted that none of this legislation actually closed the door on proclaimed practitioners. In essence, the legislation established the rules for membership in the nursing

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subordinate position within the hospital hierarchy. Melosh, *The Physician's Hand*, 7. For a discussion on the nature of professionalization, see J. Burton Bledstein, *The Culture of Professionalism: The Middle Classes and the Development of Higher Education in America*, (New York: W.W. Norton, 1976).

[46]JoAnn Magda Whittaker, "A Chronicle of Failure," 26.

[47]Ibid, 34.

association, but it did not make membership a compulsory prerequisite for the practice of nursing. In this way the legislation was materially different from that which established the professional standing of doctors and lawyers and which gave their organizations the exclusive power to determine who could and could not practice, backed by punitive authority. In this sense, the effort of the early nursing leadership to secure professional status had fallen short.[48] Though the nurses were supported by some powerful members of the medical professions, Manitoba's legislative authorities sided with those who believed that the authority of the medical profession might be diminished by such legislation. Katherine McPherson cites one such practitioner, who wrote in a 1906 article of the *Maritime Medical News*:

> The whole question is this. Is nursing a subordinate profession to medicine, or is it a separate and distinct and independent profession which when it gets old enough, is going to sever every connection with medicine and set up an entirely separate science or art? We will state this proposition less classically: Is the tail going to wag the dog?"[49]

The third category of experience which contributed to the formation of a distinct occupational identity among inter-war nurses was their relationship to the work itself.

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[48]This is the central argument in JoAnn Magda Whittaker. "A Chronicle of Failure."

[49]Cited in Kathryn McPherson, "Nurses and Nursing in early Twentieth Century Halifax," (Unpublished MA, Dalhousie University, 1982), 67. When nursing activists sought legislative authority and professional recognition, they were often met with criticisms that reflected the gender dimensions of the occupation. In attempting to control the market in caring for the sick, nurses were forced to confront criticisms of a society which saw the work as essentially feminine, and was critical of any attempt to control it. For this reason, nursing leaders emphasised loyalty, altruism, collegiality and discipline and shied away from the language of autonomy and credentialism. By doing so nurses essentialized their work. By making caring their duty, it became a function of identity rather than of work. In the words of Susan Reverby: "Autonomy was sacrificed: altruism was sanctified." Susan Reverby, "A Caring Dilemma," 7.

Central to an understanding of the occupational culture of nurses is therefore an understanding of the practical and theoretical dimensions of this work. Much of the traditional nursing history has overlooked or ignored the actual work performed by nurses. While it is to some extent true that the nature and rhythms of a nurse's work have always been determined by the needs of the primary practitioner, this view is too narrow to explain the attachment to "technique" that is so central to nursing culture and the occupational identity. "Technique" is more than the aggregation of procedures undertaken to meet medical needs. It must also be seen as a series of precisely defined protocols which comprise a nurse's proprietary knowledge base. Technique, in this sense, defines the extent of a nurse's ownership and control over her "production" and it is therefore the intellectual construct which nurses employed to define and defend their position within the workplace. [50]

Traditional interpretations have held that before the widespread use of antibiotics revolutionized medical procedures after the Second World War, the fundamentals of nursing technique remained essentially the same. These interpretations have held that only in the post-1945 era have nurses had access to the scientific skills necessary to break their connection with domestic service. This work takes a contrary view, arguing that nursing technique was in and of itself founded upon specific scientific understandings that permitted the nurses to claim a proprietary skills base. It rejects liberal-progressivist claims that, as medicine developed new and more technologically-based procedures, nurses participated

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[50]See Susan Reverby, "The Search for the Hospital Yardstick: Nursing and the Rationalization of Hospital Work," in Susan Reverby and David Rosner, eds., *Health Care in America: Essays in Social History*, (Philadelphia: Temple University Press, 1979).

in ever more complex and scientific procedures. Such histories underestimate the work of earlier generations of nurses.[51] True, by current standards, the work of the inter-war nurses appears to consist principally of domestic chores, but such a conclusion ignores the scientific basis of understanding that informed the work. In brief, it confuses technology with science. There is ample evidence that even in a context where the technological apparatus was limited, scientific principles were being applied. Even many of the mundane housekeeping chores that were a part of the nurse's daily routine such as bed-making, maintenance of hospital equipment, and preparation of trays were structured by rituals that grew out of a contemporary scientific understanding of asepsis.[52]

The actual nature of the work performed depended on the hospital rotation and upon the seniority of the nurse. Probationers and juniors were often relied upon to provide the basic personal services to patients and to perform tasks related to the upkeep of the wards. These tasks reflected not only the lesser skill of the probationer, but the prevailing philosophy that by forcing juniors to do the most menial of task, they would find the "romance" of nursing was supplanted by discipline and practicality.[53] As they acquired seniority, nurses were given more administrative responsibility and were more likely to be found attending a physician. Maternity and operating room work was generally reserved for the most senior students. The first half of the century did witness significant change in

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[51]Celia Davies tackles the liberal-progressive model of progress in "The Contemporary Challenge in Nursing History," Celia Davies, ed., *Rewriting Nursing History*, 12.

[52]Barbara Melosh, *The Physician's Hand*, 31

[53]Ibid, 55

therapeutics, which necessitated dramatic changes in the nature of nursing and how it was applied. The story here is more one of continuity than of change. Late nineteenth century practice emphasised what Florence Nightingale had called "environment." Adherents to this school of nursing emphasised order, discipline and morality as the defining components of good nursing care. These were expressed in strict rules and ritual cleanliness, and reflected in part the role that the nurse was expected to play in maintaining the respectability and decorum of the public wards. By the end of the first decade of the century, these ideas of order and discipline had been supplanted by a new paradigm anchored in a scientific understanding of germ theory and the transmission of disease. By the end of the First World War, this latter foundation was clearly ascendant, and was reflected not only in hospital procedures but in the increasing scientific and theoretical content in nursing curricula.[54]

It is important, however, not to exaggerate the degree to which nurses exercised intellectual control over their work. While ritual formed the basis for a proprietary knowledge and skills base, it functioned at the same time to place limits on the potential ownership over the means of production that a scientific understanding of the work may have provided. The steps involved in most nursing procedures were carefully delineated in a manual of routine, generally written by a physician, sometimes in consultation with a senior nurse. Such prescription of technique alienated the working nurse from the knowledge that underlay her work. In these cases, new procedures and rituals could be used to wrest control over the "means of production" away from the nurse. Making the

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[54]Susan Reverby, "The Search for the Hospital Yardstick"; and Charles Rosenberg, "Florence Nightingale on Contagion."

observation that: "...nurses were trained. But they were not educated," Susan Reverby observes that the emphasis on the efficient discharge of duty and rote learning met the primary requirement of the hospital - that the patient was minimally endangered - but resulted in nurses, for all intents and purposes, being minimally educated.[55] This level of prescription of technique also demonstrated the influence of Taylorism and scientific management, which set further limits on the occupational autonomy of nurses.

Scientific management served to enhance managerial control over production by breaking tasks into their constituent parts and prescribing specific methods for each task. This essentially de-skilled the tasks by removing elements of craft or discretion on the part of the person performing the work. The adoption of Taylorite practices by hospital managers set limits on the intellectual control that nurses exercised over the work that they performed.[56] Whether the nurse understood the scientific basis for the procedures she was performing became irrelevant: ritual replaced understanding. Carefully prescribing each step of a therapy alienated the executors of nursing tasks from the conceptualization of their work. Ritual, in this way, subverted craft and placed the greater measure of conceptual control over the work, and thus ownership over the means of production, in the hands of the managerial class of physicians, hospital administrators and to a lesser degree, nursing

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[55]Susan Reverby, "A Caring Dilemma," 7

[56]Barbara Melosh makes reference to the prevalence of external consultants, lay managers, time management specialists and motion experts in the employ of hospitals, especially in the late 1920s and in the 1930s. Barbara Melosh, *The Physician's Hand*, 163.

superintendents.[57]

Nurses faced the active opposition of the medical community in their quest to define a professional skills base. In many hospitals, nurses were not permitted to view patients' charts, for example.[58] To illustrate the efforts of the medical community to reduce the intellectual content of the nursing curricula, JoAnn Whittaker cites the case of the Draft 1916 Nurses Act from British Columbia. Under pressure from the medical community, a list of required subjects including "bacteriology, materia medica, anatomy and physiology, medical nursing (including contagious disease), surgical nursing (including gynaecology), obstetric nursing and children's diseases," was amended removing bacteriology, appending "elementary" before "materia medica," adding first aid and substituting "sick room cookery" for dietetics.[59]

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[57] Both Melosh in *The Physician's Hand* and McPherson in *Bedside Matters* tackle worker control and scientific management in the nursing context. For more on worker control and the effects of scientific management, see Harry Braverman, *Labour and Monopoly Capital: The Degradation of Work in the Twentieth Century*, (New York: Monthly Review Press, 1984); and Susan Porter Benson, *Counter Culture: Saleswomen, Managers, and Customers in American Department Stores, 1890-1940*, (Urbana: University of Illinois Press, 1986). The latter is especially germane to the nursing context for its emphasis on the co-option of third parties as agents of resistance by subordinate employees.

[58]See Thomas Olson, "Apprenticeship and Exploitation: An Analysis of the Work Pattern of Nurses in Training, 1897-1937," *Social Science History* 17, 4 (Winter 1993).

[59]JoAnn Magna Whittaker, "A Chronicle of Failure," 64. At the same time, physicians were generally supportive of nurse training, recognizing its value in enhancing their own status, entrenching their authority and facilitating the practice of technological medicine. Many historians acknowledge the support of the medical community as expressed in George Weir's *Nursing in Canada* as being critical to the introduction of nursing reform. Weir's personal role as a professor of medicine at the University of Toronto and later as a Member of the Legislative Assembly in British Columbia and a Member of Parliament were also central to reform, as Weir publicized the economic realities of nursing and

Reliance on scientific management techniques extended to include all aspects of nursing practice, not just those procedures ordered by the physician. Every task, including personal bedside care and housekeeping duties such as the making of beds, was clearly delineated in the manual of routine. These routines were practiced in a rote fashion and subject to constant scrutiny within the training hospital. In this way, even the most mundane of tasks were subject to almost industrial "standardization."[60] Modelling every aspect of hospital routine on industrial production served the hospital in several ways. It made good economic sense. Standardization permitted the care of large numbers of patients by a comparatively small staff which, once accommodated to the routine, could work with minimal direct supervision. At the same time, standardization ensured that standards of therapeutic care and decorum essential to the institution's reputational health were maintained. Finally, such techniques served the needs of the managerial élites within the nursing service itself.[61] Celia Davies has argued that this reflects a substitution of scientific understanding with ideology, which was an equally powerful and far more malleable source of occupational identity. Nursing superintendents and other nursing leaders adopted scientific management techniques as a means of legitimizing their position within the hospital hierarchy, and by creating a culture of nursing management, bolstered their own claim to professional status by creating for themselves a legitimating body of professional

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exposed the level of exploitation that many suffered. Marjorie Adams Amirault, "The Historical Evolution of Nursing Education in a Small Diploma School," 97.

[60]See Thomas Olson, "Apprenticeship and Exploitation."

[61] Celia Davies, "A Constant Casualty: Nursing Education in Great Britain to 1939," in Celia Davies ed., *Rewriting Nursing History*, 104.

knowledge.[62]

Despite these limitations, nursing technique equipped nurses with distinct advantages which included self-definition, self-protection and, in the private duty market, protection from exploitation by doctors and patients through their control of the type of work performed. Nonetheless, nurses' experience convinced them of the importance of science in distinguishing the discourse implicit in their work from that of lesser trained practitioners.[63] The apprenticeship system of hospital staffing and nursing education, the network of organizations that graduate nurses created for themselves, and a common understanding of the work they performed all contributed to forge a distinctive occupational identity among inter-war nurses. Their sense of common purpose was formed out of a common experience as skilled but subordinate workers within the hierarchies of the health care system, where they were at once junior to physicians and administrators, but superior to less-skilled workers like attendants, aides and domestics.[64]

At the same time, tensions between the occupations' élite and ordinary practitioners placed limits on the homogeneity of their experience and thus occupational identity. While some élites focused on establishing the credibility and reputation of nursing as a profession

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[62]JoAnn Whittaker, "A Chronicle of Failure," 26; and Marjorie Adams Amirault, "The Historical Evolution of Nursing Education in a Small Diploma School," 3. Tom Olson has done an analysis of the language of nursing literature and has concluded that the language was more managerial than it was medical, and suggests that this language is evidence of the emergence of a managerial class. See Thomas Olson, "Apprenticeship and Exploitation: An Analysis of the Work Patterns of Nurses in Training, 1897-1937," *Social Science History*, 17:4 (Winter 1993), 559-76.

[63]Kathryn McPherson, *Bedside Matters*, 113.

[64]Barbara Melosh, *The Physician's Hand*, 482

through credentialism and professional autonomy, working nurses placed a higher value on the skills they brought to the bedside. These élite and working cultures co-existed within the associations formed by graduate nurses of the second generation, as these organizations borrowed cultural aspects of the women's movement, and trade unionism to meet the social and economic needs of their members and to create the sense of solidarity that informed the occupational culture of the second generation nurses.

Subsequent generations of nurses saw the steady erosion of this sense of solidarity, occasioned primarily by the steady decline in the private duty market after 1920 and its effective collapse with the onset of the Depression. Notwithstanding a growing rift between élite and the rank and file which strained this sense of common cause, a persistent occupational identity rooted in a common identification with skill, shared experience and history, prevailed. This sense of common cause, in turn, was at the root of the ongoing marginalization of other practitioners within the system, including the mental nurse.

Chapter 3 - "From Asylum to Hospital" - The Baragar Years, 1920-1929

Following the damning report of the Canadian National Committee for Mental Hygiene to the Public Welfare Commission in 1919, the Norris Liberal Government was more or less compelled to address the ills of the province's custodial institutions. The general nature of these findings was probably not unanticipated, and likely came as no surprise either to the members of the Public Welfare Commission or to its political masters. Certainly Commissioners Ethel Johns and Alvin Mathers would have been amply familiar with the condition which prevailed in the province's prisons and asylums, and so too should have been the Ministerial Staff at the Department of Public Works. It is therefore reasonable conjecture to suggest that the government permitted the audit in order to create a climate of popular opinion favourable to reform at the province's custodial institutions.[1]

What was surely unanticipated was the deeply critical tone of the report, the extent of the public outcry when the content of the report was disclosed in the popular press, and the calls for a Royal Commission of Inquiry into conditions at the province's asylums. Whatever machinations led to the invitation from the Public Welfare Commission to Clarence Hincks in 1919, the consequences were far reaching. The government stopped short of appointing a Royal Commission, but it responded to the swell of popular outrage with a series of promises that amounted to the commitment to bring the province's institutions in line with the most progressive in the Americas.

The most sweeping of these changes were to occur at the province's mental hospitals. In 1919, the government signified its intention to implement reforms in mental health care

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[1]The CNCMH Report is discussed in Chapter 1.

with a symbolic step: the names of the Hospitals for the Insane were changed. In 1910, the change in the name from "Asylum" to "Hospital for the Insane" had been regarded as a significant statement of the government's commitment to the mentally ill.[2] By 1916, however, Superintendent Hicks at Brandon petitioned to have the "objectionable" name changed to reflect more progressive ideals and changes in the aetiology of mental illness.[3] In 1919, coincident with the passage of the new "Act Respecting the Care and Treatment of Mentally Diseased Persons," which for the first time defined mental disorder as a disease and provided for committal through a hospital rather than the courts, the name of the institution was changed to "The Brandon Hospital for Mental Diseases," a name which it would bear for the next half century.[4]

The change of name in 1919 was symbolic of the desire of the Norris government to effect more substantive changes. In the months that followed, the government unveiled its plans for an expanded facility which would include a fully modern psychopathic receiving hospital, new facilities for the study and treatment of mental diseases, and more acceptable facilities for the care of chronic or incurable cases. A new Office of the Provincial Psychiatrist was created to preside over the Winnipeg Psychopathic Hospital, which was opened as a provincially funded annex to the Winnipeg General Hospital.[5] The

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[2]"Act to Amend the Insane Asylums Act," RSM, 1920 Chapter 30.

[3]BMHCA SB3 F9, *Annual Report of the Brandon Hospital for the Insane for 1916.*

[4]PAM RG18 B2 Box 2, copy of "Act Respecting the Care and Treatment of Mentally Diseased Persons."

[5]A detailed narrative of the changes of 1919, and specifically the opening of the Winnipeg Psychopathic can be found in J. Matas, "The Story of Psychiatry in Manitoba,"

first person appointed to this office was Alvin T. Mathers, who had been a Public Welfare Commissioner. Mathers bore distinguished credentials, having been a staff physician at both the Bloomingdale Hospital in New York and the Boston Psychopathic Hospital, two institutions that were hailed as among the most progressive of their day.[6] Mathers' office placed him in the positions of Resident Superintendent of the Winnipeg Psychopathic Hospital and Non-Resident Superintendent at the Brandon and Selkirk Hospitals, and he was to preside over the sweeping reforms that were intended for the province's system of caring for the mentally ill. Soon after his appointment, the Brandon and Selkirk Mental Hospitals, which had languished for four years under successive Acting Superintendents, both received new, permanent medical officers.

Many of the developments of the 1920s are best understood in terms of personality. A.T. Mathers, C.A. Baragar and C.E. Barnes, Medical Superintendents at Winnipeg Psychopathic and the Brandon and Selkirk Mental Hospitals respectively, represented a new kind of institutional psychiatrist, and they embodied many of the ambitions of the psychiatric profession. Baragar and Barnes had military backgrounds, and all three had taken post-graduate training in psychiatry in the psychopathic hospitals of Progressive America. They imported to Manitoba a belief in scientific psychopathology and the firm conviction that through the application of rigorous scientific observation and pathological study, all forms of insanity were ultimately curable. They also brought with them the insecurities and

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The Manitoba Medical Review, 41 (1961), 361.

[6]T.A. Pincock "A Half Century of Psychiatry in Manitoba." *Canada's Mental Health.* (May - August, 1970).

ambitions of the new psychopathologists. Hindered by the stigma attached to mental illness, the poverty and low social standing of their patients and the absence of a consensus in the medical community about the aetiology of mental illness, they were outsiders deeply anxious to be recognized themselves as members of the medical élite. They sought to be accepted as scientists and physicians, and they sought the validation of the medical community of their explanations for the pathology of mental illness. For them, one route to the validation of their place in the medical community was for the institutions over which they presided to be recognized to be equal in status and calibre to the general hospital.[7] The institutional history of the Manitoba's mental hospitals in the 1920s is therefore distinguished by the efforts of the psychiatric community to equip their hospitals with the hallmarks of the general hospital, including facilities for the delivery of modern "scientific" therapies, diagnostic laboratories staffed by trained pathologists, and, most significantly, training schools for nurses equal in calibre to those in general hospitals.

Many of these ambitions were intended to be met at the Brandon Hospital for Mental Diseases. After the War, the Selkirk Hospital for Mental Diseases became largely a veterans' hospital.[8] Winnipeg Psychopathic was conceived to be the locus of acute care and

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[7]For a discussion of the genesis of Canadian psychiatry, see David MacClennan, "Beyond the Asylum: Professionalization and the Mental Hygiene Movement in Canada, 1914-1928," *Canadian Bulletin of Medical History*, 4:1 (1987), 7-23. On the role of the First World War in shaping psychiatry in Canada, see Tom Brown, "Shell Shock and the Canadian Expeditionary Force, 1914-1918," in Charles G. Roland, Ed. *Health Disease and Canadian Medicine*, (Toronto: The Hannah Institute, 1984).

[8]Indeed, this was not the choice of the provincial government, but rather the military. In an inspection of the Brandon Hospital for the Insane in 1918, the military found what it called "an internal atmosphere of medievalism... filled with depression." It deemed the hospital to be unsuitable for military patients and insisted that they be removed to Selkirk

diagnostic work for the eastern part of the province and a base for mental hygiene work and out-patient services, and there was no need to duplicate these capacities at Selkirk. Brandon, in contrast, was to be the regional centre for mental hygiene activities for the western part of the province. Not attached to an existing general hospital like Winnipeg Psychopathic, BHMD had the potential to become a flagship. In 1920, architectural drawings were commissioned which disclosed the scope of these ambitions. These plans called for the Hospital campus to be enlarged to include a freestanding psychopathic hospital, a stately nurses' residence, "cottages" for acute patients, and a "colony" for chronic, incurable cases and senile dements. The psychiatric establishment sought to create a mental hospital campus rival to that anywhere on the continent, and host to a full range of institutional services that reflected progressive thinking on the treatment of the mentally ill.[9]

If personality is to be a basis for understanding the development of mental health care in Manitoba in the 1920s, then the dominant narrative pattern should be the frustration of these ambitions. The efforts of the medical superintendents to effect changes in the institutional culture were hindered by the post-war recession and, in 1922, the fall of the Norris government. For the greater part of the next decade, the Bracken government imposed upon the institutions a régime of fiscal austerity. Under-funding and under-staffing confounded attempts to provide up-to-date therapeutic care. Efforts to develop a trained nursing service were frustrated both by the resistance of the general nursing community and

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forthwith. PAM RG18 B2 Box 2, Maj. General Guy Fisset to Provincial Secretary [unnamed], 24 June, 1918.

[9]PAM GR64 Box 33, File: "Nurses' Home, Brandon, 1919-23" and BMHCA SB5c contain blueprints of proposed buildings and grounds.

by the conditions which prevailed within the walls of the institution itself. In the end, the best that could be managed was an in-house training school which issued graduates a parchment which was not recognized anywhere in Canada for eligibility to write the Registered Nurse's Exam. In general, old paradigms of custodial care persisted, and working conditions were such that the Hospital was unable to attract the class of nursing attendant that the reformers had envisioned. In 1930, the hospital and its workers remained on the margins of the nursing and medical community.

By the end of the decade, reform at the Brandon Hospital for Mental Diseases had more or less ground to a halt and the labour atmosphere was poisoned. While the medical community had been able to replicate the form of the general hospital training school, it could not deliver on the intangibles. Nurses, not psychiatrists, were the gatekeepers of the general nursing system, and in a decade where the élite of the general nursing community were consolidating their authority by actively excluding marginal practitioners from the discipline of nursing, mental nurses were shut out. Without the promise of future employability and mobility, the nurses developed a culture of resistance to the long hours, poor working conditions and restrictive regulations of the nursing service. By 1930, Baragar had lost the confidence of his employees and he fled Manitoba to become Alberta's provincial psychiatrist.

When the Brandon Hospital for Mental Diseases offered the first lectures to its female attendants in 1921 and instituted a regular program of training one year later, it became the first mental hospital in Western Canada to operate a school of mental nursing. The idea of a training program for mental nurses was neither new nor without precedent, and

must be seen within the global context of the medicalization of psychiatry. David Rothman, in his work on the mental hospitals of Progressive America, has persuasively argued that the ascendent models of asylum care in the nineteenth century, moral treatment, combined with the physical isolation of the asylum, alienated psychiatrists from the rest of the medical community. Describing the early twentieth century embrace of holistic models of mental health as "revolutionary," he cites the work of Adolph Meyer and the rise of the mental hygiene movement as critical to psychiatry's entry into mainstream medicine. [10] This analysis is echoed by Olga Maranjian Church, who addresses the links between the emergence of the mental hygiene movement and the embrace of general hospital models of training for mental nurses.[11] By the end of the first decade of the century, such schools were prevalent in Great Britain, and were becoming the norm at Ontario Mental Hospitals.[12] The first Canadian asylum to implement a compulsory program of training for its attendants in Canada was the Rockwood Asylum in Kingston, which, under the superintendency of C.K. Clarke, began in

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[10]David Rothman, *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America*, (Boston: Little Brown and Co., 1980); Chapter 9.

[11]Olga Maranjian Church, "From Custody to Community in Psychiatric Nursing," *Nursing Research*, 36:1 (January, 1987), 51.

[12]See Mick Carpenter, "Asylum Nursing before 1914: A Chapter in the History of Labour," in Celia Davies, Ed., *Rewriting Nursing History*, (London: Croom Helm, 1980) on the development of asylum nursing in late nineteenth century Great Britain. For a Canadian context, see David MacClennan "Beyond the Asylum" and Cyril Greenland, "Origins of the Toronto Psychopathic Hospital," in Edward Shorter, ed. *TPH: History and Memories of the Toronto Psychiatric Hospital 1925-1966*, (Toronto: Wall and Emerson, 1996); 19-58.

1887 to offer courses based on the Nightingale training model to its female attendants.[13]

The first recorded mention of the possibility of establishing a training school at Brandon came in the Annual Report for 1913, where superintendent J.J. McFadden recommended to the Inspector of Public Institutions that such a plan be implemented as a means of enhancing the reputation of the hospital.[14] McFadden in this instance closely associated the reputation of the hospital and the presence of trained attendants. The correspondence between hospital administrators and government officials remained silent on the issue of attendant training and the employment of trained nurses until 1920, when the newly appointed permanent Superintendent, Charles A. Baragar, made his first Annual Report. Baragar's appointment as Medical Superintendent of the BHMD and of C.E. Barnes at the Selkirk Hospital signified a will and openness on the part of the provincial government to effect serious changes in the operation of its mental hospitals. It also reflected the Norris government's commitment to professionalize the Civil Service and to purge the mental

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[13]Some accounts give 1886. Margaret L. Gorrie, "Nursing," in Edward Shorter, ed. *TPH*, 195; and Dorothy Jean Sillars, "The Development of Community Mental Health Nursing in Toronto: 1917-1947, (MScN: University of Toronto, 1983); 15.

[14]BMHCA SB23 F4. *Annual Report for 1913*. After the destruction by fire of the original Brandon Asylum in 1911, McFadden had been dispatched to New England to tour some of the United States' most progressive mental hospitals. There he encountered trained nursing services. It may be suggested that McFadden's concerns were as much with politics as therapeutics. When the new Hospital was completed in 1913, like many of the public buildings of the Roblin era, it was controversially expensive, and McFadden had come under personal attack by Norris for his management of the project. Trained nurses would have contributed to the showpiece character of the institution, and thus validated some of the expense. For a discussion of the politics of the construction of the new Asylum, see Barry Edgington. "Moral Treatment to Monolith: The Institutional Treatment of the Insane in Manitoba, 1871 - 1919," *Canadian Bulletin of Medical History*, 5:2 (Winter 1988), 167-88.

hospitals of the taint of patronage that had hitherto influenced most appointments.[15]

Baragar's predecessor, J.J. McPhadden, had been superintendent of the hospital for nine years between 1900 and 1916, and his resignation coincided with the defeat of the Roblin Conservatives, with whom he had had close ties.[16] The new Norris Liberals were slow to appoint a permanent superintendent, and in the space of less than four years, the hospital was under the control of three different acting superintendents. Within weeks of the formation of the new government in 1916, McFadden resigned to take the position of House Surgeon at the Dominion Penitentiary at Stony Mountain, taking advantage of the fact that the Conservatives were still in power federally.[17] He was not replaced, and responsibility for the Hospital devolved on Deputy Superintendent R.E. Hicks. Although there is no hard evidence to that effect, there is some suggestion that Hicks proved unequal to the challenge, and he was replaced a year and a half later by J.B. Chalmers.[18]

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[15]Shortly after taking office, the Norris government moved to professionalize and de-politicize the civil service. The Civil Service Commission was created in 1918 with a mandate to recruit to the service by competitive examination. W. L. Morton *Manitoba: A History*, Second Edition (Toronto: University of Toronto Press, 1961); 350.

[16]McFadden was Superintendent between October 1900 and the September of 1903, when he resigned, in part to convalesce from an injury sustained at the hands of a patient, but perhaps also because the hospital was under attack from the Liberal MLA from Brandon for alleged mistreatment of patients. He was reappointed in 1909 when his successor, J.J. Anderson, was pensioned for reasons of infirmity. *Brandon Sun*, April 15, 21, 1903. Biographical details about the early superintendents can be found in T.J.W. Burgess. "Manitoba." in *The Institutional Care of the Insane in the United States and Canada*, Henry M. Hard, Ed. (Baltimore: John's Hopkins"s Press, 1916-17).

[17]BMHCA SB2 F1, Ernie Bunch, Interview with Valerie Heppner, Brandon, 24 March 1973.

[18]Correspondence by Baragar, and to a lesser extent Chalmers, with the Minister and his Deputy hints at Hicks' weaknesses. It suggests at very least that Hicks followed

Chalmers was near retirement at the time of his appointment, having more or less completed a distinguished career as the Superintendent of the Selkirk Hospital for the Insane. His appointment after he had publicly sought retirement had the appearance of damage control, and to be sure, the institution was in disarray when he arrived.[19] In 1917 and 1918, the Hospital was badly understaffed. To cope with the wartime shortages, Hicks had resorted to the depopulation of the hospital. In 1917, for example, he discharged dozens of patients as "cured," tripled the number of patients on probationary release and dramatically reduced the number of admissions.[20] In 1918, Chalmers used his Annual Report, which showed a modest increase in patient population, to gently criticize Hicks' "policy of freely discharging patients, not fully recovered" as a misguided but "practical means of helping out the unusual labour situation created by the War."[21]

When he was appointed in December of 1919, Baragar was the first permanent superintendent since the resignation of McFadden in April of 1916. He was to occupy this position for a decade. Major Charles A. Baragar of the Canadian Army Medical Corps was a late-comer to the study of psychiatry, having developed his interest in the specialty as a physician with the Canadian Expeditionary Force, where his experiences with the

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McFadden's tradition of keeping virtually no patient files. PAM RG18 B2 Box 4, *passim.*

[19]Civil service pensions were not established, but were often granted by Order in Council to senior civil servants. The correspondence of the Deputy Minister suggests that Chalmers campaigned for such a pension, and that he was more or less coerced into staying on the basis of the promise of superannuation. PAM RG18 B2 Box 2, *passim.*

[20]BMHCA SB23 F9, *Annual Report for 1917.*

[21]BMHCA SB23 F10, *Annual Report for 1818.*

devastation of shell shock made him a committed mental hygienist.[22] His medical training was acquired at the University of Manitoba and at the Manitoba Sanatorium at Ninette, where he studied communicable diseases under Dr. David Stewart, who was later to become a close friend and a political ally in the fight for provincially funded preventive health service. In 1915, he left Ninette for the C.A.M.C., where he served as a staff doctor at a base hospital. He returned to Canada in 1918, and, still in uniform, he then took post-graduate studies in psychiatry at the Bloomingdale Hospital in White Plains, New York, and at the Boston State Hospital.[23] It is not clear from the record, but it is probable that, through one of these institutions, he came to the attention of Alvin Mathers, who had held staff positions at both hospitals prior to his return to Manitoba in 1918.[24]

Another feature that must be considered in Baragar's biography is that he was very much in sympathy with the ideals of the nursing community, although he resented the dominion of the general hospital superintendents in the determination of the qualifications of a training school. Traditional interpretations have held that this affinity can be attributed in part to the influence of his wife, and if the governance of the Brandon Hospital for Mental Diseases is seen to have been dominated in the 1920s by the politics of personality, then one

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[22]For a discussion of the relationship between shell shock and the rise of psychiatry, see Tom Brown, "Shell Shock and the Canadian Expeditionary Force, 1914-1918," in Charles G. Roland, Ed. *Health Disease and Canadian Medicine*, (Toronto: The Hannah Institute, 1984).

[23]BMHCA, Unsorted Materials, Sidney J.S. Pierce, "Obituary for Charles Baragar," (carbon copy of original typescript).

[24]For a brief biography of Alvin Mathers see T. A. Pincock, "A Half Century of Psychiatry in Manitoba."

must consider not only Charles Baragar, but also Eugenie Ledoux Baragar. Ledoux was a trained nurse and a graduate of Winnipeg General Hospital. After graduation, she served as a head nurse at the Manitoba Sanatorium concurrently with her future husband. Both left Ninette early in the War to join the Canadian Army Medical Corps, and they married in 1917 while serving at the same hospital in Lenham, France.[25]

Popular histories and reminiscences suggest that Mrs. Baragar had considerable influence on her husband's advocacy of training for mental nurses. There is no surviving evidence of Mrs. Baragar's's formal participation in the affairs of the hospital except records of her serving as hostess to events like Christmas dinners in the Nurses' residence, nor is there evidence which shows her to have actively participated in the graduate nurses' community in Brandon. Nonetheless, the frequency with which her name is mentioned in connection with the founding of the nursing school suggests an influential, if informal, role.[26] Some indication of Mrs. Baragar's role is to be found in a letter written to the Curators of the Brandon Mental Health Centre Museum in 1989. Prompted by newspaper reports of the Hospital Centenary, Barbara Johnstone, the relative of a patient consistently refers to Dr. and Mrs. Baragar collectively. She writes in this letter that her uncle, a veteran whose breakdown was attributed to wartime stress, and who should properly have been sent to Selkirk, was committed to Brandon because her aunt who was a nurse, was familiar with

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[25]Sidney J.S. Pierce, "Obituary for Charles Baragar."

[26]Thomas Pincock, who was Assistant Deputy Miniter of Health in the 1920s, for example, in his history of psychiatry in Manitoba, puts them on the same plane: "Doctor and Mrs. Baragar (the latter a trained nurse) were pioneers in this movement [the establishment of training schools]. BMHCA SB1 F1a, T. A. Pincock, "The Care of the Insane in Manitoba," (unpublished manuscript, 14 November 1933); 6.

the Baragars' reputation.[27] She closes the paragraph with the exclamation: "How kind he and his wife were!"[28]

Perhaps the most persuasive evidence of the influence of Mrs Baragar, however, can be found in the words of Dr. Baragar himself, who wrote to his successor Thomas Pincock:

> Mrs Baragar was always so deeply interested in mental nursing and the progress of the training school for Mental Diseases at Brandon -- In fact had it not been for her interest and encouragement we might have been much slower in getting established than we were -- that I would like to do something, if I may, to perpetuate the memory of that interest. It is not much but it may perhaps help to remind the nurses there in what was the first mental hospital training school in Canada west of the Great Lakes. That the work was begun in the first place with the earnest thought and support of a very small group of women, not the least among them was Mrs. Baragar... I thought that I would like to present a medal in gold to the nurse attaining the highest aggregate standing in the combined affiliate course in Mental and General Nursing when that materializes.[29]

Such a course did not materialize for more than a decade, but the first Blanche Eugenie Baragar Medal, "presented annually to the graduating nurse who throughout her course has manifested those qualities of compassion and efficiency exemplified by Mrs. Baragar," was presented to a Diploma of Mental Nursing graduate in 1931.[30]

Although Baragar was appointed in December of 1919, he did not assume his post

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[27]There are periodic references to veterans at Brandon, like Red Cross Packages that were sent to patients at Christmas, but after 1919, all Dominion War Veterans were to be housed at the Selkirk Hospital For Mental Diseases. PAM RG18 B2 Box 4, Baragar to McLean, 16 December 1925.

[28]BMHCA, Unsorted materials, Barbara Johnstone to Jessie Little and Doug Smith, 8 October, 1989.

[29]BMHCA, Unsorted materials, T.A. Pincock to Miss B. Pullen, Supt. of Nurses at Winnipeg General Hospital, 20 August, 1946.

[30]BMHCA, Unsorted materials, Blanche Eugenie Baragar Medal parchment.

at the Hospital until April of 1920. In the intervening months, he toured some of the most progressive mental hospitals in the United States, stopping for extended visits at the Bloomingdale Hospital, the Manhattan State Hospital, the New York State Psychopathic Hospital and the Boston State Psychopathic Hospital. His intention was to garner as much information as possible about the operation of these hospitals, and to formulate recommendations which would form the basis for reforms in Manitoba.[31] The Hospital remained in this period under the acting superintendency of Richmond Goulding. Goulding, also a military doctor, was appointed in May of 1919. He was discharged early from the R.A.M.C. to relieve acting superintendent Chalmers, whom the Deputy Minister perceived "must be provided with assistance immediately or he would assuredly collapse."[32]

The change that Baragar represented was evident in the confident tone of the first Annual Report which he submitted to the Minister of Public Works early in 1921. This document, as much as any other, captures the optimism and ambition he brought to the institution. While the reports of his predecessors were almost apologetic about the expenditures of the Hospital and often padded with statistics which exaggerated its cure rates, Baragar's first report boldly communicated a vision for change. He did not hesitate to point out either the inadequacies of the Hospital or those of his predecessors. For

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[31]BMHCA SB23 F12, "Annual Report for the Brandon Hospital for Mental Diseases for the Year Ending 1 December 1920 [Annual Report for 1920], Typescript Version." Baragar was appointed in December of 1919, being released early from active service with the C.A.M.C. to take the office. Richmond Goulding, also R.A.M.C. was concurrently appointed Deputy Superintendent and immediately relieved Chalmers, who finally got his pension.

[32]PAM RG18 B2 Box 2, Oxton to Acting Director of medical services for Winnipeg C.A.M.C. [unnamed], 3 May 1919.

example, he changed the reporting system for discharged patients, eschewing the habit of over-reporting cure rates as had been the practice of his predecessors, and he honestly admitted that only 19.7% of those he discharged could meaningfully be considered cured. Proper care, he insisted, was impossible in the existing circumstances, and meaningful cures required the administration of scientific psychopathology in a modern, adequately staffed hospital.[33]

To this end, Baragar showed he was willing to stand his ground with respect to the authorities in Winnipeg and Selkirk. He told the Minister flatly that he would no longer accept the "pernicious policy" of dumping the most unmanageable cases on Brandon. He complained that of 349 patient transferred from Selkirk in 1920, all but 59 were hopeless incurables:

> The presence of so large a number of undesirable patients has had a very detrimental influence on the whole institution, lowering the general tone, increasing the tendency to descent of the other patients with whom they are associated, discouraging physicians and attendant staff in their desire to achieve results, and increasing the *per capita* costs. Only one reason can be adduced for transferring such patients from one institution to another, and that is for the purpose of making the Receiving Institution a Chronic Colony, and that only.[34]

Certainly this version of BHMD as a chronic care facility was at odds with Baragar's idea of a modern psychopathic hospital. He complained that the resources allocated to him and the prevailing conditions in the hospital as he found it made proper clinical work nearly impossible:

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[33]BMHCA SB23 F12. *Annual Report for 1920.*

[34]Ibid.

> During the year, there has been much uphill work and in many respects it has been discouraging. The medical Staff has been so short-handed that it has been impossible to do much more than provide each Patient with custodial care and the treatment of urgent physical ills. Individual attention so necessary in the treatment of Mental Diseases has been almost out of the question. Owing to the overcrowded conditions of the large wards of the Hospital, adequate classification has been impossible. Convalescents have perforce been mixed with dements. Acute disturbed cases have had to be grouped with disturbed dements. Daily has the urgent need of a well-equipped and well-organized Occupational Department been felt. Owing to the large proportion of Dements [sic] and disturbed cases or untrustworthy Patients, it has been difficult to get enough help to carry-out the various Industrial Departments so necessary for the well-being of the Patients themselves, and of such economic importance to the Institution itself. The absence of a Pathological Department has served to impress the Medical Staff with its extreme importance and its daily usefulness to any living Institution.[35]

Baragar hailed the government's incipient conversion. Citing the direction of the Commission of Public Welfare published in 1917, he commended the Minister to act quickly to construct a nurses' residence and Reception Unit for the diagnosis and treatment of acute cases, calling the latter "the Keystone on which the efficiency and success of the whole institution depends."[36] Baragar then went on to map out his vision of the ideal organizational structure of the hospital. This section was the largest in the Report, and it followed the rather lofty sub-heading, "General Survey of Future Policy."

Under "Acute Services," Baragar again made the case for a fully equipped psychopathic hospital capable of facilitating "the most searching investigation of new

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[35]Ibid.

[36]Ibid. In fact the Public Welfare Commission was only created in 1918. It is probable that the document to which Baragar refers to is the Report of the Public Welfare Commission of 1919, which made such a recommendation. [MLL *Second Interim Report of the Public Welfare Commission of Manitoba*, (Winnipeg: King's Printer, February 1919.]

admissions, containing Laboratory, Operating Room, Departments for Hydrotherapy, Electrotherapy and Occupational Therapy." To this section he added a convalescent centre built on the cottage model, offering ample grounds and recreational facilities, and a Social Services Unit equipped to monitor probationary patients after discharge. Under "Chronic Care," he called for "as stable an environment as possible for those patients who have lapsed into an incurable state."[37] He argued that given the especially impaired judgement of these individuals, extra care should be taken to safeguard the physical health of the patients. Baragar also suggested that industrial work should be limited to those patients in the chronic wards. Implicit in this comment is the recognition that much of the work performed by patients in this period was economic more than it was therapeutic, and an inappropriate occupation for patients destined for discharge. Finally, under the banner of "Auxiliary Services," he included not only shared departments like the recreation department, but a small, fully equipped general hospital.[38] Clearly Baragar recognized the desirability of such a unit from the point of view of patient care and the isolation of contagion. He also must have recognized the prestige that would accrue to the hospital if it were able to claim the presence of mainstream medical services.

The Annual Report for 1920 was more than a laundry list of the deficiencies of the institution and its staff. Baragar set the precedent here for reporting in detail the work of the hospital which validated its claims to be a medical facility. Characteristic of this tendency was the habit of reporting in great detail the work in the Laboratory. This and subsequent

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[37]BMHCA SB23 F12, *Annual Report for 1920.*

[38]Ibid.

reports contained itemized lists of procedures performed, and the page space allotted was out of all proportion to the actual role of the lab in the day to day operations of the hospital. In a similar vein, sections on therapies and medical procedures provided a detailed enumeration of procedures performed, quantitative proof of the institution's hospital status. This section also shared a feature in common with other reports, and that is Baragar's's use of the Report to make petition directly to the Legislature for improvements to the Hospital. In 1920, for example, he included a section on "Electrotherapy and Hydrotherapy" which simply noted that due to the lack of adequate facilities, no such services were offered.[39]

The Annual Report for 1920 also gave some indication of the prevailing labour situation, and particularly of the transiency of the female staff and the chronic shortages of female attendants. Baragar indicated that in 1920, for the first time, the male staff was put on an eight hour day, although he made no mention of the labour dispute that occasioned this change.[40] He noted that at the same time there was no possibility of instituting the same

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[39]Ibid.

[40]In 1919, before Baragar came to the Hospital, male and female attendants both formed a Union to press their grievances, primarily with the conditions and hours of work. Although the events of the Winnipeg General Strike derailed the process, the attendants persuaded the Civil Service Commission that the eight hour day should be instituted. As later events revealed, implementation was not entirely successful. Baragar in fact never expressed any enthusiasm for the eight hour day for nurses. In 1923, he wrote to Mathers:

> As a result of three years experience I am of the opinion that the straight eight hour shift is unsatisfactory... because in general eight consecutive hours on duty is perhaps not conducive to the best service, also sixteen consecutive hours off duty as at present arranged has not been in my experience in the interest of good ward administration nor in the interests of the nurses themselves;, in fact in my opinion it does anything but encourage a nurse to take the desired interest in the work.

BMHCA SB3b F9, Baragar to Mathers, 25 May 1923. See also BMHCA SB3 F5, File:

arrangement for the female staff, as "no sufficient staff has been available to put this into effect, though by arranging more time off duty the number of duty hours per week has been materially reduced."[41]

Throughout the Annual Report for 1920, Baragar made reference to raising the standards of care and increasing the application of scientific principles to the matter of classification and care of the mentally ill. Such changes must have assumed the introduction of a type of attendant with much higher skills than had theretofore been employed at the hospital, but it was not until the final pages of the Report that specific reference was made to the non-medical staff. This section revealed, however that fundamental to Baragar's vision of the hospital was the creation of a nursing service closely modelled on the general hospital school of nursing. A trained staff, he argued, was indispensable to the proper care and classification of mental cases, and this was to be best achieved through the immediate establishment of a school of nursing and the hiring of trained head nurses who would attend to the needs of male and female patients alike.[42]

Baragar concluded the Report for 1920 with a statement which conveyed the optimism and moral suasion that he hoped would convince the government of the merits of his plan:

The past has been dark. The present leaves much to be desired, but the

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"Hours of Work, 1919-57" and BMHCA SB31 F2 File: "Correspondence Re: The Mental Hospital Workers Federal Union," *passim.*

[41]BMHCA SB23 F12, *Annual Report for 1920.*

[42]Ibid. Baragar does not make the case for females in the chronic service, but for infirmary nurses and nurses on the acute wards.

> future is full of promise. The Province of Manitoba is commencing to realize that and acknowledge the just demands made upon it by those who are mentally defective or mentally ill.[43]

Despite the optimism conveyed by Baragar in the Report for 1920, changes were not immediately forthcoming.

In 1920, the Annual Report for the Winnipeg Psychopathic Hospital stated that "The state of overcrowding in the two institutions at Selkirk and Brandon has become so acute that it has become necessary, in some degree at least, to prevent further overcrowding by holding patients out of the hospital..."[44] Mathers' proposed remedy was, not surprisingly, the same as Baragar's. Although the overcrowding at the province's mental hospitals was conditioned primarily by bed shortages, Mathers also felt that the capacity of the hospitals was diminished by their inability to attract adequate staff. He concluded that the "most outstanding difficulty has been the retention of an adequate female nursing service." Elsewhere, he noted that "We have been able to keep the staff of male attendants well up, but at neither of the institutions outside of Winnipeg has it been possible to provide an adequate number of nurses."[45]

Throughout the 1920s, the Annual Report continued to be a politically charged document wherein Baragar employed, in combination, optimism about the future, faith in science and mental hygiene, and the government's obligation to propagate this social vision

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[43]Ibid.

[44]BMHCA SB2f [Carbon Copy of Typescript for Sessional Papers: Introduction to Section on Public Institutions], Mathers to Oxton, 20 December, 1921.

[45]Ibid.

of mental health care. As such, they are useful documents not only for establishing the narrative of the development of the institution, but also for discerning the politics of change and the role of individual personality and ambition in directing it. In 1921, for example, Baragar invoked moral arguments in his call for capital improvements when he emphasised that nearly half of the 40 deaths in the hospital could be attributed to the "stress and exhaustion associated with psychotic episodes." He argued that:

> With proper hydrotherapeutic equipment and the constant attention of a full staff of well-trained mental nurses it is possible that some of these deaths may have been prevented, and as the psychosis in each case was of a recoverable type, the patient, once past the crisis might have returned again to his friends and a useful life. These needs should be largely covered with the opening of a well equipped psychopathic department and the organization of a training school.[46]

Under-staffing was to be a chronic problem for the Hospital. In 1921, Baragar projected that the hospital needed a minimum complement of six physicians, exclusive of the pathologist and the superintendent of the psychopathic hospital, in order to meet the minimum needs of the patients. At this time, there were only two physicians, plus occasional summer interns and a lab technician.[47] With respect to the non-medical staff, the hospital seldom suffered from a serious deficiency of male attendants, but Baragar complained of "frequent and numerous" staff changes which rendered the hospital unable consistently to meet the most basic need of the patient population.[48] While the male

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[46]BMHCA SB23 F13, *Annual Report for 1921.*

[47]Reta McCullough, C.A.M.C., was a graduate nurse, and although she was titularily only the Lab Technician, she in fact performed in the capacity of a pathologist until the arrival of a physician-pathologist, Mary McKenzie, in 1928.

[48]BMHCA SB23 F13, *Annual Report for 1921.*

attendant staff was considered to be minimally adequate, institutional correspondence reveals the female staff to have been wholly inadequate, "so much so [in 1921] that it has been impossible to properly supervise patients on the wards, not to mention the organization of work and exercise parties."[49] The implementation of a school of nursing can be seen in this context to serve not only the ambitions of the medical superintendent to enhance the efficiency and reputation of his hospital, but to address a state of perpetual labour crisis that prevailed on the female wards.

The first steps towards the establishment of a school of nursing were taken in October of 1920. Although a formal training school was not established until the following year, lectures in mental nursing were offered for the first time to those staff who wished to take them.[50] The Superintendent recorded in his Annual Report that the medical staff at the Hospital provided about eighty lectures in mental hygiene and related subjects over the course of the year, and that a further three laboratory demonstrations were put on by the Lab Technician. He reported that the lectures were attended by "a fair number of the attendants, both male and female.. [who were] sufficiently interested to attend regularly." Baragar commended these staff and saw it as a sign that they were "coming to regard their duties

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[49]Ibid.

[50]Ibid. The Annual Report for 1921 was the first to reserve a special place for the Training School, even though a training school would not be in place for another year. In this section of the report, Baragar noted that his failure to establish a training school to that point could be attributed to a variety of factors, including the lack of medical staff and trained instructresses to deliver courses and the absence of proper accommodations for apprentice nurses. Primary among those factors was the chronic staff shortages at the hospital. Nursing staff were already working hours that the superintendent acknowledged to be undesirably long, and due to persistent staff shortages, it was almost impossible to spare the nurses from the wards for lectures during their working day.

more in the light of nurses than of guards, and to regard the Institution as a Special Hospital rather than an Asylum."[51] There is no indication of the eligibility requirements to attend these lectures, whether male and female attendants attended together, nor of how many of these lectures were repeats offered to accommodate the rhythms of shift work.[52]

Although the first courses were optional and were represented as a means of individual career advancement, Baragar signalled as early as his Annual Report for 1921 his intention to make the courses compulsory for all staff in direct contact with patients. Furthermore he revealed his ambition to implement a proper female nursing service throughout the hospital:

> It is further considered advisable that female nurses should be assigned certain of the male wards, especially the Reception and Infirmary departments. There is abundant evidence that the natural aptitude of women for nursing, their superior tact and intuition in caring for those who are sick, is a very valuable asset in mental work.[53]

Baragar wrote in his Annual Report for 1921 of his strategy to attract women of the middle classes in to the service of the Hospital:

> No effort should be spared to impress upon the public at large and young women in particular the greatness of the work at hand and the need there is for the finest type of young women to train as nurses in hospitals such as these. The nursing of mental patients requires women of finer personality, of wider sympathies, greater self-control and higher intelligence than even the nursing of those who are physically ill.[54]

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[51]BMHCA SB23 F13, *Annual Report for 1921.*

[52]Although the language of Baragar's report suggests that each lecture was presented twice. BMHCA SB23 F13, *Annual Report for 1921.*

[53]Ibid.

[54]Ibid.

Central to the strategy of attracting this "finest type of young woman" was the construction of a nurses' home. Available accommodation did not meet the standard of even the poorest hospital nursing school. Prior to 1922, female attendants slept in four-bed dormitory annexes to the wards. This was clearly out of keeping with ambitions for creating a nursing service populated with young women of the respectable middle classes. The creation of a respectable school of nursing therefore hinged not only on attracting a staff of trained instructresses to create the proper cultural context and to impart the non-medical elements of nursing education, but also a proper residential environment. Aptly, then, construction of an elaborate nurses' residence, offering single-room accommodation for senior students and finished in the fashion of a stately home, was commenced even before construction of the reception hospital.[55]

Some of the Ministerial correspondence regarding the Nurses' Residence is illuminating in that it reveals the conflict between the prevailing culture at the hospital and the ambitions of Baragar, Mathers and the psychiatric community. In a report to the Minister in December of 1921, Deputy Minister S.C. Oxton wrote of the activities of a committee involving the architects, Mathers, Baragar, Barnes and himself. The Deputy Minister revealed that the plans for the building extended beyond the establishment of a training school and anticipated the creation of a post graduate program:

> A great amount of thought has been given to every detail. It is designed to provide a suitable home and training quarters for seventy-five nurses, whom I am given to understand, will be Graduate Hospital Nurses taking [a] Post Graduate Course in Mental Nursing, and will undoubtedly be educated,

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[55]To be fair, this decision was conditioned also by the relative economy of the project, and also by the need to alleviate the severe overcrowding in the female wards.

refined young ladies who come from good homes.[56]

The necessity of providing for such a class of nurse was not without its controversies, and the lavish amenities of the nursing home and high construction costs were challenged by Chief Attendant Charles McRae. Oxton answered the criticisms with the following:

> The next step in the conversion of the Asylums into Hospitals necessitated the Accommodation for housing and training of the right kind of girl in mental nursing, viz:- the Hospital Nurse; it being the ultimate objective to eliminate what is at present known as the 'male and female attendants' and staff both sides of the Institution with Nurses and Orderlies...
> This is the first point at which Mr. McRae falls down fundamentally; he has the idea that the Nurses' Home is to house the type of female Attendant that is at present found in the Asylums and for which he thinks that the crudest of accommodation is good enough. Mr. McRae is living in an age long past.[57]

Beginning in 1922, two courses were offered at the Institution and a formal process of evaluation was introduced. The first was a Mental Nurses' Diploma Course. It was a two year program and included courses in Anatomy and Physiology, Nervous and Mental Diseases, Psychology, Bacteriology, Sanitation and Hygiene, Elementary Pathology, *Materia Medica* and Toxicology, Nursing of Mental Diseases, and General Nursing.[58] In its first year, this course was compulsory for all female attendants in supervisory positions, and was open to all members of the female attendant staff. Although the course had no official

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[56]PAM GR 34 Box 33. "Memorandum for the Minister" [Oxton to McPherson], 7 December 1921. That the ambition of the medical community should tend towards the creation of a post-graduate program is consistent with the known affinity of the three superintendents to mental hygiene work. All three were of the belief that all nurses should be compelled to do training in mental work.

[57]Ibid.

[58]BMHCA SB3 F1, "Results of the Examination in Order of Standing, May 1923." Course names changed frequently.

sanction from the province, it was approved by the Provincial Psychiatrist and exams were set with the assistance and advice of the University of Manitoba Medical College.[59] In addition to the diploma course, a brief course which included demonstrations in Anatomy and Physiology, Mental Diseases and Practical Nursing was also offered. This latter course was compulsory for all of those who elected not to take the Diploma Course.[60] A male attendants' course was also conceived which included instruction in Anatomy and Physiology and Mental Diseases. This course was not compulsory, and due to limited interest and teaching resources, it did not run every year.[61]

In 1924, a direct relationship was established between completion of the training courses and compensation. In a letter to the Deputy Minister in the spring of 1924, Baragar wrote:

> In view of the fact that there is a tendency on the part of some members of our nursing staff not to take seriously their opportunities to improve themselves in the skill and knowledge of nursing mental cases without something of a monetary reward, I would recommend that the automatic increase in salary from $45 to $50 a month hitherto taken [sic] place at the termination of three months' service be changed to take place after the successful passing of the first year examination of the Diploma Course.

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[59]Ibid. and "Examination Results, Senior Class, 1925." Course names changed often. The lack of official sanction was to become an issue in 1926, when the authority of the Superintendent to unilaterally exclude nurses from lectures was challenged. PAM RG18 B2 Box 3, "Return to the House," 26 March, 1927.

[60]BMHCA SB23a F2, *Annual Report for 1924.*

[61]Factors cited for the course not being offered every year included a lack of available physician time to provide lecture, lack of interest, and the lack of new candidates due to the relative continuity in the male inside service. In 1927, the male course was cancelled mid-term owing to a shortage of medical staff. BMHCA SB23a F6, *Annual Report for 1927*, and BMHCA SB6 F2, "Return to the House #30" Copy of letter, Baragar to All Male Attendants, 1 May 1928.

As an incentive to the male attendants to take the voluntary course he recommended that the same principle apply to the granting of salary increments to them. This would have had the effect of deferring planned increments to some staff members by as much as one year, and he promoted this to the Deputy Minister as an "economic expedient."[62]

The first class graduated from the Diploma Course in 1925 to much public acclaim. The Hospital published the names of the graduates in the Brandon and Winnipeg newspapers, and C.M. Hincks, Dean of Medicine at the University of Toronto and the primary author of the damning 1919 report of the Canadian National Committee on Mental Hygiene, was on hand to make the address to the graduates.[63] This first class saw seven women receive diplomas, and in the following year, ten more women completed the program and a further six male attendants completed the attendants' course.[64] To outward appearances the program had the desired effect. Baragar reported in his submission to the Minister for 1924 that for the first time in his tenure at BHMD that, "A sufficient number of satisfactory applications for training have been received to meet our needs, and we are able to maintain a fairly high educational standard."[65]

From the outset, the designers of the program of instruction on Mental Nursing, who included Baragar, Mathers and Barnes, recognized that in order for the program to attract suitable candidates, it would be necessary to be able to offer the possibility of continuing

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[62]PAM RG18 B2 Box 3, Baragar to McLean, 2 April 1924.

[63]*Brandon Sun*, 19 and 21 June 1923.

[64]BMHCA SB23a F1, *Annual Report for 1924.*

[65]Ibid.

into a general nursing career. They proposed that this need would be best met by creating a three year affiliate program in general and mental nursing. Such a program was imagined to consist of a two year course of instruction at the mental hospital followed by a year of training at a general hospital. Graduates of this program would be recognized to have standing sufficient to qualify for registration with any of the provincial registries, and they would have specialty training in the care of mental patients that would make them especially suitable as administrators, supervisors and staff nurses at a mental hospital. These goals were frustrated by the absence of any hospital willing to strike an affiliate relationship. Baragar lamented the "lack of knowledge about what has been accomplished in mental nursing" and "the feeling on the part of Registered Nurses that the training of nurses should be the prerogative of the General Hospital and finally the fear that the profession of nursing may become overcrowded."[66] Even before the "crisis" in private duty nursing which closed the ranks of registered nurses even further, the élites within the nursing community were reluctant to propose affiliation and to recognize the legitimacy of a mental hospital based nursing school.

In 1925, there was a small advance in this respect. In that year, Baragar secured an agreement with the Sister Superior of the St. Boniface General Hospital in Winnipeg to do a two year trial of such an affiliate course. Under the plans laid down for the trial, BHMD students who had passed their second year exams would be eligible to take an eighteen month course of training at the general hospital, after which time they would be recommended to write the Registered Nurses' examination. The course would thus be three

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[66]BMHCA SB23a F2, *Annual Report for 1925.*

and one half years in duration, and it not only would lead to eligibility to become a Registered Nurse, but also would include a special Certificate in Mental and General Nursing issued by the Provincial Psychiatrist.[67] To all accounts, this was the first program of its sort in Canada. In 1927, the first two women completed this course, and in the following year, four more graduated. Five of these women returned to the employ of the Hospital as supervisors and staff nurses[68]. This second class was also to be the last, and the program was terminated after three years. It is not clear from the archival record what the reasons for this termination were, but it was concurrent both with changes in the Registered Nurses' Act, which reflected a concerted effort to exclude mental nurses from eligibility for registration, and with labour problems at Brandon which damaged both the Hospital's reputation and its capacity to deliver adequate nursing instruction.[69]

Although the affiliate program was to collapse in 1927, representing a significant setback in the efforts to bring respectability to the School of Nursing, that year also witnessed a significant step forward, and that was the establishment of a post-graduate program. In its first year, the course attracted four students for a three month course of lectures and practical ward experience. The course was open to Registered Nurses or

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[67]BMHCA SB23a F1, *Annual Report for 1924.*

[68]PAM RG18 B2 Box 4, "Data Re: Staff, Brandon Hospital for Mental Diseases, 31 October 1927." and BMHCA SB6 F2, "Return to the House 40,1 and 40,2: Staff Lists." nd [ca. 1928].

[69]An unpublished history in the BMHC Archives also indicated that in 1927, two Brandon Nurses were accepted into the University of Manitoba Registered Nurses Program as Affiliates, but no other reference to these two nurses has been found. SB 6 F1. [Lloyd Henderson] "History of the School of Nursing," nd [ca. 1960].

graduates of a recognized training school, and at its completion, the graduate was presented with a post-graduate certificate in mental nursing.[70] This program fulfilled many of the hospital's needs, although it had occasional problems of recruitment in those first years, attributable perhaps to the reputational damage associated with the labour troubles of the 1926-8 period. Especially after 1929, when unemployment forced many nurses into institutional service, the hospital was able to attract and retain graduate nurses in greater numbers. The presence of hospital trained nurses on the wards increased the standards of medical care and facilitated the implementation of new therapeutic techniques. Many of these graduate nurses remained at the hospital, and the establishment of a post-graduate program provided a ready pool of staff nurses and supervisors which facilitated many of the changes in the service in the 1930s.

The establishment of a school of nursing was the keystone of a broader strategy to implement a progressive therapeutic régime at BHMD. Evidence of this agenda can be discerned in other developments at the Hospital. Most significant among these was the construction of a freestanding psychopathic hospital. Referred to officially either as the Reception Hospital or the Receiving Unit, this facility was known simply as The Unit. It was at once the locus of many of the most significant changes in the rhythms of Hospital life and the most obvious outward manifestation of the changing philosophy of psychiatric care.

Before the opening of the Unit, another area of visible change in the early 1920s was in the area of pathological work. A lab technician was hired in 1921 to operate the

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[70]PAM RG18 B2 Box 3, Mathers to McLean, 18 November, 1927.

laboratory.[71] Notwithstanding that the position of pathologist was not filled until 1928, a considerable body of pathological work was done at the Hospital under the charge of technician Reta McCullough and with the assistance of medical interns from the University of Manitoba.[72] In 1929, the Superintendent was able to report that the lab was sufficiently advanced that it was able to "unofficially" perform work for the Province and for the City of Brandon, and he requested that this capacity be officially recognized.[73] The laboratory became one of the heralded successes of the hospital, and it figures prominently in the institutional correspondence, where Baragar carefully quantified the work of the "scientific centre of the hospital." The Superintendent's emphasis on the laboratory may be seen to have several origins. The first was personal. Prior to his entry into psychiatry, Baragar had trained and worked as a pathologist.[74] Beyond his personal affinity for pathological work and pathological explanations for the cause of mental illness, the Hospital's emphasis on its

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[71]RG18 B2 Box 4, Copy of text of Order in Council Appointing Reta McCullough to the position of Laboratory Technician, 1 May , 1920.

[72]At first the Laboratory was rather rudimentary, and it was only able to perform the most basic tasks like blood counts and urinalysis. In 1925, the lab benefitted from the installation of basal metabolism apparatus. In the same year, it was taken over by Mary McKenzie, a medical intern (and also a graduate mental nurse), while McCullough obtained further training and credentials. In 1927, the hospital hired an assistant lab technician, and in 1929, McKenzie returned to the hospital as a physician-pathologist. PAM RG18 B2 Box 3c, Baragar to McLean, 2 August 1927; PAM RG18 B2 Box 3b, Baragar to Bowman, 11 August 1924; and PAM RG18 B2 Box 3, Baragar to Mathers, 1 December 1924.

[73]BMHCA SB23a F7, *Annual Report for 1929.*

[74]Baragar's work as a pathologist took place at the Ninette Sanatorium, where he researched communicable diseases. As a medical student, he was remembered as an accomplished laboratory researcher and for the series of paraffin tissue sections he donated to the teaching laboratory. Sidney J.S. Pierce, "Obituary for Charles Baragar."

laboratory reflected his desire to be seen to be doing active medical work. The Lab, despite its deficiencies, like the school of nursing, was one of the few areas of real and demonstrable advance for the Hospital.

Baragar's ambitions to re-cast BHMD as a psychopathic hospital were early frustrated by the post-war economic slump and changes in the province's political culture. In 1922, the Liberal government was defeated at the polls and was succeeded by a United Farmers government under John Bracken. The Norris government's ambitious public works projects, including the reorganization of the mental health system, had been the cause of several unpopular government deficits. The Bracken government tended towards fiscal retrenchment, and began their term with the sharp curtailment of building projects and other public works.[75] As a consequence, construction on the Nurses Residence and the Receiving Hospital, which had commenced in 1920, stalled. The nurses' home was eventually ready to be occupied in 1923, but the Receiving Hospital was not opened until 1925.

The failure to complete the latter structure as planned created a crisis of overcrowding in the facility. Congestion in the main building was partially alleviated in 1921 with the opening of The Colony. This was a sprawling, single story structure that was built a mile north of the main building. It was intended to house seventy chronic male patients, especially those suffering from senile dementia. This relief was short-lived, however, and by the end of the year, The Colony had seventy-seven residents and the crowded conditions of the main male wards persisted.[76] In 1922, Baragar, in an urgent plea

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[75]See W. L. Morton, *Manitoba: A History*, Chapter 15.

[76]BMHCA SB23 F13, *Annual Report for 1921*.

to the government to complete the Receiving Hospital and to put an addition on the Colony, noted that the congestion on the institution was such that the cubic air space per patient was only 60% of that prescribed by the building codes for a hospital, and indeed it was less than 75% of that allowed for a military barracks facility.[77] Similar pleas were made for the construction of married doctors' quarters in the form of freestanding cottages. The goal was to improve the retention of physicians and to free-up space for more staff accommodation in the main building.[78]

Even after the completion of the nurses' home, overcrowding and the lack of adequate staff accommodation undermined efforts to attract and retain female staff. Congestion on the male side was alleviated by the construction of the Colony, by boarding male attendants in the Power House and farm out-buildings, and by permitting some male attendants to live out.[79] None of these options was available for the female service, where congestion, deteriorating working conditions and unfavourable patient to staff ratios contributed to a very high turnover. In 1920, the Hospital tried to remedy its staff shortages by recruiting in England and Scotland. That fall, Superintendent Annie Connolly took her first vacation since 1915. As she was escorting a patient who was being deported, her

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[77]Ibid.

[78]RG18 B2 Box 4, Mathers to Oxton, 14 January, 1921, and 17 December 1920. In 1920, Baragar had warned of the pending resignation of a Dr. Whittaker, who was forced to sleep in a dressing room backstage of the auditorium with no running water or toilet. RG18 B2 Box 4, Baragar to MacNamara, 16 October, 1920.

[79]In 1921, a monthly living-out allowance was instituted for married male attendants. This allowance was rescinded in May of 1923. PAM RG18 A4 Box 12, File: "Papers Related to Brandon Mental Hospital, 1920-28," *passim.*

passage was paid to Scotland, and she was granted two months paid leave, some of which was to be used for the recruitment of nurses.[80] Several suitable candidates were found, and the hospital proposed to them a contract whereby recruits would have their passage paid by the provincial government. Such employees would be indentured to the service of the Hospital for one year, during which the cost of the passage was to be repaid through payroll deduction.[81] The institutional correspondence reveals that this was a highly unusual arrangement, and reflected a resort to unconventional recruitment to meet pressing staff needs.

Staff shortages were not confined to the nursing service. In the early 1920s, the Hospital had a clinical staff of four or five, and no hospital-trained nurses to assist. Early in his tenure Baragar made every effort to enlarge his clinical staff, largely through the summer employment of interns from the University of Manitoba Medical College. In 1923, such an arrangement was formalized when the University established a program whereby final-year students did a three month internship at one of the Saskatchewan Sanatorium, the Municipal Fever Hospital or the Brandon Hospital for Mental Diseases. This arrangement helped the hospital meet its most immediate medical needs, and it served a recruitment function for the psychiatric community by providing rudimentary training in mental hygiene and psychiatry for twelve physicians per year.[82] Even with this additional staff, the hospital

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[80]RG18 B2 Box 4, Goulden to Mathers, 19 February, 1920; and MacNamara to Goulden, 4 March, 1920.

[81]PAM RG18 B2 Box 4, Baragar to Mathers, 10 September, 1920 and MacNamara to Baragar, 23 October, 1920.

[82]BMHCA SB23 F14, *Annual Report for 1922.*

was desperately short of physicians, and in 1924, Baragar complained that there was but one physician responsible for 400 chronic patients.[83]

The much awaited opening of the Reception Hospital in 1925 did signify a change in the operation of the Hospital, although due to chronic staff shortages and the general state of overpopulation that prevailed, the changes were far less significant than the "complete transformation of the institution from Asylum to Hospital" that was claimed by the superintendent.[84] Certainly the opening of the "Unit" did improve the opportunities for the classification of patients, and acute patients and new admissions were entirely segregated from the chronic population for the first time. Staffing routines were changed to reflect the needs of an acute service, and measurable advances were made in the amount of medical and diagnostic work done.

Early efforts were made to make the routines of the Unit resemble those of an acute care facility. Weekly staff conferences were initiated, and under the supervision of George Davidson, plans for medical research at the Unit were launched. In 1925, the first controlled experiments were done, using injections of sodium bromide, a depressant, on agitated patients who did not respond to hydrotherapy.[85] After the first year, Davidson claimed promising prospects, but in his report of 1927, he reveals that while the use of depressants continued, the experiments had more or less broken down.[86] In the same year, Davidson

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[83]BMHCA SB23a F2, *Annual Report for 1924.*

[84]Ibid.

[85]BMHCA SB23a F3, *Annual Report of the Reception Hospital for 1925.*

[86]BMHCA SB23a F4, *Annual Report of the Reception Hospital for 1926.*

reported that experiments were conducted in the use of Luminal and Borax on epileptics as measure to control seizures. Also mentioned were the use of mercury and neo-arseph-enamine for the treatment of syphilis.[87]

The late 1920s witnessed slow, incremental growth in the medical staff. Stuart Schultz was appointed in 1925, bringing the complement of physicians to five. Two more were added in 1928. In 1929, although the total number of physicians remained unchanged, there were two appointments of note. One former attendant was replaced with another on the medical staff. George Davidson had been a physician at the hospital and before that an intern and an attendant. He was replaced by Mary McKenzie, who had served as acting lab technician in 1927 while a medical intern, and was among the graduates of the Diploma of Mental Nursing class of 1925[88] In the same year, Donald (Ewen) Cameron was appointed to the hospital.[89] The appointment of Cameron, a prodigious researcher and publisher of academic papers, was intended to place the hospital "on the map" as far as research was concerned. Cameron was a graduate of Glasgow, and he had completed post-graduate studies under both Adolph Meyer and Hans Meier, arguably the two most prestigious figures in psychiatry of the day. Cameron was a "rising star" and he was later to gain international recognition as an expert witness at the Nuremberg Trails and as the founding President of

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[87]BMHCA SB23a F3, *Annual Report of the Reception Hospital for 1925.*

[88]RG18 B2 Box 3, Baragar to Mathers, 1 December 1924.

[89]BMHCA SB6 F2, "Return to the House 40,1 and 40,2: Staff Lists." [undated - ca. 1929].

the International Congress on Mental Health.[90] Under Cameron's supervision and with Baragar's encouragement the medical staff placed a greater emphasis on experimental practices. In 1929, for example, Cameron supervised experiments in the use of dehydration for the treatment of epilepsy and the use of induced malarial fevers to treat neurosyphilis.[91]

Changes such as these demanded higher skills of the ward staff, and one of the significant innovations of the 1920s was the presence of general hospital trained nurses on the wards. In 1920, there was no graduate nurse on staff at the Brandon Hospital for Mental Diseases. The first graduate nurse was appointed surgical nurse in that year.[92] By 1925, this number had grown to three, and for the first time, female nurses were placed on the male wards. Baragar reports on this innovation in his Annual Report of 1924, which was submitted in May of 1925 after the Unit had opened:

> An important forward step has been taken in the nursing service during the year. Women nurses have been placed in charge of the Men's Infirmary and of the men's wards in the Reception Hospital. The Minister approved the appointment of Miss Marion McCauley, Reg. N., graduate mental and general nurse, in charge of the men's infirmary on Dec. 10, 1924. Later she was transferred to the Male Reception Service. So far a properly qualified mental and general nurse has not been found to take charge of the Men's

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[90]Fame turned to notoriety in the 1960s with the public disclosure of the nature of human subject research conducted under his supervision at McGill University's Allen Memorial Institute. Cameron has been the subject of several biographies. Although concerned with events of his later life, several contain useful introductions which deal with his experiences at the Brandon Hospital for Mental Diseases. See especially Anne Collins, *In the Sleep Room: The story of the CIA brainwashing experiments in Canada*, (Toronto: Lester and Orphen Dennys, 1988), and Don Gillmour, *I Swear by Apollo: Dr. Ewen Cameron and the CIA brainwashing experiments*, (Montréal: Eden Press, 1987).

[91]BMHCA SB3c F9, File: "Papers Published at the Brandon Mental Health Centre."

[92]PAM RG18 B2 Box 4, Suggested text for Order in Council to appoint Miss Grace Cox-Smith as Surgical Nurse, 28 September, 1920.

> Infirmary, but our own mental graduate nurses have been carrying out the work. The presence of good women on the men's wards of acute and infirmary services has a splendid influence on the patients, and reacts to the benefit of the nurses themselves and is significant to the public of the change from Asylum to Hospital. This does not reflect on our male attendants in any way, for no more faithful or loyal a group of men could be found in any institution in Canada.[93]

At first, female nurses were seen only on the infirmary wards and on the acute wards in the Unit, and only graduate nurses were used in this capacity. By the following year, however, female nurses were employed throughout the acute services, and, owing to the lack of a sufficient number of Registered Nurses, Graduate Mental Nurses also began to appear in these capacities.[94]

Few details have survived about the day to day life of the Hospital in the 1920s. Nurses worked seven days a week, with one half day off every three weeks. Several efforts were made over the course of the 1920s to reduce the hours of work and to implement an eight hour day, but these were generally frustrated by lack of staff, and nurses spent many of their waking hours with their patients. Ward routines were established on a weekly rotation. Patients were washed on one day, on another the wards were scrubbed and washed, etc. Medical rounds happened daily on the acute wards and weekly on the chronic wards.

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[93]BMHCA SB23a F2, *Annual Report for 1924.*

[94]In February of 1925, Baragar sought permission to place a mental graduate in charge of the main building infirmary to replace Miss Marion McCauley, who had been promoted to head nurse for all male wards in the Unit. This is the first recorded instance of such a promotion, and they became frequent thereafter. Nurses receiving such promotions were compensated at a rate of pay halfway between that offered to a mental graduate in a Supervisor's capacity and that of a graduate nurse. Such promotions were not made by Order in Council, but by the Superintendent, and they could be rescinded at any time. PAM RG18 B2 Box 4, Baragar to McLean, 6 February, 1925.

Interviewed in 1973, one nurse recalled that before rounds, female patients were given starched white aprons and male patients were fitted with collars, which were collected and stored immediately after the physician left the ward. Rounds closely replicated the ritual of the general hospital. The physician was conducted through the ward by the senior nurse, and all other ward staff stood silently at attention until the physician had left the ward.[95] Occupations for patients included the care of their own ward, where linens, walls, and furniture were washed and floors washed and waxed on a weekly rotation. Other activities included Occupational Therapy and "outside work," or industrial work. Disturbed patients were confined to single rooms, and were often placed in straitjackets or muffs, restrained in bed, or given paraldehyde to subdue them.[96] After the completion of the Unit, there is evidence that the continuous tubs were used increasingly as a means of coping with disruptive patients. [97]

Lectures and exams for nurses were held outside of the working day. Generally each lecture was delivered twice, once in the afternoon for the night staff and again in the evening for the day staff. Any assigned ward duty that was missed when the nurse attended a lecture was to be made up at a later date.[98] In addition to their lectures, nurses were to make

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[95]BMHCA SB2 F3, Margaret (Halley) Carter, Interview with Valerie Heppner, Brandon 8 March 1973

[96]Ibid., and BMHCA SB2 F28. Jack Seymour, Interview with Valerie Heppner, Brandon, 29 January, 1973.

[97]BMHCA SB2 F15, William Halley, Interview with Valerie Heppner, Brandon, 19 March 1973.

[98]Hazel (Moffatt) Wright, Interview with the author, Brandon 19 October, 1995.

themselves available to the hospital on a variety of other occasions for "volunteer" service. Nurses were to remain in uniform in the evenings six days a week, ready to be called to the wards in the event of an emergency or elopement. Only on their "night-off" were they permitted to be out of uniform or away from the hospital.[99]

The Hospital Rulebook contained a section on "extra duty" which read:

> All nurses and employees must be ready to perform temporarily, on holidays, or when called upon by the Superintendent, any extra duty that may be assigned them, and without extra remuneration.[100]

This clause was invoked frequently. Often, this extra duty consisted of attending patients' dances, film screenings or religious observances. When such activities were planned by the hospital, patients were supervised not by the on-duty staff, who remained on the wards to look after patients who were unable to attend, but rather by off-duty staff who were informed, generally by way of a notice appearing on the bulletin board in the nurses' home, that they were to appear at the event. Nurses were intended to involve themselves in these activities, and were instructed, for example, that they were never to refuse a dance with a patient.[101] Other "spare time" activities that went without compensation included relief

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[99]*Rules and Regulations of the Manitoba Hospitals for Mental Diseases*, (Winnipeg: King's Printers, 1924), 10-32, passim and BMHCA SB2 F26, Mrs. Frank Roberts, Interview with Valerie Heppner, Brandon, 19 February, 1973.

[100]*Rules and Regulations of the Manitoba Hospitals for Mental Diseases*, 29.

[101]Ibid, 16. The *Rulebook* specified that "All nurses shall attend patients' dances unless special permission to be absent has been obtained. Nurses shall assist patients to get partners and see that unsuitable patients do not dance together." Mrs. Kate (Oakett) Clarke recalled in 1973 that even laundresses and housekeeping staff were required to attend the dances, and that a patient was never to be refused a dance. BMHCA SB2 F5, Kate (Oakett) Clarke, Interview with Valerie Heppner, Brandon, 7 March 1973.

nursing on the wards and operating the telephone switchboard.[102]

Despite the apparent absence of free time, nurses did have some time at their own discretion. Even when "on-call" at the hospital in the evenings, there were recreational opportunities, and nurses took part in games, picnicked on the grounds and often held their own dances after the patients' dances. At these times, the hierarchical divisions that segregated the staff through their daily routines seemed to break down in the face of the needs of a small community, and employees from all quarters of the hospital seem to have participated.[103] An area of particular interest was sports. The Hospital offered a variety of recreational sporting opportunities like skating, curling, baseball, badminton and tennis, and male and female teams played in the Commercial Leagues for curling, soccer, softball and baseball.[104] Nurses were also afforded occasional opportunities to go to the City of Brandon, although these were limited by the walking distance to town and the absence of affordable transportation. Until 1932, there was no public transportation system, and although there were private taxis, the cost of such a service was $1.50 each way, prohibitively expensive on a salary of as little as $24 a month, before deductions and breakages. The hospital did provide a bus to the city twice a day on Sundays so that both shifts could attend church services, and by the mid-1920s, sent the "rig" to town on Wednesdays, the night of the week

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[102]BMHCA SB2 F4, Margaret Hall, Interview with Valerie Heppner, Brandon, 28 March 1973.

[103]Hazel Wright Interview.

[104]BMHCA SB2 F19. Evelyn McKenzie, Interview with Valerie Heppner, Brandon, 7 May 1973.

that the Brandon movie theatres were open.[105] The staff received a mixed welcome in Brandon. Even on their modest salaries, they often had more disposable income than many of the other residents of the community, and they were welcomed at local establishments for the custom that they represented. At the same time, they reported that they were ostracised by the general community of Brandon because of the stigma that was attached to them for their work with the mentally ill.

That their training did not confer upon them any positive change in status in the broader community may have influenced nurses' perception of the value attached to the course. It seems that not all nurses approached the courses that were offered them with the gravity that the Medical Superintendent would have desired, and in 1924, he posted a bulletin in the nurses residence, reprimanding the "number of nurses that are not performing satisfactorily" and complaining that lectures "are not taken sufficiently seriously." The notice went on to say that any nurse failing in more than one subject would be asked to withdraw from the program and "will not be regarded as worthy of being retained on the staff as likely to be a satisfactory or efficient nurse..." [106] This initial message was not heeded to the satisfaction of the superintendent, and bulletins went up twice in the autumn of the same year threatening nurses who were absent from lectures or who failed to submit their lecture notes to the Superintendent of Nursing within one day of the physician's

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[105]BMHCA SB2 F26. Interview with Mrs. Frank Roberts.

[106]BMHCA SB 6 F1, Memo dated 24 March, 1924, "Bulletins and Memos posted on Bulletin Boards for Nurses - Return to the House No. 30, 2."

lecture.[107]

Hospital staff were closely controlled even outside their hours of duty. Strict curfews were imposed, and nurses were expected to be in their rooms at 10:00 or 10:30 PM. Late leaves could be applied for and were granted at the discretion of the superintendent of nursing, but were not freely given.[108] The Hospital guarded its reputation closely by monitoring the activities of the nurses while they were off the hospital grounds, and nurses were not infrequently reprimanded or punished for their activities outside the hospital. Although dismissals for moral misconduct are not specifically recorded in the hospital record, several individual cases appear in the Ministerial correspondence. For example, there is the case of one nurse who was dismissed for "disregard for the rules" which "reflected most seriously on the nursing service of this Hospital." The breach in question was staying out until 5:30 AM in a motorcar. Although the nurse in question was given another chance, this was conditional upon giving the Superintendent an undated signed letter of resignation, which was later invoked after another episode of returning home late from leave.[109] This dismissal was seen to have been unduly harsh in light of the fact that the nurse was only a few weeks from her graduation at the time. The nurse's father made a complaint against the Hospital to the Minister.[110] In defence of his actions, Baragar claimed that it was important in this instance to make an example of the offending nurse for the sake of the

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[107]Ibid., 30 September, 1924 and 21 November, 1924

[108]BMHCA SB2 F26. Interview with Mrs. Frank Roberts.

[109]PAM RG18 B2 Box 4, Baragar to McLean, 19 September, 1925.

[110]PAM RG18 B2 Box 4, Cowie to McLean, 10 September, 1925.

Hospital's reputation:

> Looked at from the standpoint of the majority of nurses who are taking full advantage of their opportunity, and with regard to the nursing profession in general it would be a mistake to grant a diploma to one who had a record such as [hers].

Baragar asserted his right to act as arbiter of a student's success or failure and as judge of her moral character and suitability to work:

> A training in nursing consists not only of lectures and examinations, but, what is of more importance, of practical ward work, skill and consideration in the care of patients and the development of a sense of high personal responsibility and trustworthiness.... In the interest of the public in general, and the nursing profession in particular it would be highly desirable that, regardless of academic standing, if it appeared even as late as the last day of her course, that a nurse was inconsiderate and not dependable, the diploma should be withheld."[111]

This exercise of paternalism must be seen primarily to have originated with the desire of the hospital to safeguard its own reputation, but may be seen also to have had practical dimensions. The rigid control that the hospital exercised over off-duty hours was justified in the name of maintaining the health of the nurses. One of the daily realities that nurses faced was the threat of disease. Although the institutional records do not generally break down the number of days lost to illness or injury in any detailed way, in most years in the 1920s, there were more than one thousand days lost to illness or injury across the Hospital. In 1926, 70% of lost days were in the female service, and 54% of these, accounting for 43% of the total lost days, were due to respiratory illness.[112] Implicit in these figures is the suggestion that the nurses were far more susceptible to tuberculosis than the male attendants.

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[111]PAM RG18 B2 Box 4, Baragar to McLean 19 Sept 1925.

[112]BMHCA SB23a F4, *Annual Report for 1926.*

This was attributable to several factors. The most obvious was that it was female nurses that were responsible for the infirmary wards, and therefore most likely be in direct contact with tubercular patients. Several other factors might also have contributed. These include the chronic overcrowding on the female wards, which, due to the absence of an equivalent structure to the Colony, was much more acute, and the indoor conditions under which female attendants and nurses alike laboured. While male patients tended to work outdoors moving coal or on the farm, female patients were employed in the laundry and the sewing rooms The enclosed, humid surroundings, especially in the laundry, would no doubt have been more conducive to the transmission of disease than the outdoor work sites of the male service.[113]

The presence of the general hospital graduates complicated relationships within the nursing community and between nurses and other members of the hospital staff. With the completion of the nurses' home in 1923, all female staff, including housekeepers, resided there, and this situation was to prevail until the completion of the Women's Pavilion in 1932, when the support staff were removed to the attics there. Recollections of life in the nursing community in the 1920s often include memories of what was referred to as "class distinction." The primary unit of identification for nurses was their year in the program of instruction. Hierarchy was communicated in the language of architecture, and the nurses' home itself reserved a different floor or a different wing for every class of nurses or female

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[113]Baragar acknowledges this in part. In 1929, the hospital started administering regular chest x-rays on first enroling at the hospital and at regular intervals thereafter. BMHCA SB23a F4. Annual Report for 1926 and F7, *Annual Report for 1929.*

staff.[114] Housekeeping staff slept in two or four bed rooms, while probationer and first year nurses shared a room. By her second year, a student nurse received a private room, which was in keeping with the practices of the larger hospitals.[115] Rituals of deference in domestic life reinforced class distinctions. Classes were seated separately at meals and were served according to rank. Junior nurses were expected to defer to their seniors by opening doors, proceeding second into elevators, and standing when a senior nurse entered the room.[116]

The appearance of more and more general hospital graduates at the hospital created a new stratum within this hierarchy. Initially, the only general hospital graduates were in executive positions within the hospital, such as the superintendent or the instructress, or practiced a specific specialty, such as the surgical nurse. As the number of staff nurses increased after 1925, however, the availability of the general hospital graduates served also to constrain the upward mobility of the mental hospital graduates. As a general rule, mental graduates could progress as far as the position of supervisor, but were not generally eligible to become Head Nurses.[117] Some exceptions were made to this rule when no suitable registered nurse was available, but in all instance, such promotions were deemed

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[114]Hazel Wright Interview.

[115]Overcrowding resulted in the discontinuance of this practice sometime in the mid-1920s. Although senior students were required to share a room, graduate nurses and post-graduate students always had private rooms. BMHCA SB3 F10, Charlie Duguid, Interview with Valerie Heppner, Brandon, 8 February 1973.

[116]Hazel Wright Interview.

[117]Ibid.

temporary.[118]

Relationships between the locally trained nurses and the graduate nurses trained elsewhere were sometimes strained. Ingiborg Cross, a graduate of Winnipeg General, recalls that when she came to the hospital in the late 1920s as Supervisor for Male Hospital, she found that the locally trained nurses "had no technique at all" and although she had high praise for the Chief Attendant, she found much of his staff to be "incompetent." She recalled that she was met with resistance when she attempted to implement the quarantine techniques that she had learned during a scarlet fever epidemic, and that she required the intervention of not only Baragar, but of David Stewart from Ninette to impose what she considered to be an appropriate régime for the isolation of communicable diseases.[119] In the labour dispute of 1926, one of the primary grievances cited by the Union was that graduate nurses were being hired to supervise local graduates, and that local graduates were not being promoted to supervisory positions.[120] The Superintendent of the Hospital had little sympathy with this particular grievance, and wrote to the Civil Service Commissioner:

> Mental Nurses, if they were wisely interested in their own welfare will welcome the opportunities which in this way increases the prestige of their hospital and secure more extensive training.[121]

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[118]This precedent was established in 1925 and seems to have prevailed throughout the second half of the decade. PAM RG18 B2 Box 4, Baragar to McLean, 6 February, 1935.

[119]PAM C 922-4 1988-211, Ingiborg Cross, Interview with Kathryn McPherson, Richmond, 20 July 1988.

[120]BMHCA SB31, Mental Hospital Workers Federal Union to Baragar, 18 September, 1926.

[121]BMHCA SB31 "Notes of the Meeting of the Mental Hospital Employees on Tuesday Sept. 17th, 1926, At BMH with the Civil Service Commissioner, to Hear

That the locally trained graduates were less than willing to see the appointment of better trained staff in positions superior to them as an opportunity is not surprising.

Staff hierarchies were codified through costume, and the status of a nurse at BHMD could be discerned through uniform. It is not clear when attendants at the hospital first began to wear a uniform, but in 1913 the uniform for female attendants was changed to more closely resemble a hospital nurse's uniform. Prior to 1913, all female staff, both attendants and housekeepers, wore a dress of either solid or striped grey material, while the matrons wore dark blue. In 1913, this uniform was changed for one white in colour. It consisted of a dress with separate starched collar and cuffs and was covered with a separate apron and bib. Also in this period, a pleated nurse's cap was added to the uniform. [122] After the nurses' training program began, the Hospital modified this uniform to match the convention followed by general hospital nursing schools and to further signify a nurse's credentials. Probationer nurses, under this tradition, did not wear caps until they were promoted to junior nurse. All students wore black shoes and stockings as a badge of their apprentice status. On graduation, mental nursing graduates were presented with a pin bearing the insignia of the School of Nursing, which was worn on the bib. Graduate nurses also received a black band for their cap and changed their shoes and stockings for white. Graduate nurses, according

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Complaints."

[122]One nurse from the 1920s recalled that many of the nurses found it very difficult to make their caps, and that they employed one of the patients, a former nun, to make them. She recalls that it was the only time a female patient was ever permitted to operate an iron.
BMHCA SB3 F19. Interview with Marilyn McKenzie; and Jessie Little [Curator, BMHC Museum], p.c.

to the tradition of the time, always wore the cap and pin of their home institution, as did graduate nurses taking the post-graduate course.[123] Non-nursing staff, like the housekeepers, retained the original grey pin-striped dress, and were thus clearly differentiated from the nursing staff.[124] In this way, a nurse's status was immediately obvious to any other nurse or employee of the hospital, and reinforced "class distinction" as a dominant construct by which life at the hospital was organized.

Despite Baragar's protestation that the presence of graduate nurses on the male wards "does not reflect on our male attendants in any way," the introduction of graduate nurses altered the relationship between the nursing staff and the male attendant staff. Historically, women in the employ of the BHMD had been more transient than men, and had generally been employed at about half the salary.[125] Consequently, they enjoyed a status which was inferior to the male attendants. While female nursing students continued to earn only about half the salary of the male attendants, increasingly in the 1920s they began to perform functions that were not available to men. Like their counterparts in the general hospitals, these nurses possessed a distinctive body of knowledge which differentiated them from the other staff on the wards, although the general lack of therapeutic régimes limited the potential for this body of knowledge to significantly change relationships.

The growing authority of the graduate nursing staff was evident in the dismissal of David Graham in May of 1925. Graham's reason for termination was given as "Insolence

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[123]Jessie Little, p.c.

[124]BMHCA SB2 F5, Interview with Kate (Oakett) Clarke.

[125]BMHCA SB23a F3, *Annual Report for 1925.*

towards a head nurse." In a letter to the Deputy Minister, Baragar reports that Graham refused an instruction to clean a patient's room "and was insolent to a head nurse in this connection."[126] This is the first indication in the correspondence of the hospital of the hierarchy that was being established that put female nurses in charge of male attendants. Although she was not named, the nurse in question was almost certainly Marion McCauley, formerly head nurse in the men's infirmary ward, who was placed in full charge of all male wards in the Receiving Unit early in 1925.[127]

The notion of a head, or a charge nurse was one which Baragar imported from the general hospitals with some fanfare in 1923. Under this system, a graduate nurse was made responsible for her ward or wards twenty-four hours a day, whether she was in attendance or not. This expedient created administrative efficiencies for the hospital, but it also enhanced the power of the head nurses, generally all general hospital graduates, over the Supervisors, who were usually Diploma Graduates.[128] The Supervisors in this relationship came to find themselves directly responsible not to the Superintendent of Nursing, but rather to another nurse, and the interposition of a new level on the hierarchy for which they were not eligible had the same effect as knocking them down one rung of the ladder.

Despite the emphasis that the Hospital placed on the recruitment of trained nurses, these efforts were not always successful. Frequently, graduate nurses who came to the

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[126]PAM RG18 B2 Box 2, Baragar to McLean, 9 May 1925.

[127]PAM RG18 B2 Box 2, Baragar to McLean, 6 February, 1925.

[128]PAM RG18 A4 Box 12, Baragar to Fleming, 11 September, 1926, and RG18 B2 Box 2, Baragar to Mathers, 25 May, 1925.

hospital did not remain on the staff long. For example, in 1926, the Hospital lost its entire staff of graduate nurses at one point.[129] It does not seem that any of the registered nurses who left the hospital in the spring of 1926 did so because their resignations were requested, but rather left to seek more attractive work elsewhere. Marion McCauley left to take up private duty work in Montréal, Dell Cannon to work at the Bigelow Clinic in Brandon, and Ingebjorg Johnson also to take up private duty.[130] These positions were not soon filled, and Baragar complained to the Deputy Minister that "there is a great shortage of general hospital graduates who have the personality, ability and special training to satisfactorily fill such positions."[131] Although the departures in this year were probably attributable to the un-favourable working condition created by the labour problems -- Baragar prefaced his report on the resignations with, "Owing to the unsettling and disturbing influences that arose during the year, the number of changes among nursing staff have been greater than has been the case in several years" -- it underscores the reality that mental work was one of the least attractive options available to a graduate nurse[132]

No doubt the unique conditions which prevailed at a mental hospital were alien to most and very stressful. In 1923, for example, Miss L.R. Aikman lasted only two months as Superintendent, with the implied reason for leaving being job stress. Certainly the

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[129]In fact, the Lab Technician, who was a graduate nurse, was briefly compelled to leave her position to become acting Superintendent of Nurses in 1926.

[130]PAM RG18 A4 Box 12, Baragar to Clubb, 26 March, 1926.

[131]BMHCA SB23a F4, *Annual Report for 1926.*

[132]Ibid.

resignation was not requested and Baragar wrote to the Deputy Minister that he withheld the resignation for two weeks in the hope that it would be rescinded:

> The duties of the superintendent of nurses at this hospital, especially during periods of reorganization are exceedingly difficult and the work is often very discouraging. Miss Aikman perhaps took her work and its problems too seriously for her own good. She felt that she had not the ability to carry the work through to a satisfactory conclusion under the circumstances and hence desired to be relieved of the responsibility.[133]

That Aikman was a seasoned mental nursing administrator may suggest that the conditions at BMHC were extraordinary. eLizabeth [sic] Ramsay Aikman, R.N., R.A.M.C., who was so overwhelmed by the position, had post-graduate specialty training in Mental Nursing from Craig House, one of Great Britain's most respected Mental Hospitals, where she had also served as Deputy Superintendent of Nursing. She was recommended by Craig's Superintendent, Sir Thomas Clouston, whom Baragar described to the Deputy Minister as "one of the foremost psychiatrists of his day." She had completed her General Training at Winnipeg General in 1912, and prior to the War, she served as Head Operating Nurse at Winnipeg General and the Superintendent of Nursing at a small private hospital. She had five years of War Service, including active service in the clearing hospitals of France.[134]

The language employed by Baragar in the letter cited above shows the credentialism that characterized his approach to staffing his hospital and the earnestness with which he approached his job. His enthusiasm for the formal course of training, however, was not always matched by the nurses enroled in it. The superintendent frequently complained to

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[133]PAM RG18 B2 Box 4, Baragar to McLean, 11 July 1923.

[134]PAM RG18 B2 Box 4, Baragar to McLean, 17 May, 1923.

his political masters that the nurses did not take the courses seriously enough, and some of these complaints suggest a collision of values and social class. In February of 1922, two nurses were dismissed for breaches of discipline which reflected "a general lack of interest in [their] work." This disinterest was evidenced by the failure to attend a class, and by a subsequent failure to submit a report to the superintendent explaining the reason for the absence. At the time when they were to have reported to the medical superintendent, the two nurses were in Brandon "for purely recreational purposes." Baragar closed the letter with one of his frequent complaints about on the lack of responsibility and the difficulty in recruiting "suitable young woman."[135]

To understand why the mental nurses of the 1920s did not embrace with enthusiasm the possibilities offered by the training school, it is important to look at both the intellectual and economic foundations of the training school. Scholars have argued that central to the identity of nurses was identification with technique. Nurses separated themselves from the untrained attendants with whom they worked and laid claim to professional status on the basis of their mastery of a proprietary knowledge base. Such a claim in the mental hospitals of the 1920s was much weaker than in the general hospital. In the general hospital the rituals that formed nursing technique were deeply rooted in a scientific understanding of the aetiology of disease, specifically in an understanding of the importance of aseptic technique and of maintaining a "sterile field." In the mental hospital, many of these rituals were replicated, particularly in the realm of maintaining ward discipline and cleanliness, but other rituals lost some of their meaning.

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[135]PAM RG 18 B2 Box 2, Baragar to Oxton, 13 Feb 1922.

While there were in the mental hospitals of the 1920s many deteriorated patients and patients of unclean habit who were more susceptible to illness, and while Baragar rightly boasted on several occasions that the BHMD contained within its walls one of the province's largest general hospitals, the greater part of the mental hospital population were afflicted with conditions the cause of which was neither obvious nor understood. Unlike the patients in an acute care facility whose illness generally had immediate physical manifestations that required attention, the vast majority of the patients in the mental hospital were in good physical health with few outward manifestations of their illness.

To be fair, there were specific therapies available in the treatment of mental illness. The hospital record from the 1920s shows evidence of a number of aggressive or intrusive medical procedures employed in the name of cure. After the opening of the Unit in 1925, the Hospital experimented with a number of forms of chemotherapy, for example.[136] On other occasions, experiments were done on the efficacy of x-rays and heat cabinets in the treatment of mental illness. Various forms of shock therapy, including the use of hypothermia and faradic shock are also alluded to in the record.[137] Such treatments demanded a level of nursing skill, but they were applied only in the acute care wards of the Unit, and therefore involved only a small portion of the nursing staff. In fact, from 1921, the hospital employed a graduate nurse in the capacity of Surgical Nurse, and this person was designated to assist on most such activities.[138]

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[136]PAM SB23a F3, *Annual Report of the Reception Unit for 1925.*

[137]PAM SB23a F4, *Annual Report of the Reception Unit for 1926.*

[138]RG18 B2 Box 4, Text of Order in Council, 28 September 1920.

The dominant form of therapy available to patients on the acute and chronic wards alike was the continuous bath, although due to a shortage of tubs, these too were most often employed in the treatment of patients on the acute wards. Contemporary scholars generally classify the continuous tubs as a form of restraint rather than as a form of therapy. Such analyses tend to ignore the role that the baths occupied in the minds of those who applied them. Nurses who applied the baths and other forms of hydrotherapy, like hot and cold wraps and packs, recalled the precise procedures that needed to be followed and the regular monitoring of the patients' body temperature and pulse rate.[139] Notwithstanding, some staff recognized that the baths and packs did constitute a form of restraint, if a more humane one. Baragar made the distinction in his report for 1925 when he reported that the tubs were in almost continuous use, and that as a consequence, restraint had been almost entirely eliminated.[140] Jack Seymour, an attendant from the 1920s, was more sanguine. He recalled in 1973 that one purpose of the therapies was to "subdue violent behaviour" and that the baths and packs "tended to weaken the patients and thus served to calm or subdue them."[141]

Nurses were provided with instruction in the rudiments of psychology, and were advised in their written job description that their role was to assist in the diagnostic activities of the psychiatrists.

> Nurses are expected to take an especial interest in the study and observation of patients under their care, and to report any new feature which may arise.

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[139]Hazel Wright interview.

[140]BMHCA SB23a F3, *Annual Report for 1925.*

[141]BMHCA SB2 F28, Jack Seymour, Interview with Valerie Heppner, Brandon, 29 January 1973.

> Symptoms and peculiarities are often manifested before nurses which the patients would carefully conceal in the presence of the doctor.[142]

This aspect of the job description underscores the relationship of dependence that existed on the part of psychiatrists. British historian Mick Carpenter comments on the thesis that a nurse's power was enhanced by the relative dependence of the medical community on the nurses to validate their activities and to secure the safety of their patients. He posits that this relationship was even more pronounced in the case of psychiatric nurses. The absence of outward manifestations of disease and the ability of patients to "conceal" their illness in the typically brief encounters with the psychiatrist, Carpenter writes, made the psychiatrist even more reliant than the physician on the diagnostic services of the nurse. This dependence was further enhanced by the greater dependence on the presence of the nurse to validate the work.[143]

Several factors limited the potential for the mental graduates to identify themselves as nurses. Within the confines of the hospital, it is reported that they were sometimes treated with condescension and disdain by the general hospital graduates.[144] Their inferior position with respect to these nurses reinforced the inferior quality of their credential. Outside of the hospital, they discovered that their credential had even less value. There is

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[142]*Rules and Regulations of the Manitoba Hospitals for Mental Diseases*, 22.

[143]This argument is made by Mick Carpenter, "Asylum Nursing Before 1914, a Chapter in the History of Labour," in Celia Davies, Ed. *Rewriting Nursing History.* (London: Croom Helm, 1980). See also Thomas E. Brown, "The Origins of the Asylum in Upper Canada, 1830-1939," *Canadian Bulletins in Medical History.* 5:2 (Winter 1988), 167-88.

[144]Hazel Wright interview.

some record of the graduates of the Diploma program finding work in other mental hospitals, and certainly the ambition of some graduates to go on to general nursing suggests that it might have been viewed as an appropriate stepping-stone, but in general, their credential was without value outside of the hospital.[145] The further absence of an affiliate program limited their range of opportunities after 1927.

One of the realities that the graduates of the Diploma program in the 1920s must have faced was the incipient closure of the nursing community to new entrants. Toward the end of the 1920s, a crisis of oversupply of labour in the nursing community was becoming apparent. The establishment of the nursing community reacted by attempting to restrict entrance into the occupation. In this effort, they largely targeted smaller schools of nursing, especially those in smaller hospitals, but the Brandon Hospital for Mental Diseases was not unaffected.

In 1928, Baragar emphasised in his report to the Minister the importance of mental training for nurses and the importance of general training for mental nurses:

> It is interesting and important from a nursing standpoint that within the walls of this institution there exists a moderately large general hospital, one that is considerably larger than many of those giving a course in general nursing.[146]

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[145]*The North Star*, a newsletter internal to the hospital listed "to go on to general nursing" as the ambition of one nurse in the graduating class of 1927. It is not known if this woman ever obtained her RN, but two other members of this class went on to general training, and (Dora Muir) later became Superintendent of Nursing. This, however, should be seen as exceptional, and before 1932, only five graduates had gone on to do hospital training. PAM RG18 A4 Box 12, *The North Star*, 1:2 (July 1927); and BMHCA, Unsorted Materials, Pincock to Hoey, 18 May, 1931.

[146]BMHCA SB23a F6, *Annual Report for 1928.*

In the following year, these words were repeated almost verbatim:

> As within the walls of this institution there is a moderately large general hospital, the importance of mental nurses receiving an adequate grounding in general nursing is obvious.[147]

These ambitions, however, were at odds with those of the graduate nursing community. By the late 1920s, the first effects of what was to become what Katherine McPherson called "the crisis in private duty nursing," a crisis of under-employment created by the concurrent over-supply of trained nurses and the reduced use of private duty nurses by middle class families, were being felt. This "overcrowding" of the nursing profession strengthened the desire of the nursing élites to restrict entry into the profession by raising the standards of training. This was done in such a way that consolidated the power of the general hospital-based superintendents as the arbiters of who was and was not a nurse.[148]

No better illustration of the agenda of the general hospital based élite of the nursing community exists than the Act Respecting the Manitoba Association of Graduate Nurses introduced in 1927. The proposed new Act substituted the words "general hospital" for "recognized hospital" in naming institutions suitable to the training of Registered Nurses. The objective was specifically to exclude institutions like sanatoria and mental hospitals from the provision of training for nurses leading to registration. The Act went on specifically to exclude any but general hospitals:

> Any hospital giving training in special branches of nursing such as mental diseases, obstetrics, tuberculosis or contagious diseases must before its students will be considered eligible for Registration provide them with

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[147]BMHCA SB23a F7, *Annual Report for 1929.*

[148]See Chapter 2.

eighteen months affiliation in a general hospital.[149]

Baragar made frequent references to the fact that were its infirmary considered, BHMD was the largest hospital in the province outside of the three urban centres of Winnipeg, Brandon and Portage la Prairie, and no doubt he wished to reserve the possibility that failing an affiliation, nurses might be prepared for registration in-house. He reacted to the legislation with hostility, and in February of 1927, he wrote a letter of protest to Mathers in which he interpreted the possible consequence of this legislation:

> In other words, it makes the special hospital absolutely dependent on the favour and good will of the general hospitals. In other words, the general hospitals could come to a mutual understanding and absolutely bar any or all special hospitals without reason.

Baragar went on to make the case for amendments to the Act which would recognize the role of an institution such as his in the provision of training:

> [This legislation] limits recognition of training in the special hospital to a branch of nursing that the parent hospital was instituted to give, the inference being that children's diseases or Paediatrics only could be taught and recognized at a children's hospital, tuberculosis in a sanatorium, and psychiatry in a mental hospital, and obstetrics in a maternity hospital, whereas as a matter of fact much of the nursing in the children's hospital, in the sanatorium and maternity hospital is general nursing and exactly the same as nursing on the wards of a general hospital, and in the Hospital here, as you know, we usually have more beds occupied by individuals physically ill and requiring general nursing care than in any other hospital in the Province outside the cities of Winnipeg, Brandon and Portage la Prairie. That means that our nurses, provided they took full advantage of the opportunities, would receive a fair degree of training in general nursing. That means that while they receive unusual training in psychiatry they do receive some training in general nursing, and that some allowance should be made for that too. As the academic side of the nurses' training is more or less stressed at the present time, that also should be taken into consideration, but

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[149]RG18 B2 Box 3, "[Draft] Act to Amend the Act Respecting the Manitoba Association for Graduate Nurses."

> undoubtedly here our nurses receive academic training that is equivalent to the greater part of the nurses' curriculum to that of any general hospital in the Province.... I have no doubt in the world that our nurses, may at the end of three years training here, be better qualified to do general nursing than some of the nurses graduating from the smaller hospitals.

Aware of the potentially damaging nature of this last statement, he asked that the last argument not be made publicly.[150]

The emotion evident in this letter gave sign to the vulnerable position that such legislation put the BHMD programs in. If the Hospital were finally unable to operate a school of nursing except at the pleasure of the general hospital-based élite of the nursing community, who often regarded its training school with disdain and perhaps as a competitor, then it faced an immediate crisis. Only with the promise of training had BHMD been able to operate with an adequate complement of nurses, and only by the employment of apprentices to do the majority of the ward work could it afford to retain an adequate staff. Furthermore, Baragar must have viewed the training school as the primary source of prestige for the Institution, prestige that was communicated by the presence of trained nurses.

Baragar must also have been aware that the legislation had powerful patrons, and that he was unlikely to be able to compel sweeping changes to it. In the event that special hospitals were excluded, he sought to improve his position slightly. He solicited the aid of the Provincial Psychiatrist in pressing for amendments that would enshrine the importance of psychiatric training. He argued:

> Certainly a general hospital in the province is not in the position to fully train nurses. Through the general hospitals, only a minority of nurses receive adequate training in infectious diseases, a few in tuberculosis, also a few in

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[150]PAM RG18 B2 Box 3, Baragar to Mathers, 15 February, 1927.

> mental diseases, three health problems that are of far greater importance from a nursing standpoint than operating room training. For example, the nurse in private duty is rarely called upon to prepare for a major operation, but she is almost certainly in constant contact with infectious, tubercular and mental conditions.

On this basis, Baragar's recommended amendments would make the relationship of dependency created by the new Act mutual. He proposed that the general hospitals be compelled to provide as a requirement for registration, some experience in all three of a mental or psychopathic hospital, a sanatorium and an infectious diseases hospital if these three did not exist adequately within the walls of the hospital in which the training was received. He further recommended the introduction of an amendment by which hospitals with more than fifty beds were compelled to accept affiliate students from specialty hospitals as a condition for the receipt of public funds.[151]

Throughout the 1920s, the mental nurses trained at BHMD existed on the margins of the general nursing community. The dissolution of the affiliate program at St. Boniface General Hospital and the introduction of the new *Act Respecting the Manitoba Association of Graduate Nurses*, signified setbacks in the campaign for the recognition of the medical status of the Hospital. Even before these doors closed, however, there were indications that mental nurses identified differently with their career prospects than general nurses. Unlike hospital trainees, who generally left their home institution when they graduated, the larger part of the mental nurses remained in the Provincial Mental Hospital system. The lack of upward mobility and portability conveyed by a Diploma of Mental Nursing might be assumed to have caused the Mental Nursing students to identify differently with their work

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[151]Ibid.

and their training than their hospital counterparts, and indeed there was evidence even before 1927 that the nurses were willing to take risks to ensure that working conditions at the hospital were improved for the long term.

Although the correspondence between Baragar and his political masters often complained of the material deficiencies of the hospital and staff shortages, references to the nursing staff were generally suffused with a sense of optimism and progress. This changed in the spring of 1926. In that year, even the Annual Report reflected that not all was well with the nursing service. Baragar commented in the report:

> In the development of such a nursing service, progress has been more or less steady since 1921 though in some respects at a standstill in the last two years. This last summer, a serious setback was sustained. Lost ground is however being rapidly recovered and it is confidently anticipated that within the next few years mental nursing in every respect will have attained the same high professional standard as general nursing.[152]

Baragar's optimism was perhaps not well placed. The "setback" to which he referred was a serious breakdown in the labour relations at the hospital. These troubles were to last three years, and in the course of time, a number of staff and nursing students were dismissed, nearly all of the graduate nursing staff resigned, and the labour conditions of the Hospital were the subject of a Royal Commission. The troubles of this period were almost certainly also dominant factors in Baragar's resignation in 1929 and the collapse of the Affiliate Program in Mental and General Nursing with the St. Boniface Hospital after 1927. The event that triggered the troubles was the formation of a Union which signed up a large majority of the Hospital's employees, including members of the female nursing service, male

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[152]BMHCA SB23a F5, *Annual Report for 1927.*

attendants, support staff, and perhaps most significantly, students at the School of Nursing. This attempt to form a union was not the first at the hospital, but it was the most disruptive and it is significant in that it involved the greatest proportion of the staff, male and female alike.[153]

In the early 1920s, the hospital made genuine efforts to secure for its employees an eight hour day. This was a daunting task given the labour shortages that plagued it. In correspondence with the Minister, Baragar revealed in 1920 that to implement such a reduction of working hours would necessitate the hiring of more than twelve male and thirty female attendants.[154] In the context of the post-war slump and economic retrenchment, such an increase in the payroll was out of the question, and even if funds were available, there were insufficient staff beds to accommodate any increase in staff. Instead, a complex system of split shifts was devised for the male service in an attempt to create a fifty-six hour week, although this was predicated on such things as considerable unpaid overtime (such as volunteering to supervise patient dances and movie screenings). In the female service, so desperate was the staffing situation that no real attempt was made to implement the eight

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[153]A previous attempt had been made in 1919 to form a union at the hospital, and this union significantly also involved female staff. The events in Winnipeg and Brandon in the spring and summer of that year eclipsed these organizing efforts, and the Union dissolved in the summer of 1919 when the government promised an eight hour day. Union funds were largely given over the Winnipeg General Strike Leaders' Defense Fund. BMHCA SB31 F1 and F2, *passim*. See also Doug Smith et al. *Lives in the Public Service: A History of the Manitoba Government Employees Union*, (Winnipeg: MGEU, 1993).

[154]PAM RG18 B2 Box 4, Baragar to Oxton, 12 May, 1920.

hour day, and twelve hour shifts remained the norm.[155]

The labour relations problems occasioned by the failure to meet the promise of a forty hour week were compounded after 1923 when wages began to decline. The Bracken government, reluctant to run the deficits of its predecessor, demanded economy from the civil service, and wages and benefits were clawed back. Those most penalized were the male attendants who lived off-site. In 1920, provision was made for a "living-out allowance" for married male employees, but in 1923 the economy-minded government rescinded the allowance and froze the incremental wage increases for long service that had been promised in 1920.[156] Two years later, a further wage reduction was imposed on all staff.[157]

By 1925, increases in the number of resignations indicated a worsening labour situation. Resignations on the female service doubled in that year, with many nurses leaving after their first year in the service.[158] In the spring of 1926, discontent had occasioned the formation of a Union, the Mental Hospital Workers' Federated Labour Union, Local 33. The list of demands that the Union presented to Baragar that summer was brief. The Union demanded that the living-out allowance be re-instated, that the long-promised eight hour day be implemented without split shifts, and that the wage scale established in 1923 (after the

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[155]There is a great deal of institutional correspondence concerning hours of work. See PAM RG18 A4 Box 12; see also BMHCA SB3b F5, File: "Hours of Work."

[156]PAM RG18 A4 Box 12, McLean to Clubb, 16 May, 1923

[157]Reversing this second cut was at the heart of the demands of the Union in 1926. PAM RG18 B2 Box 3, Mental Hospital Workers' Federal Labour Union N°.33 to Baragar, 17 September, 1926.

[158]PAM RG18 A4 Box 12, [Return to the House] 26 March, 1926, "Changes in Nursing Staff."

first wage cut, but before the second) be reinstated. Their only other significant demand was that a book of rules governing the conduct of employees be printed and circulated to every employee.[159] This last demand was probably significant, in that it revealed something about the culture and discipline of the Hospital, and perhaps even the character of its superintendent, who was known to be a man of rigid, military disposition.[160]

On instructions from the Deputy Minister, Baragar did not recognize the Union, but it persisted in its demands and petitions[161]. This created a difficult situation for Baragar. The Union claimed 134 of the 160 members of the staff, and with this strength, was hard to ignore.[162] Baragar was himself in a relatively helpless position, having no means at his disposal to meet what he grudgingly acknowledged were legitimate demands for reduced hours and better compensation. In a letter to Mathers, he betrayed his ambivalence:

> I am not in favour of unions in Government Services, especially in hospitals. It shouldn't be necessary. It should be possible to expect from men and women in this hospital the highest form of service, to eliminate promptly all who failed to measure up to a high standard, but it should also be possible for them to secure ready consideration of all reasonable demands.[163]

This ambivalence did not extend to the participation of apprentice nurses in a union. Baragar's correspondence on this issue is full of venom and condemnation. For him, such

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[159]PAM RG18 B2 Box 3, Mental Hospital Workers' Federal Labour Union No.33 to Baragar, 17 September, 1926.

[160]BMHCA SB2 F1 Interview with Ernie Bunch; and Thomas Pincock, from a private memoir written for his children. Joan (Pincock) Friesen, p.c.

[161]BMHCA SB31 F1, 2, *passim.*

[162]PAM RG18 A4 Box 12, Baragar to Clubb, 18 September, 1926.

[163]BMHCA SB31, Baragar to Fleming, 10 February, 1927.

an affiliation was inappropriate for a professional woman, and its suspect nature was only compounded by the secret manner in which the union was organized. Baragar reacted with further indignation to the nurses' demand that lectures be compensated, rather than being considered part of nurses' "free time" activity:

> I can scarcely believe that any nurse had so little interest in her work as not to find the lectures added inducement. As a matter of fact, this Hospital has a far greater number of applicants and more desirable applicants since the lecture program was commenced.[164]

Baragar was keenly aware of the incompatibility of unionism with the prevailing models of nursing care and nursing instruction. He must have therefore been aware that the formation of a union involving apprentice nurses would significantly diminish the reputation of the school in the eyes of the nursing community and put into great peril his existing affiliate program and his prospects for a post-graduate program. Certainly, the union activity would have been noted by the élites within the general nursing community, and although there is no firm evidentiary base, there is reason to suspect that the discontinuation of the affiliate program in mental and general nursing was at least in part due to the discomfort that the presence of nurses with a known affinity for unions would have created for the superintendents of the general hospitals. This may have been Baragar's anxiety when he wrote of Labour MLA William Ivens, who had taken up the attendants' cause:

> He has lost sight of the fact that we are trying to develop a training school not only for the sake of the patients, but to actually improve the status socially and economically of those who are caring for mental patients...[165]

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[164]Ibid.

[165]PAM RG18 B2 Box 3, Baragar to McLean, 26 March 1927.

Mathers expressed similar concerns in a lengthy letter to the Deputy Minister in March of 1927, wherein he railed against the possibility of allowing unions in health care facilities. This letter was accompanied by a clipping of an editorial from the *Manitoba Free Press* beginning "No Government in Manitoba has ever given its Civil Servants the right to form a union which is subject to outside domination and control..." Mathers stated that while he was generally favourable to collective bargaining in the industrial sector, it was death to a hospital:

> The primary aim of any hospital must always be the care of sick people and in every phase of hospital activity the patients' welfare must have the first call of consideration. The care of sick people - certainly of mentally sick people - is not a thing which can be made to conform to any set of principles or actions. Life and disease are very uncertain, unpredictable things, and where there is this uncertainty, where it is impossible to forecast future happenings accurately, where emergencies of greater or lesser magnitude are constantly arising, it is impossible to lay down a fixed and realistic schedule of governing work or responsibility.... Principles that apply excellingly in factory or workshop where materials worked with are inert... could not be expected to apply in work with human lives. A Union among nurses and attendants would inevitably bring into antipathy the welfare of patients and the welfare of employees to the detriment of the former sooner or later.

Even more perilous was the probable consequence of union affiliation for the trained nurses' program:

> For five years strenuous efforts have been made to have the training of Nurses in mental hospitals recognized by authorities of the Nursing profession. This recognition is going to be based upon a system of affiliation with the training schools of the General Hospitals with interchange of pupils with the purpose of instruction. At the present moment, the long looked for arrangements are at the point of being satisfactorily concluded. All this work will be lost and the mental hospital nurses refused the recognition so long sought for if the principles of Trade Unions are allowed to play a part in the workings of Mental Hospital Training Schools. These principles are looked upon by General Hospitals as subversive influences and they will not receive for training, nurses coming from unionized hospitals nor will they allow their

own pupil nurses to go on to such hospitals and for special training.[166]

Perhaps in part for those reasons, and certainly because they were the most vulnerable members of Local 33, it was the female nurses who were singled out as the point for breaking the union. On the instruction of the Deputy Minister, Baragar called several assemblies of the nurses at which he condemned them for their actions, impugned their motives and appealed to their sense of duty with regard to the welfare of their patients.[167] At the end of the meetings, each nurse was asked to sign a pledge indicating that she would dissociate herself from any union activities. The text of this undertaking is transcribed as follows:

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Medical Superintendent,

Brandon Hospital for Mental Diseases.

Sir:

I beg to inform you that I have dissociated myself entirely from the Trade Union and promise not to join this or any other unapproved organization of a similar nature while I am a nurse in training.

I further promise to faithfully comply with all the rules of the Hospital and the Training School.

Signature:_____[168]

The hospital's trump card in its effort to break the nurses was the training school. As historian Michael Rosenberg has observed, both hospitals and nursing students were cash

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[166]PAM RG18 A4 Box 12, Minister's Carbon Copy of letter from Mathers to McLean, 17 March 1927.

[167]PAM RG18 A4 Box 12, Baragar to McLean, March 1926

[168]BMHCA SB31, *passim*.

poor, and their relationship was founded on barter -- diplomas for work.[169] As apprentices, the reward for their years of service to the school was the certificate with which they graduated and the credibility and mobility that it bestowed upon them. The meaning of Baragar's threat that the medical staff of the hospital might not "give of their own free time to the instruction of nurses who had thought so little of the opportunities they had" was not lost on the nurses, and most signed the pledge and withdrew from the union.[170] Of the student nurses, those who refused to sign, although they were not dismissed, were debarred from attending classes. The tactic was successful, and in the end, all the nurses withdrew from the union.

Contrary to later claims by hospital officials, union membership did not always go unpunished. Although Baragar denied that any nurse was demoted or otherwise prejudicially affected because of membership in the union, later testimony revealed that this was not entirely the case:

> The qualifications and character of the individual are the factors taken into consideration when promotions are being made... The participation in a union secretly formed, not recognized, and based on grievances largely selfish in character and ignoring the welfare of the patients and not for the mere purpose of organization... indicates a serious flaw in character of viewpoint or the person concerned..."[171]

One such case was that of Miss H.J. Scott, a graduate mental nurse who was demoted from Supervisor to Ward Nurse, for her union activities. Baragar's version, as recounted to the

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[169]See Chapter 2

[170]PAM RG18 B2 Box 3, Baragar to McLean, 24 September, 1926.

[171]PAM RG18 B2 Box 3, "Return to the House," 26 March, 1927.

Civil Service Commissioner, was that Scott's position was a two month term, and that at the end of the term, finding her work satisfactory, he offered her the job on a permanent basis. In the course of this interview, Baragar reported, Scott "answered in the affirmative when asked if she could loyally perform her duties." Subsequently, Baragar learned that Scott was a "leader in the Union, and [I] therefore deemed her loyalty was compromised." In the eyes of the medical superintendent, her union affiliation amounted to evidence of punishable dishonesty:

> ...she was lying when she said that she was satisfied with the terms of employment, and she was therefore sent back to her customary ward.[172]

After the withdrawal of the nurses, the union continued to press its demands, and although it was never officially recognized, representatives were permitted to meet with the Civil Service Commissioner. Fleming acquiesced to some of the demands of the staff, including the issuance of rule books and a small pay increase. On the issue of the eight hour day, however, the Commissioner found that "The present plan was as good as could be worked out," and cited the primacy of the practical needs of the hospital: "Hours must be arranged to suit institutional necessity."[173]

Fleming praised Baragar for his general handling of the affair, and he made special note of his handling of the nurses. In his general summary he encouraged the superintendent to take this course of action to its logical conclusion:

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[172]BMHCA SB31, Baragar to Fleming, 10 Feb 1927.

[173]PAM RG18 B2 Box 3, Fleming to Clubb, 21 February, 1927. Fleming's behaviour in this instance is unusual, and must certainly have seemed contradictory to Baragar, whose authority he compromised when he permitted a meeting between himself and the leaders of an unrecognized union.

> I believe taking everything into consideration, the employees of the mental hospital are exceedingly well treated, well paid and comfortably housed... I cannot understand the reason for the agitation that has taken place, except that it may be the work of a few agitators. If this is so and these agitators are members of the staff their services should be dispensed with.[174]

The Superintendent dismissed several employees in the course of "cleaning-up" after the ugly affair. At least one of these employees, A.G. Anderson, was blacklisted by Baragar, who sent a letter to at least the five other mental hospitals in Western Canada labelling him as an "undesirable employee."[175] Anderson took his grievance over his dismissal to William Ivens, a Labour MLA, and between 1926 and 1928 Ivens pressed hard for an investigation into the labour situation at BHMD. Ivens' charges were eventually answered in the spring of 1928, shortly after the Hospital was placed under the authority of the newly created Department of Health, when Minister Montgomery named Justice Gregory Barrett of Carberry, former Winnipeg Mayor Thomas Sharpe and former Labour M.P. Arthur Puttee to a Royal Commission of Enquiry into the affairs at the Hospital. In May and June of 1928, the Barrett Commission toured Manitoba's custodial hospitals and heard testimony about the conditions of work at the Brandon and Selkirk Mental Hospitals.

Baragar did not fare well in the testimony presented to the Royal Commission. Even Baragar's supporters, like Thomas Pincock, then Deputy Minister of Health, recognized that his disposition was sometimes cold and authoritarian. Pincock wrote in his memoirs:

> His demands on the staff to live up to his enthusiasm for reform brought him into conflict with some of the old time members of the staff who took the

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[174]*Ibid.*

[175]Cited in Kurtland Refvik, *A History of the Brandon Mental Health Centre, 1891-1991,* (Brandon: Brandon Mental Health Centre, 1991), 69.

> opportunity to over-react and exaggerate some justifiable complaints into open hostility and unjustifiable charges against Dr. Baragar who was less tolerant of them than a man of weaker personality might be.[176]

This opinion was mirrored by David Willey, an attendant at the hospital between 1926 and 1930 who wrote in 1978: "Dr. Baragar was in some respects a proud man... His ego strongly mirrored his desire for success, and tempered with better human relations, he could easily have made it."[177] Willey commended the work that Baragar did between 1920 and 1925, and suggested that in this period he was largely respected by the staff.[178] He posited that the sour relations were in part a product of a struggle between Baragar and the Department of Public Works over staffing. Willey recounted that Baragar ignored an Order in Council issued in 1926 that extended paid holiday time at a time when the hospital could little afford to grant it. Employees of the hospital became aware of the Order, and went "over the head" of Baragar, who was drawn into open conflict with the Deputy Minister. Willey concludes: "Dr. Baragar strongly resented the action by Winnipeg, and laid his fury on the staff particularly, by changing hours of duty, and generally making things miserable for the staff."[179]

In the end, the Commission's report was only six pages long and found entirely in favour of the Hospital and its administrator. Baragar was found to be highly competent in

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[176]Thomas Pincock Memoir.

[177]BMHCA, Unsorted Materials, David Willey, Notes appended to front of copy of Report of Barrett Commission, 20 November, 1978.

[178]Although Willey was not in the employ of the hospital in the early 1920s, three of his siblings were. BMHCA SB2 F31, Interview with David Willey.

[179]Notes appended to front of copy of Report of Barrett Commission

the discharge of his duties:

> We consider that it is an institution of which the Province of Manitoba can be justly proud and in our opinion a great deal of the credit for its present successful condition should be given to Dr. Baragar. We also feel that much of the success of the administration of the institution is owing the kindly, tolerant, and humane character of Dr. Baragar.[180]

The Commission concluded that Ivens had been "deceived" by the parties that had led him to make his charges, and that the whole incident was not attributable to the end of the living-out allowance and the failure to implement the principle of one day's rest in seven.[181] On this count, the Commission expressed sympathy for the situation in which the hospital administration found itself, acknowledging the under-staffing at the hospital and the lack of funds either to employ more staff or to find accommodation for new staff should they be employed.[182]

Although he was not only exonerated, but in fact praised by the Royal Commission, Baragar was damaged by the two and a half years of labour strife. Relations at the Hospital

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[180]MLL. *Report of the Royal Commission of Enquiry into the Conditions of the Brandon Hospital for Mental Diseases*. (24 August, 1928). 6

[181]Even after the report of the Commission, Ivens did not let the issue go, accusing the Commission of partiality and "eulogizing" about the benefits of the institution. He charged that the testimony rendered at the Commission had been the cause of "wholesale dismissals. He accused the Commission of neglecting the real cause of his complaints, and of using their investigation instead as a means of weeding out undesirable employees:

> When the [Commission's] report is filed upon matters I had not complained of, this is used as ground for dismissing of employees whose complaints seem very largely substantiated.

PAM RG18 A4 Box 12, Ivens to Montgomery, 21 Sept 1928.

[182]MLL, *Report of the Royal Commission of Enquiry into the Conditions of the Brandon Hospital for Mental Diseases*, 2.

continued to be poisoned, and at least three employees were dismissed as a result of the testimony that they gave before the Barrett Commission, which offered no protection to its witnesses.[183] In what was seen to be a punitive move the training course was extended from two years to three.[184] This had the effect of delaying by one year the pay increase which accompanied the completion of the course. Shortly after the Report was released, Baragar requested and received a one year leave of absence at half pay to do post-graduate research in England. He was not to return. In April of 1929, a meeting of off-duty attendants, no longer calling themselves a union, voted eighty percent in favour of sending a petition to the Minister requesting that Baragar not be permitted to return. The remaining twenty percent favoured a petition requesting that his return be probationary.[185] In September of 1930, Baragar gave notice of his resignation to take up the position of Commissioner of Mental Health for the Province of Alberta.

The events of 1926-9 provide some insight into the occupational culture of the first generation of trained mental nurses. The affiliation with and the rapid withdrawal of most of the apprentices from the union in 1926 is best understood with reference to a rational actor model. Their credential was of little value outside of the Manitoba mental hospitals, and the evidence is that many of the nurses remained on staff with the hospital indefinitely

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[183]Doug Smith *et al.*, *Lives in the Public Service.* 42.

[184]Notes appended to front of copy of Report of Barrett Commission. In fact this charge is probably not well founded, and the motivation for the extension of the course was probably to bring it more closely in line with the courses offered at general hospitals, and in the case of the male attendants, with similar courses offered in Ontario and the United States.

[185]Doug Smith *et al.*, *Lives in the Public Service*, 43.

after graduation. When their initial effort to improve the conditions of their labour failed, they withdrew to ensure that their diploma, the key to upward mobility within the closed system of the mental hospital community, was not threatened. This strongly suggests an instrumental, as opposed to a professional, identification with the work.

This episode also clarified the position of the nurses within the power structure of the institution. The relationship between the Hospital and its student nurses was one of reciprocal dependence, but it was the nurses who had the most to lose. The hospital was the final arbiter of whether a nurse would receive her diploma or not, and the threat of being debarred from courses represented not only a loss of upward mobility, but of one of the few tangible (and marginally merchantable) rewards for the work performed at the training school.

It can be argued on this basis that the mental nurses of the 1920s occupied an intermediate position, identifying neither fully as nurses nor fully as wage workers. Unlike their hospital trained counterparts, mental nurses found it difficult to lay claim to a proprietary knowledge base or a set of defining skills that permitted them to differentiate themselves either from their untrained predecessors or from other workers at the hospital, including the male attendants. This intermediate position was reinforced by the gradual introduction of general hospital trained nurses onto the wards of the mental hospitals in the 1920s. The promotion of these nurses into supervisory positions that were unavailable to Diploma Graduates provided immediate and obvious evidence of these nurses' inferior position and the lesser value of their credential.

Historian Kathryn McPherson has argued that nurse training consisted of two parallel

and equal processes. The first was the imparting of scientific language and skill, and the second was communicating an appreciation for the "system" or ideology of nursing as a profession.[186] The BHMD School of Nursing of the 1920s only marginally met these tests. With respect to the first, there was a weak link at best between the practical and the theoretical dimensions of the apprenticeship. With respect to the second, because the "system" promised no future rewards, nurses were reluctant to support it. The apprenticeship system survived because it was supported by a fundamental economic logic. Nurses endured the rigorous, often restrictive life of the training school and tolerated the hard and often dirty work not for its own rewards, but because it promised economic security and admission into a privileged community. Because the psychiatric community could not compel the recognition of its nurses by the broader medical community, this logic broke down. The mental nurses of the 1920s evolved a culture of resistance precisely because that basic economic rationality did not underlie the ritual of the training school. With no real prospects for advancement, the nurses of the 1920s sought to meliorate their immediate situation, even if they did so at the peril of their institution's reputation.

In the end, the establishment of the training school must be seen primarily to have served the ambitions of the psychiatric community to have their practices validated by the broader medical community. The existence of a trained nursing service was the hallmark of the hospital, and thus it should be no surprise that the establishment of a training school should be central to the strategy of the psychiatric community to improve their standing. To

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[186]This is a central contention of Kathryn Mae McPherson, "Nurses and Nursing in Early Twentieth Century Halifax," (Unpublished MA Thesis, Dalhousie, 1982).

be fair, the presence of nurses on the wards was not adornment. The psychiatrists' understanding of the aetiology of mental illness called for rigorous, interventionist and decidedly medical treatment. The absence of a range of effective therapeutic devices, however, limited the extent to which medicine was practiced, and with the persistence of paradigms of custodial care, it may be argued that the mental nurses at Brandon in the 1920s may have had as much in common with the asylum attendant of the previous century as with the general hospital nurse.

Chapter 4 - "When Love and Skill Work Together, Expect A Masterpiece" - Motto of the BHMD School of Nursing
Therapeutic and Demographic Change, 1930 - 1939

The 1930s represented at once a continuity and a disjuncture from the preceding decade for the Brandon Hospital for Mental Diseases. The hospital continued to be plagued by problems of overcrowding and under-funding, but the decade, on the whole, was a period of growth and development. Modest capital improvements, including the erection of a third primary structure, the Women's Pavilion, continued through the decade. The most significant changes however, were not manifest in bricks and mortar. Numerous progressive reforms were made, including the institution of a parole system, the opening of an outpatient department, and the abolition of visibly fenced airing courts. Significant advances were made in occupational therapy, and although no "cure" was forthcoming, the psychopathic Unit became the locus of increasingly ambitious programs, with new therapies and interventions being introduced.

One of the ironies of this growth was that it took place in the global context of the Depression and in the regional context of drought and high unemployment. The economic collapse of 1929 devastated the international economy, leading to poor market demand for the products of the prairie and causing the failure of numerous businesses. The global effects of the Depression were compounded at a regional level by the large-scale failure of agriculture. As a provincially funded institution, the hospital was compelled to endure sharp declines in funding. The Bracken government, which had been parsimonious during the 1920s, became even more tight-fisted in the 1930s when faced with declining revenues and

growing demands for new expenditures on relief projects. Nonetheless, the beginning of the 1930s signified the beginning of a new era for the hospital. Changes in staff demographics and the introduction of new therapeutic régime helped to create the cultural context - a sense of a modern therapeutic institution - that had been so elusive in the Baragar years.

The beginning of this new era was marked by a change at the helm. In 1930, Thomas Pincock left his position as the Assistant Deputy Minister of Health and Public Welfare to assume the superintendency that had been vacated a year before by Charles Baragar. Like his predecessor, Pincock took control of an institution that was facing a crisis of public confidence. By his own account, the hospital which he inherited "could not be said to measure up to desirable standards."[1] Although the hospital was much transformed in the ten years after the first report of the Canadian National Council for Mental Hygiene[2], the results of another institutional audit by the same organization in 1929 were no less damning. The second report generally bears the name of its author, D.M. LeBourdais, but the hospital visit was conducted by Clarence Hincks himself, who was accompanied by social work activist (and his soon-to-be wife) Marjorie Keyes, Dr. Grant Spalding of McGill University and a Mr. Spalding of the [American] National Committee for Mental Hygiene. This investigation had been sparked by a journal article written by LeBourdais, a freelance writer and Hincks' personal assistant, after a visit to the hospital at an undisclosed date earlier in the year. LeBourdais described the hospital as filthy and overcrowded:

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[1]BMHCA, Unsorted materials, Thomas Pincock, Unpublished Memoir Written for his Children, unpaginated.

[2]Ibid.

> The beds were so close together that the patients could not fall out of them. Many patients slept on straw mattresses made of rough ticking filled with straw, which were burned when soiled..."[3]

While, unlike the 1919 report, this one was unsolicited, its effect was similar. Pincock recorded that in the end he welcomed the political resonances of the LeBourdais Report, even if they made for "not a very auspicious start" of his term as director of the hospital. By 1930, the Bracken government's reluctance to spend on public institutions was deepening and the LeBourdais report gave Pincock the political clout that he needed to make demands of the government. He recalled:

> In the end it was a good thing as it alerted the government to the need for changes to improve the plant and the service, and this made my way less difficult than it otherwise would have been. This public expected change and were willing to support reform even if it did cost them something.[4]

Pincock's invocation of public sentiment was reminiscent of Baragar, and indeed he shared with his predecessor the same public passion for hospital based mental health care reform. As in the previous decade, it would be the passion and personality of a psychiatrist that would be the primary engine of change at the institution. Pincock was a former medical missionary and, in the years immediately before his appointment, Manitoba's first Deputy Minister of Health and Public Welfare. Like Baragar, Mathers and Barnes, Pincock traced his entry into psychiatry to his experiences during the First World War. Although not yet a doctor, Pincock was stretcher bearer, and according to his personal memoir, was greatly influenced by his "almost daily contact with psychoneurotic and psychotic soldiers... in the

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[3]BMHCA SB4 F9, Unpaginated photocopy of the LeBourdais Report.

[4]Pincock Memoir, 73.

form of malingering, self-inflicted wounds, phobias, hysterics, amnesia... and an array of psychosomatic complaints"[5]

As the LeBourdais report identified, one of the fundamental continuities from the 1920s was overcrowding, and the 1930s witnessed a steady increase in the daily patient population. The number of patients grew from just over 1,000 in 1930 to nearly 1,300 in 1935. By 1940, there were on average about 1,500 patients in the institution.[6] Although LeBourdais doubtless took some liberty when he claimed that patients' beds were placed so close together that they could not fall out of them, Pincock's recollections bear out the substance of this accusation. The dormitories of the main building were filled well beyond capacity throughout the decade, and large numbers of patients were housed in basically windowless rooms originally constructed as trunk rooms. Pincock recalled that "a good many" patients were obliged to sleep on corridor floors and in day rooms, and that at the height of the overcrowding crisis, some patients even slept in stair landings.[7]

The opening of the Colony in the mid-1920s had alleviated some of the population pressure on the male wards, and in the early 1930s, it was the female side that was in crisis. The first years of the decade witnessed a dramatic decline in the general health of the female

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[5]Pincock Memoir. Thomas Pincock " A Half Century of Psychiatry in Manitoba," *Canada's Mental Health,* (Department of National Health and Welfare, May-August, 1970), in which Pincock briefly assesses the impact of the War on institutional psychiatry in Manitoba.

[6]BMHCA SB23a F8, *Annual Report for 1930*, and SB23b F4 and F8, *Annual Reports for 1935 and 1940.*

[7]Pincock Memoir.

population, both of patients and the staff who cared for them.[8] This situation was remedied in part by the erection of the Women's Pavilion, started in 1931 as an employment creation project.[9] Described as "a building suitable for the care of chronic disturbed female patients," the Pavilion was designed to accommodate 140 women. In addition to its other amenities the Pavilion was to contain eight prolonged baths for therapeutic use, and a number of cell-like single rooms for violent or destructive patients.[10]

Besides alleviating the pressure on the female wards of the Main Building, the Pavilion was intended to reduce the pressures of overcrowding in the Nurses' Residence. On its completion in the fall of 1933, all of the two dozen kitchen, laundry and sewing room staff were removed from the Residence to the top floor of the Pavilion, as were about a dozen male attendants who had previously been compelled to sleep on the wards with the patients.[11] This is significant on several counts. From a practical standpoint, the simple creation of twenty-five new beds freed-up additional accommodation in the Nurses Residence, which permitted the hiring of additional staff. Without these additional beds not only would the hospital have faced acute shortages of female staff, but the re-instatement

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[8]BMHCA SB23a F8, *Annual Report for 1930*; BMHCA SB23a F8 *Annual Report for 1931*; and SB 23bF1 *Annual Report for 1932*. See especially section on staff illness and respiratory disease. The death of a student nurse of tuberculosis in 1932 had a galvanic effect on Pincock, who lobbied tirelessly for better conditions in the female service.

[9]Pincock memoir.

[10]PAM GR 164 Box 33, MacNamara to McGillivary, 4 July 1931.

[11]BMHCA SB23b F1, *Annual Report for 1932*, and BMHCA SB4 F15, File: "Construction and Maintenance, Women's Pavilion, 1931-33." *passim*.

of the post-graduate program would have been improbable.[12] At the level of institutional culture, it also had the function of creating a division between the nursing and the support staff which had not been previously so strongly signified. The rooms in the Pavilion were definitely of an inferior type. Far from the stately home environment provided in the Nurses' Residence, Pavilion rooms were utilitarian and sparely finished. The residents were provided with neither a parlour nor a dining room: they entertained in their rooms, and continued to dine in the Nurses Residence which, being an unconnected building, required that they traverse the grounds to take their meals. Even the beds were narrower, the doctors and the nurses being given full-sized fully sprung beds, while male attendants and female support staff received only a cot-width bed.[13]

The removal of the support staff not only created a more homogeneous social environment within the Nurses' Residence, but it facilitated at least in the short term, a slight re-configuration of the accommodations. Although probationer and first year nurses continued to share rooms or to live four to a room, the opening-up of a whole wing facilitated the creation of more single rooms for senior students, supervisors and graduate nurses. Single rooms were more in keeping with contemporary notions of respectable accommodation, and were thought to be more consistent with the standard generally offered in a large urban general hospital. They were also more in keeping with the original design

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[12]BMHCA SB23b F1, *Annual Report for 1932.* The post-graduate program was re-established in the fall of 1932, just over a year before the Pavilion was occupied, but it is improbable that without the promise of further accommodation that the hospital would have attempted to attract graduate nurses.

[13]PAM GR164 Box 33, Pincock to MacNamara, 4 October 1933; Margarie (Johnson) Anderson, Interview with the author, Brandon, 2 April 1995.

of the Residence, which had been constructed with a much smaller staff in mind and was originally to have provided single rooms for all nurses, regardless of seniority.[14]

Relief was only temporary and the steady increase in patient numbers quickly compelled the hospital to increase its staff again beyond the capacity of the Residence. In 1937, the total number of nurses, students and staff accommodated in the Residence had risen to 113, more than half again as many as it was designed for. That year, Pincock reported: "Our Nurses' Home has long since failed to provide sufficient privacy and comfort, especially for student nurses in their senior years, and graduates who are obliged to occupy double rooms designed for one person."[15] Pincock was less circumspect in a letter to the Minister of Public Works earlier the same year. Here he ventured that the hospital was jeopardizing the "physical and mental health" of nurses who were "living under conditions that cannot be defended."[16] Pincock shared his predecessor's emphasis on nurse training based on the general hospital apprenticeship system. Early in his career at the hospital, he wrote to the Minister of Education of the need for the Training School to be recognized as on par with those in the general hospitals:

> Public and professional recognition of such a nursing service is necessary for its full development. In Great Britain this has, I believe, been already granted. There the psychiatric nurse has taken her place beside the general nurse. In the more advanced parts of the United States the same recognition

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[14]The importance of "respectable" single room accommodation in the nurses' home is extensively justified in a letter from the Deputy Minister of Public Works to his superior at the time of construction. PAM GR 34 Box 33, "Memorandum for the Minister" [Oxton to McPherson], 7 December 1921. See also chapter 3.

[15]BMHCA SB23b F6, *Annual Report for 1937.*

[16]BMHCA SB4 F11, Pincock to McGillivary.

> has been granted when her training includes a supplementary course at an affiliated hospital.

In the same letter, Pincock revealed his ambition to form such an affiliate course to make up for the deficiencies in the training offered locally:

> In Manitoba we favour the latter method of training ['supplementary courses at a general hospital']. Mental patients are even more prone to suffer from physical disease than normal people, and require the same care during bodily illness. In the best interest of humanity she should in every sense be able to take her place beside her sister, the general nurse. With this object in view the course at this hospital has been designed to dovetail into a further course of training at an affiliated general hospital.[17]

In the absence of any such program, Pincock acknowledged the need to continue to offer a course leading to a mental nursing diploma, and it was this situation that was to prevail for the duration of his tenure at the hospital. While Baragar had been consistently frustrated by his inability to attract to service at the hospital the women of the respectable middle classes that he deemed necessary to build the nursing service he envisioned, his successor was not faced with the same problem.

The onset of the Depression and the scarcity of employment both in Brandon and in the rural communities of southern Manitoba altered the composition of the nursing service. Long deemed an employer of last resort, the Hospital had for most of its existence drawn from the economically disadvantaged classes, and a large proportion of the early ward attendants and the first generation of trained mental nurses were recent immigrants from Ireland and Scotland. During the Depression, widespread unemployment forced a wider cross section of the public to consider employment at the mental hospital, and Pincock

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[17]BMHCA, Unsorted materials, Pincock to Hoey, 18 May 1931.

recalls in his memoirs that "the recruitment of staff in all categories, professional, trained and untrained, was a comparatively easy matter."[18] As the decade progressed and the economic crisis deepened, the hospital was able to exercise a preference for hiring native born women, many of whom came from urban middle class and trades backgrounds, or from agricultural communities.[19]

For many of these women nursing was not a career of first choice, but rather it was a decision born of economic necessity. For Eleanor (Greene) Noakes, for example, nursing represented nothing more than a stable job that offered free room and board to someone who was "scared to death" of the prospect of unemployment. For Madeline (Ballard) Whyte:

> I thought, well, I can start there, and at least we are paid our board and room and uniforms and twenty-five dollars a month, which was a fortune at that time.[20]

Others entered after an earlier career path proved impossible to follow. In the graduating class of 1937, for example, fully one half of the graduates had a normal school certificate, and some had taught school before affiliating with the hospital.[21] For these women, teaching was simply not economically feasible. Marjorie (Johnson) Anderson put it most succinctly when she repeated, "The pay was pitiful." Anderson recounted that she and several other friends from Brandon Normal School applied together in the fall of 1934 when faced with

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[18]Pincock Memoir.

[19]BMHCA SB45 F3, Nursing Register, 1925-1942.

[20]Madeline (Ballard) Whyte, Interview with the author, Selkirk, 5 January 1996; Eleanor (Greene) Noakes, Interview with the author, Brandon, 12 February 1996.

[21]Marjorie (Johnson) Anderson, Interview with the author, Brandon, 2 April 1996.

another season of teaching at a base rate of pay of thirty dollars per month, exclusive of room, board, and personal maintenance. Compared to teachers' pay, the twenty-five dollars paid monthly to nurses, who received free room and board and uniforms, was a "princely" sum.[22] Lillian (Goodman) McLennan, who was attracted to the hospital in 1934 by her sister who went to work there after being laid off as a public health nurse, put it similarly:

> It was all economics. Teaching, you got forty dollars per month for ten months and had to pay your way, and nursing you got twenty-five dollars a month and your board and uniforms. So you got more money as a student nurse than as a rural teacher, and a roof over your head twelve months a year.[23]

Mental nursing was even able to attract those who had not yet entered teaching. One nurse recalled that she had had ambitions to teach, but that they were frustrated by her family's inability to pay her tuition and support her at home for the duration of her training. Affiliation with the mental hospital training school was the only form of work preparation that was available to her.[24]

Even for those who had ambitions to pursue a career in nursing, there were impediments. For most, the main impediment was financial. Some historians have argued that nurse training offered an acceptable means to financial independence for women of limited means because, unlike normal school or business college, apprentice nurses were not

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[22]Ibid. This situation was prevalent across the province. Mable Lytle recalled that when she was doing apprenticeship at Winnipeg General in the mid-1930s, a large proportion of the domestic and serving staff were unemployed teachers. PAM Oral History Collection, C 910 - 912. Mable Lytle, Interview with Kathryn McPherson, Winnipeg, June 1987.

[23]Lillian (Goodman) McLennan, Interview with the author, Winnipeg, 11 April 1996.

[24]Anonymous nurse, Interview with the author, Winnipeg, 16 November 1995.

required to pay tuition.[25] Even so, with its poor compensation and its requirement that the pupil nurse supply her own uniforms, general training remained prohibitively expensive. Jean Young, in her interview with Kathryn McPherson in 1990, commented that nursing at BHMD offered her the only entrance into nursing that would allow her to be financially independent of her family. As the oldest sibling in a large family, she could not count on the financial support of her family to help her with the expenses of general training.[26] Madeline Whyte expressed exactly the same view.[27] Marjorie Anderson noted that the rate of pay for a pupil nurse at Brandon General Hospital was a mere four dollars a month, and that out of that, nurses were expected to pay for their own uniforms and to contribute to a "breakages" fund[28]. Employment at BHMD, with its comparatively generous salary created for those pupils a context in which they could save the money that would permit them to go on to a course of general training. [29]

For those women intent on pursuing their general training, BHMD offered an interim career in another way. With an over-supply of suitable candidates in the 1930s, hospitals became very particular about whom they accepted. The favourable labour market permitted nursing superintendents to exclude younger women, who were judged to be a potential

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[25]Charles Rosenberg *The Care of Strangers: The Rise of the American Hospital*, (New York: Science History Publications, 1979).

[26]PAM C-1769-98. Jean Young, Interview with Kathryn McPherson, Winnipeg, 8 May 1990.

[27]Madeline Whyte interview.

[28]Marjorie Anderson interview.

[29]Anonymous Nurse, Interview with the author, Brandon, 14 February 1996.

liability to the hospital because of their immaturity and because they were thought to be more susceptible to tuberculosis and other diseases.[30] Kay Dennis, for example, recalled that as an eighteen year old applicant to Brandon General, she was advised that she would not be accepted before the age of twenty-one, and the Superintendent of Nursing frankly told her that if the she had the option, she would employ no nurse under the age of twenty-five.[31] A three year course at a mental hospital with the option to continue with the service indefinitely, filled the years between Grade XI and the age of twenty-one, providing practical work experience, economic independence, and skills that would make a women a more attractive candidate in the highly competitive bid for a place in a general hospital training program.

The prevalence of ambitions to go into general nursing may be seen in part to have reflected the changing demographic of the second generation of trained nurses. This change may also be seen in their prior educational attainment. Although all that was required for entrance into Training School was Grade X, most of the nurses that entered in the 1930s had completed Grade XI.[32] Some had completed grade XII, and one nurse recalled that at least three nurses in her immediate group had completed university degrees.[33] For many of these

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[30]See Chapter 2.

[31]Catherine Dennis, Interview with the author, Brandon, 11 December 1995.

[32]Prior educational attainment, as well as parental occupation were recorded in the Nursing Register. No careful analysis of this document has been completed, owing largely to its disappearance or loss from the BMHCA archives in the winter of 1996. BMHCA SB45 F3, Nursing Register, 1925-1942.

[33]Lillian McLennan interview.

women, mental nursing was no more than an interim position to be occupied until they could find the means to advance into something more in keeping with their level of education. The sense that many of these women were working below their station seems to have been shared by the senior nurses at the hospital. One nurse who began her training in 1940 recalled that the assistant superintendent, Miss Wilkes (Katherine Weiermann), had told her at the time of her initial interview: "With grade XII, you should be looking for something else." Wilkes advised her at that time that she should pursue affiliation with a general hospital after she completed her mental training. "Because I had Grade XII (along with many others), it sparked them that this was not a place for my life's work."[34]

The demographic change occasioned by the entry of these women into mental training was reinforced by the arrival at the hospital of a large cohort of graduate nurses. These were recruited from three main sources. First, in 1932, the Hospital re-established its post-graduate training program. This took the form of an intensive three month course of lectures and theoretical training, with a lesser requirement for ward work than the standard diploma program.[35] Many of the nurses who enroled did so due to the lack of available work in the general nursing community, and for the same reason, many of them remained beyond their period of training as staff nurses and supervisors.

One of the features of the 1930s was what has been called the "crisis of general nursing", the crisis of over-supply in the private duty nursing market that coincided with the

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[34]Jean Young interview.

[35]BMHCA, Unsorted materials, "Brandon Hospital for Mental Diseases School of Nursing" [prospectus for the post-graduate program, 1932]; Katherine (Wilkes) Weiermann, interview with the author, Winnipeg, 11 December 1995.

rise of the modern hospital. Widespread unemployment among graduate nurses prompted a growing number to seek employment in the more secure world of institutional nursing. Katherine (Wilkes) Weiermann was one such nurse. After a brief career as a school teacher in the 1920s, Weiermann, who had been strongly influenced by her aunt, a public health nurse, qualified at Winnipeg General. Weiermann recalled that at the time of her graduation in 1932, "nurses were simply starving to death," and that institutional employment was her best prospect. She briefly considered staying on at Winnipeg General, which was by then hiring back its graduates on a short term basis to alleviate the worst effects of the Depression, but concluded that there was no long term future in general nursing and did not foresee that she could make a career in hospital nursing. She chose the Brandon Hospital for Mental Diseases, largely on the basis that it provided long term employment and free accommodation:

> If I went to Brandon I would get my room and board and a little bit of pay.... I figured that they [mentally ill persons] would always be with us, and better I get settled in something that was going to carry on.[36]

The second source of general hospital trained nurses on the wards was the Neepawa General Hospital, which in 1929 struck an affiliate relationship with the hospital whereby apprentices were required to complete a three month rotation on the wards of BHMD.[37] Again, with diminishing opportunities for employment elsewhere, several of the nurses gravitated back to the service of the hospital. These were joined in 1930 by graduate nurses from the public health nursing service, who were all given a short course in nursing mental

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[36]Katherine Weiermann interview.

[37]BMHCA SB23a F7, *Annual Report for 1929.*

disorders. This course, which consisted of one week at each of Winnipeg Psychopathic and BHMD was probably too short to have made much impact on the institutional culture but it alerted a number of women to the potential for affiliation, and a number of registered nurses who came to work for the hospital in the mid- and late-1930s had a public health background.[38]

A third source of graduate nurses took the form of a one-time infusion of former public health nurses who came into the more or less permanent employ of the hospital in 1932. In that year, the province laid off more than half of its public health nursing service. These women were given preference for alternative employment at public institutions, including the two mental hospitals, the Portage School for Mental Defectives, and the Ninette Sanatorium. In all, six nurses took up with BHMD, roughly doubling the number of graduate nurses on the wards.[39]

By the mid-1930s, therefore, the wards at the BHMD were populated by a significant and growing number of graduate nurses. This presence could only have strengthened the position of the hospital with respect to the general nursing community. Not only did the presence of a large cohort of Registered Nurses signify to the public at large the medical legitimacy of the hospital, but these women themselves, many of whom had come from the élite sector of public health nursing, must have connected their own reputation to that of the hospital. Although no hard evidence of graduate nurses working for the recognition of their hospital remains, throughout the 1930s, the Nurses' Residence was the meeting place of the

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[38]BMHCA SB23a F8, *Annual Report for 1930.*

[39]BMHCA SB23b F2, *Annual Report for 1933.*; and Lillian McLennan interview.

Brandon and District Graduate Nurses' Association, and several of the graduate nurses at the hospital participated in these activities.[40]

The same factors which persuaded more women to seek employment at the hospital in the 1930s also compelled them to stay for longer periods of time after graduation. While it is true that transiency remained very high, with as much as a third of the female staff turning over in any given year, the number of graduates on staff grew through the decade. In 1934, the number of mental graduates for the first time surpassed the numbers of pupil nurses.[41] This situation prevailed for the rest of the decade, and two years later the numbers showed an even greater persistence of trained staff, with only twenty-two pupil nurses on staff as compared with fifty mental graduates, eight general graduates and twelve general graduates with post-graduate certificates in mental nursing.[42] In the Annual report for 1937, Pincock repeated: "With few exceptions all our pupil nurses stay for an indefinite period after receiving their diplomas. Some leave to take general training and are encouraged to do so. We regret the loss of some recently to other mental institutions offering greater monetary inducements."[43] This last statement doubtless referred to the four recent graduates

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[40]BMHCA SB23a F7, *Annual Report for 1929.*

[41]In July of 1935, when the Annual Report for 1934 was filed, there were forty-one mental graduates on staff and only thirty-nine pupil nurses, excluding the eight who were either probationers or summer relief nurses. In addition to the above named, there were six registered nurses on general staff. The enrolment for the post-graduate program in 1934/5 is unavailable, but Pincock noted that without exception, each of the staff nurses employed at the hospital had also completed the post-graduate program. BMHCA SB23b F2, *Annual Report for 1934.*

[42]BMHCA SB23b F5, *Annual Report for 1936.*

[43]BMHCA SB23b F6, *Annual Report for 1937.*

who left in the spring of 1938 to go the Alberta provincial mental hospital at Ponoka.[44] This problem was not isolated and the following year, Pincock made a similar statement: "We have lost many valuable trained nurses due to inducements from other mental institutions."[45]

The meaning of these demographic changes was not lost on the hospital administration. Pincock recorded in his memoir:

> The economic depression was actually a blessing in disguise, at least for the Mental Health Services. As an economy measure, the Provincial Government reduced the Public Health Nursing Staff by 50% and a score or more of their well trained nurses with community experience, were recruited to post-graduate training in psychiatry and continued to serve the hospital as head nurses, surgical nurses and supervisors. Six of them succeeded to the posts of nursing superintendents and instructresses of nursing education.[46]

In his first annual report, Pincock echoed this sentiment when he referred to the improving labour market from the hospital's point of view:

> Applications are being received from a sufficiently large number of young women with good personal and cultural qualifications to meet our requirements except that the policy of accepting only when a vacancy occurs is a handicap in selection and in teaching.[47]

The same assertion was made about the doctors who came to the hospital after 1929:

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[44]Mable (Davies) Mills. Interview with the author, Winnipeg, 26 October 1995. BHMD was not unusual in employing large numbers of graduate mental nurses. In fact, Ponoka was staffed entirely by graduates. Many of these were recruited from Brandon, probably due to the close ties between BHMD and Ponoka. In the early 1930s, former superintendent Charles Baragar was superintendent at Ponoka and former matron Catherine Lynch was matron. By 1938, Baragar was dead and Lynch was at Winnipeg General, but the ties remained strong.

[45]BMHCA SB23b F7, *Annual Report for 1938.*

[46]Pincock memoir.

[47]BMHCA SB23a F7, *Annual Report for 1929.*

> There was little incentive for the medical graduates to start practice in rural Manitoba at the time and many of them came to us, fresh from their internship, full of ambition, and receptive to the new methods and ideas which occurred in rapid sequence during the thirties.[48]

In this manner the Depression worked to the advantage of the institution, which in a more favourable economic climate would have been unable to attract the desired type of employee. It will be argued that this demographic shift, coupled with the changing orientation to work occasioned by the introduction of new clinical and therapeutic régimes, created for the second generation of trained mental nurses a cultural context which set them apart from the nurses of the 1920s. New therapies and interventions facilitated at least for a few years the realization of the longstanding ambitions of the psychiatric community to "medicalize" their care, but more importantly for the present purpose, placed technical and clinical demands on nurses which formed the basis for the claim to a proprietary skill set, and thus an occupational identity as knowledge workers.

In 1930, the two year course for female nurses was eliminated and replaced with a three year program. The intention behind this change was to provide sufficient grounding in theory and practical nursing to permit the entry of the Hospital's nurses into a program of general training at the second year level, although no affiliate program was to appear for more than a decade. The requirement of an additional year was imposed upon those nurses who had already commenced their program, and the first of the "three year nurses" graduated in 1931.[49] In 1932, the three month post-graduate course for general hospital graduates,

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[48]Pincock memoir.

[49]BMHCA SB23a F8, *Annual Report for 1930.*

dormant since the labour troubles of the 1920s, was re-instituted, with fourteen students graduating. Filled by graduate nurses from the deteriorating labour market, this program was met with consistently high enrolment. Its capacity was determined by the availability of suitable accommodation in the Nurses' Residence more than any other factor.[50] In 1933, the post-graduate course was extended to a full year, and while the first course had been largely academic in content, the new course included longer rotations of ward work that were intended to expose the students to a variety of conditions, disorders and treatments (and perhaps to meet the emerging need of the hospital for a larger complement of skilled general practitioners).

Nurses were taken into training only in September of their first year at the hospital. Most nurses were hired during the summer to replace those who had graduated the previous spring or as relief nurses to fill the gaps left by vacationing nurses, but probationers could be taken on at any time of the year.[51] It was even theoretically possible for a nurse to be at the hospital for eleven months before attending a single lecture if she was taken on in the fall after lectures were started. Lillian (Goodman) McLennan, for example, recalled that when she was permitted to attend lectures immediately, having been taken on more than a month after her class had commenced, this was regarded as an exceptional precedent.[52]

For most nurses, therefore, training started well into their term of employment. Nurses who were accepted in the middle of the year or who were hired as summer relief

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[50]BMHCA SB23a F9 and SB23b F1. *Annual Reports for 1931 and 1932.*

[51]Marjorie Anderson interview.

[52]Lillian McLennan interview.

reported that they were sent on the wards from the first day, often without so much as an orientation. So minimal was the guidance given that several recounted that they got lost on the way to the wards or required assistance in applying the collars and cuffs to their uniforms.[53] Although the nursing superintendent apparently made an effort to place nurses on the smaller wards like the "hospital" (infirmary) wards at first, or on one of the Unit wards where there were only fifteen or twenty patients, there was no strict policy. Marjorie Anderson, for example recalled that her first day on the job earned her a black eye on "West B Special," the single room isolation ward for violent female patients in the Pavilion. Even experienced nurses recounted that they never overcame their fear of this ward, and no doubt this would have been a baptism by fire.[54]

Formal training, in the shape of lectures in medicine and psychiatry, and demonstration classes in nursing technique and pathology, occupied a significant portion of apprentice nurses' time for eight months of the year. Lectures were generally offered during the afternoon "time-off," the window between 1:00 and 4:00 PM when the main day shift were off duty (nearly all hospital employees worked split shifts in the 1930s). Some lectures were offered in the evenings, especially those conducted by Brandon physicians like Sydney Pierce, a close personal friend of Baragar's who maintained an association with the hospital.

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[53]Until the late 1930s, when a more contemporary white uniform was adopted, the nurses' uniform consisted of a blue dress with a separate white starched collar and cuffs. Typical of a nurse's uniform, it was years out of date, and several women reported that they had difficulty figuring out how to put it on. Kay Dennis Interview; and Jessie (Murison) Little (curator of BMHC Museum and class of '47), personal correspondence.

[54]Lillian McLennan interview; Mable Mills interview; and Marjorie Anderson interview.

Beginning in 1935, obstetrics and gynaecology were also taught in the evening, offered to third year mental nurses in common with the second year class from Brandon General.[55]

The utility of these courses varied according to the nurse interviewed. Few were willing to criticize them outright, and some described them as an essential part of their experience. Others suggested that they were of comparatively little importance to mastering the day to day functions of the ward. One nurse went so far as to almost entirely dissociate the lectures from the learning process:

> The experience of a probationer can only be understood by those who experienced it. There were not the formal classes of planned clinical practice that makes up today's educational system...Buddy system with the most junior student on the ward: we soon learned to bathe, feed, clothe and protect. We did have classes from September to April and exams, and in certain areas we had to have experience, but we certainly learned by the apprenticeship system.[56]

The same nurse also emphasised the importance to the learning process of informal networks. She cited, for example, two locuses of learning outside of the lecture room.

> [I remember] the jam sessions on probie lane where we exchanged the events of the day. We knew by reputation the patients on a new ward before we got to it...[and]
> the courtyard where the patients milled about and we kept watch learning more about human behaviour than any psychiatric textbook ever revealed.[57]

It is not clear how intellectually demanding the lectures were, but available evidence suggests that they did not reach the standard of general hospital training. Kay Weiermann

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[55]BMHCA SB23b F4. Annual Report for 1935; and Mary (Churcher) Smeltz, Interview with the author, Brandon, 14 February 1996.

[56]BMHCA SB2 [un-numbered file]. "Recollections of Kathleen (Christie) Wood, Class of '41]."

[57]Ibid.

recalled that when she first arrived at the hospital as a registered nurse in 1932, she found herself providing informal tuition in clinical practice to mental graduates, whom she described as lacking experience. In her mind, there was little question of the inferiority of the training at BHMD. When asked to describe the program she superintended, she replied: "We taught the same things at BMH as at WGH, although at a different level."[58] Similar sentiments were echoed by Mable Mills, who recalled that the course of lectures was much less demanding than her grade twelve year at Brandon College had been, and Jean Young, who recalled that it was rare for a nurse to fail an exam.[59]

It is also unclear the extent to which the lectures prepared nurses to understand the theoretical bases for the procedures that they performed. Some answered quite definitively that they understood the basis for the therapies, while others of the same generation felt that they were equipped only with the practical knowledge of how the therapies were executed. The contradictory nature of these responses suggests that while the theoretical basis for techniques may have been explained, as it was in several of the selections from the nursing library from that period and in the surviving lecture notes of a nurse, such explanations did not occupy a significant place in the minds of the nurses administering the treatments. [60]

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[58]Katherine Weiermann Interview. Note that Brandon Mental Hospital was the name in general use in the 1930s. The formal name of the institution remained the Brandon Hospital for Mental Diseases, but even the nursing uniforms were embroidered with a "BMH" insignia. Samples of uniforms are found in the Brandon Mental Health Centre Museum.

[59]Mable Mills interview; Jean Young interview.

[60]Wallace, Phyllis, "Second Year Lecture Notes, 1938-39" Collection of BMHC Museum. Three surviving works in the library at BMHC that were acquired in the 1930s and that provide detailed descriptions of afflictions and their treatments are: *Handbook*

Outside of the lecture room, nurses continued to provide basic personal services to patients on the wards. For the vast majority of the patients at the hospital, the inter-war years were decades of continuity rather than change. Although clinical advancements were made in the 1930s, the new procedures were generally tried only on a small number of recent admissions, and custodial care remained the dominant paradigm. Within this framework, however, there were several innovations which made the institution more hospitable. One of the most heralded advances was the implementation of parole policy for the third floor wards on the Unit, the wards reserved for patients for whom discharge was imminent. Beginning in 1932, these wards were unlocked during the day, and patients were permitted to come and go with considerable freedom. This privilege was later extended to some of the patients on the chronic wards and at the Colony.[61] This parole program was accompanied by an increase in patients being placed in responsible positions, and the Annual Report for 1932 listed the operation of the telephone switchboard and indexing of periodicals in the medical library among the tasks routinely performed by patients.[62]

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for Mental Nurses. Seventh Edition (London: The Royal Medical-Psychological Society, 1923 [adopted as the textbook for the nurses' course in 1926]; Irving J. Sands. *Neuropsychiatry for Nurses.* Third Edition. (Philadelphia: W.B. Saunders Company, 1937); and Nicholas Gotten and Letitia Wilson. *Neurologic Nursing.* (Toronto: The Ryerson Press, 1940)

[61]BMHCA SB23a F9, *Annual Report for 1931;* and SB23b F1, *Annual Report for 1932.* It should be noted also that the third floor wards contained a number of patients who were not mentally ill but were housed at the hospital for lack of any better accommodation. These included persons whose conditions demanded close supervision or regular medical care, like epileptics or insulin dependent diabetics. Kay Dennis interview.

[62]BMHCA SB23b F1, *Annual Report for 1932.*

Similarly, efforts were made to reduce the number of patients subject to the confines of the airing courts by the institution of walking parties, some of which would include hundreds of patients walking the ground in the charge of no more then a handful of nurses.[63] These parties were reported to take place twice daily "during all seasons in clement weather" and to have taken maximum advantage of the new recreation park (built by patients), which was said to have provided "adequate space, pleasant shade and surroundings." For those patients who were not suited to the walking parties, the cosmetics of the courts were improved by tearing down the high board fences that had surrounded the court and replacing them with a wire fence concealed inside a caragana hedge.[64] Of this innovation, Pincock recalled in his memoir that the board fences were "hideous" and "emphasise[d] the custodial and punitive atmosphere:"

> It was a pitiable site to see rows of poorly dressed dements standing or sitting in complete idleness against these walls in an area from which all the grass had become denuded by the continuous relentless marching of hundreds of patients which [sic] had nothing useful to do... The so called 'bull pen'; openly referred to, as such, in the presence of patients, was an enclosure between two wings of the building. This was surrounded by a high wall and situated on the north side, receiving no direct sunlight and offering no view, and consequently summarily abolished despite some dissenting voices and resistance on the part of some of the attendants who predicted that many escapes would result.[65]

These dissenting voices may have had a slightly different perception of this issue, as evidenced by an anonymous letter to Pincock from a group of male attendants in 1931:

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[63]Marjorie Anderson interview.

[64]BMHC SB23b F1, *Annual Report for 1932.*

[65]Pincock memoir.

> Airing court for the patients is we feel a very poor place. The attendant there is a custodian. He has to sit on the benches and watches [sic] the patients so that they do not run away. We feel that this is contrary to the principles of occupational therapy. Airing court should be a place where the patients can play games, enjoy themselves, and where attendants can carry out their knowledge of true psychiatric nursing. If a fence were erected around it which would not permit the patients to run away then instead of Airing Court being a centre where patients wander up and down listlessly it could be a centre where some attempt towards their recovery can be made.[66]

In this document one finds evidence of an increasingly self-aware staff of male attendants asserting their skills in the face of a doctor driven model of care. The terms of the debate introduced in this letter reflect another key feature of the 1930s - the growing maturity of the hospital as a locus of care delivery.

Another such indicator was the library. An examination of the shelf lists reveals that the collection of books expanded the 1930s.[67] In 1929, Baragar described the library and its collections as "a profit to the medical staff and indirectly through them to the institution as a whole. Its presence is a constant stimulus to good scientific work on the part of the medical staff."[68] That the library of the 1920s was limited to serving the interests of medical research is evident from even the most cursory examination of the shelf lists, as the vast majority of titles from this period were clearly medical in their intended use and audience.[69]

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[66]BMHCA SB3a F3, "From a Group of Attendants [to Pincock], 1931"

[67]BMHCA SB55 F2, "Accession of books printed/acquired."

[68]BMHCA SB23a F7, *Annual Report for 1929.*

[69]To be fair, the number of medical books from this period is skewed by the addition of Baragar's personal library to the collection. One hundred and eighty four volumes from this collection were bequeathed to the hospital and were accessioned into the medical library after Baragar's death in 1937. BMHCA SB23b F6, *Annual Report for 1937.*

Beginning in the 1930s, however efforts were made to diversify the holdings of the library, and new titles included a number of works on psychiatric nursing and nursing administration. To some extent, this must be seen to reflect the maturity of the field of psychiatric nursing and the development of a North American field literature. At the same time the prevalence of texts on general nursing, and especially the appearance of books on "manners and morals," signified a library which was increasingly providing materials preparatory to entry into hospital nursing or which entertained the possibility of advancement into private duty. Titles such as *Studies in Ethics for Nurses* and *Social Customs and the Art of Gracious Manners*, for example, can be seen as nothing other than preparatory texts for aspiring private duty nurses.[70]

Another indicator of the increasing complexity of the work that was conducted by nurses at the hospital and of the growing maturity of the institution in the 1930s was the profusion of internal publications. Prior to 1934, the only item in the staff's personal reference library was the *Rulebook*, first published in 1921 for both the Brandon and Selkirk mental hospitals. In 1934, Stuart Schultz and Gerald Creasy co-published a *Handbook* which was designed to standardize the administration of drugs and therapies. Within its pages were formulae for the dozens of rinses, douches, washes, poultices and plasters used at the hospital, details and definitions of special diets that might be prescribed for patients, as well as brief accounts of the procedures for the collection of laboratory specimens and

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[70]Charlotte A. Aikins, R.N. *Studies in Ethics for Nurses.* (Philadelphia: W.B. Sanders and Company, 1937) and Theodosia Crosse, R.N. *Social Customs and the Art of Gracious Manners.* (Philadelphia, S.B. Lippincott Company, 1938).

the administration of hydrotherapy.[71] The scope of this manual encompassed the activities that a nurse might conduct on her own, without the supervision of a physician. Activities that would take place under the supervision of a doctor or a psychiatrist were not included.

At about the same time, George Little authored a separate *Manual of Routine* for the Reception Hospital. Unlike the *Handbook* the emphasis of this volume was the role of the nurse as assistant to the physician in surgery or in administering any of the drug-based therapies of the latter 1930s.[72] Finally, a third publication, this one called *Nursing Procedures*, was provided to all nursing students after 1935. It was identical, except in the sections dealing with admissions procedures, to the publication *Nursing Arts* produced by and for the staff at Winnipeg General Hospital, perhaps suggesting a desire to standardize nursing procedures to the general hospital standard.[73] This volume consisted of precise and detailed descriptions of hundreds of bedside nursing procedures. Without any information on specific surgical or medical procedures it stretched to over two hundred pages, delineating every procedure in precise detail. For example, the section on making an unoccupied bed was four pages long. This book's dual status as manual and textbook is indicated by page references to standard nursing textbooks at the head of every section. The presence of these publications suggests the growing maturity of the nursing service and an

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[71]BMHCA, Unsorted materials. Stuart Schultz, MD and Gerald Creasy, MD. *Handbook: Brandon Hospital for Mental Diseases*, (Brandon Mental Hospital Press, 1934). Note that most internal publications were printed on the hospital's own press, which was operated by patients in the male occupational therapy department.

[72]George Little, MD, *Manual of Routine, Reception Unit, Brandon Mental Hospital*, (Brandon: Brandon Mental Hospital Press, 1942 [1936]).

[73]*Nursing Procedures*, ([Brandon: BHMD]: 1942 (1937)).

increased emphasis on technique and standardization of care. It also suggests that the range of skills and techniques required of a nurse was, by the mid 1930s, becoming sufficiently broad that it could not be mastered without reference to standardized texts. Both factors point to the increasing medicalization of care at the Hospital as the decade progressed.

Another area of development which both reflected the growing maturity of the institution and placed new demands on the nursing staff was medical research. Although the treatment of mental disorder was the primary goal of the hospital, original research constituted an important part of the work of the medical staff of the Reception Hospital. Not surprisingly, therefore, the records of the hospital show not just the application of "proven" therapies, but other activities of the psychiatrists, including experimentation and the publication of journal articles and conference papers. Without question, Donald Ewen Cameron was the most prolific in this regard, reflecting both the advantage conferred by his position as superintendent of the Unit and his ambition to build a career beyond Brandon as a research scientist. Other doctors were not without healthy publication records, and the archives of the hospital record more than a dozen referenced publications by doctors at the hospital dating to the 1930s.[74]

This research is important not just for the technical demands that it placed on nurses, but occasionally for the moral or ethical dilemmas that it created. Of Cameron's research, Pincock ventured forty years later that:

> His personal ambitions overrode any scruples that he might have had in using subordinate staff to aid him in achieving his goal, and in some

[74]BMHCA SB31b F24, File: "Research Conducted at BMHC, 1930 - 35" and SB48 F3, File: "Staff, Medical - Publications."

> instances he appeared, to me, too indifferent to the welfare of the patients, upon whom he was carrying on his experiments; and this even to the point of risking their survival.[75]

Several nurses expressed that they were disquieted by the apparent disregard for patients demonstrated in some of these experiments, and like their ambivalence about other therapies that they took part in, this underscored for them the question of power and authority in the hospital community.

> There were some things I didn't like. There was a doctor there who didn't seem to much care for the patients...as people...[but] you just suppressed it; that's the way it was.[76]

It may be argued that with respect to training that the substantive change in the training experience of the second generation of mental nurses was not in the content of the training -- the lectures remained substantially the same -- but in the degree to which the lectures could be related to the actual work performed. One of the areas in which pronounced changes occurred in the latter half of the 1930s was in that of treatments and therapies administered.

The fundamental continuity was in the administration of various forms of hydrotherapy, which included prolonged baths, offered in the Unit and the Pavilion,[77] and

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[75]Pincock memoir. Some sections have been blocked out by the family. See also the early chapters of Anne Collins, *In the Sleep Room: The Story of the CIA Brainwashing Experiments in Canada*, (Toronto: Lester and Orphen Denny, 1988), and Don Gillman, *I Swear by Apollo: Dr. Ewen Cameron and the CIA Brainwashing Experiments*, (Montréal: Eden Press, 1987).

[76]Interview with anonymous nurse.

[77]When the main building was constructed in 1911, prolonged baths were installed in both the male and the female wards there, but there is no record or recollection of them being used after the completion of the Unit in 1925.

a variety of wet packs, both hot and cold, that could be applied to patients on any ward. These baths, while generally remembered favourably by the nurses who administered them, required limited clinical skills. Once a patient was placed in the bath, the nurse was responsible to maintain the temperature of the water and to periodically check the body temperature, heart rate and respiration of the patient. Nurses reported that they could readily supervise three patients at a time, and that they often brought a book with them, as bath duty usually represented a rare moment of down-time when on duty.[78]

The most notable therapeutic innovations came in the form of the introduction in 1937 of Insulin shock therapy for depressive and schizophrenic patients, and Metrazol shock therapy the following year. Prior to the introduction of these two forms of treatment, intrusive or aggressive therapeutic techniques were limited. Malarial fevers had been used since 1929 to kill syphilis, and several experiments had been done in the use of various drugs, dehydration, x-rays, heat lamps and other things in the early 1930s but to limited effect.[79] Few of these experiments were conducted on a large scale, and they involved only a very limited number of nurses and attendants.

The use of the malaria organism merits special consideration because it posed a specific moral quandary which illustrated the relative powerlessness of the nursing staff when confronted with what they felt to be the inappropriate treatment of a patient. The malaria serum was very difficult to sustain outside of a human host. In the large institutions

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[78]Eleanor Noakes interview; Lillian McLennan interview.

[79]The fragility of the malaria serum prompted experiments with the use of heat lamps in place of malaria in 1933. BMHCA SB3 F6, Pincock to Mathers, 1 March, 1933. See also Chapter 3.

in the United States where the therapy had been developed, there was always enough syphilis to maintain the infection, but in Brandon this was not the case. As a consequence, in instances when the "supply" of syphilitics ran out, it was the practice of the hospitals to use "non-specific patients," usually catatonic schizophrenics as hosts. At one point in time, the use of patients from the Home for the Aged and the Infirm in Portage la Prairie was even discussed, but was not followed through on the basis of what the director there described as "The lack of a real basis to commit them [to BHMD]."[80] Despite the ethical difficulties presented by this pattern of treatment, it persisted until 1950, by which time Syphilis was being successfully treated with antibiotics.[81] Former nurse Eleanor Noakes recalls one such patient, whom she was assigned to accompany from Winnipeg to Brandon as a malaria carrier: "I felt that it was very, very, very improper... You just did what you were told."[82]

Insulin shock therapy is perhaps the most important therapy for the purposes of the present consideration because it was the largest and most ambitious program of the 1930s and involved the most nurses. Insulin placed considerable demand on the clinical skills of the nurses, and will be treated below in the context of an examination of the clinical skills of the nurses. Metrazol shock therapy was a more limited program, and it involved fewer

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[80]There are no fewer than two dozen letters treating this issue passed back and forth between Pincock, Mathers, Goulden, Baragar (in Alberta) and Harry Atkinson, Director of the Home for the Aged in Portage la Prairie between August of 1930 and December of 1931. BMHCA SB3c F6, *passim.*

[81]Kurtland Refvik, *History of the BMHC: 1891-1991*, (Brandon Historical Society, 1991), 90. As late as April of 1950, Schultz was making arrangement for the acquisition of frozen malaria serum for a hospital in Verdun, Québec. SB3c F6, Schultz to Superintendent of Verdun Mental Hospital, 3 April 1950.

[82]Eleanor Noakes interview.

nurses. Furthermore it was more limited in the demands that it placed upon the nurses, as the role of the attending nurse was more or less limited to the application of restraint (ie. holding the convulsing patients down) and monitoring the patients after the convulsions appeared to have stopped to guard against the possibility of injury should an after-seizure take place. Metrazol was significant however, in that like malaria, it posed a moral and ethical dilemma for a number of the nurses involved in its administration. Some nurses were unequivocal in their support for the program, citing the approximately one third of patients who showed a noticeable, if ephemeral, improvement following the treatment.[83] Others, however, were reluctant to discuss the details of the administration of Metrazol, were openly critical, or reflected on the personal difficulty that participation in the program created.

Metrazol therapy consisted of the injection of a patient with a camphor solution. This induced sudden and violent seizures, so violent in many cases that the patients broke bones, and indeed the written procedures for the administration of Metrazol called for the patient to receive a spinal x-ray to check for fractured vertebrae at the conclusion of each treatment.[84] The *Manual of Routine* noted that a patient was to be given morphine prior to the injections as a relaxant, but several of the nurses interviewed recalled the terror that patients experienced during the treatment and the difficulty that they had in conducting a patient down to the treatment room.[85] Such statements underscored the powerlessness of the

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[83]Madeline Whyte interview.

[84]*Manual of Routine* "Procedures for Insulin and Metrazol Shock Therapy," unpaginated.

[85]Mable (Davies) Mills, Interview with the author, 26 October 1995. Mills and others noted that in later years, after Metrazol had been supplanted with the generally safer

nurse with respect to the hierarchies of the hospital. When asked how she dealt with her ambivalence about Metrazol therapy and the employment of cold packs and hydrotherapy as restraint, two aspects of life in the Unit that made her very uncomfortable, one nurse replied that "you just suppressed it."[86] No nurses recalled having protested this form of treatment nor having any recourse but to comply with the administration of the treatment.

The relative powerlessness of the nurses and their sense of solidarity with the patients also suggests a fundamental difference between the mental hospital and the general hospital as far as power relations were concerned. Scholars of general nursing have pointed to the existence of triads of power that included the medical practitioner the nurse and the patient.[87] They have suggested that one of the means by which nurses have historically expressed resistance is by allying themselves with patients to control the conditions of their labour, their workload, and even the administration of therapies. In the mental hospital, however, the relative political power of the patient with respect to the doctor, and the potential of the patient as an ally for the nurse, was significantly diminished.

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electroconvulsive shock therapy, patients were paralyzed with curare to guard against fractures. It was further noted that ECT became the preferred treatment not only because it was cheaply administered but because patients were more compliant: the electric shock had the side effect of erasing short term memory, so there was not the same fear reaction.

[86]Eleanor Noakes interview.

[87]Much of this scholarship has relied on the work of Susan Porter Benson and her examination of managerial relations in the service industry in the United States. Porter Benson asserted that retail clerks were able to create a "space" for herself on the jib by playing the manager and the client off one another. See Susan Porter Benson, *Counter Cultures: Saleswomen, Managers and Customers in American Department Stores, 1890-1940* (Urbana: University of Chicago Press, 1986).

This is not to suggest that the nurses were without resources in negotiating their position with respect to the psychiatrists. British historian Mick Carpenter, in his study of mental hospital attendants in late nineteenth century Great Britain, postulated that in some circumstances, mental hospital attendants might have enjoyed quite considerable influence over the psychiatrists precisely because of their closer relationship (and sometimes class solidarity) with the patients. For example, the psychiatrists might have relied on the nurses for the diagnosis and monitoring of patients. Carpenter pointed out that the contact between mental patients and psychiatrist was often more limited than that between patient and physician, quite simply because of the much lower doctor to patient ratios at a typical mental hospital. Diagnoses might have been further complicated by resistance and deceit on the part of the patient, which could be effectively sustained over the short period of clinical interviews and rounds. That this deceit was more difficult to maintain over the long term, and that nurses might often have been better able to assess the condition of a patient based upon sustained contact, Carpenter suggested, might have given them a source of political power.[88]

May (Churcher) Smeltz and Lillian (Goodman) McLennan's recollections of staff conferences bear out Carpenter's theory, but shed little light on the extent to which any political advantage accrued from this dependence. Both recalled that attendance of student nurses at the medical conferences in the Unit where a patient was assessed was a fundamental part of the pedagogy of the training school. Nurses were required to sit silent

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[88]Mick Carpenter, "Asylum Nursing Before 1914: A Chapter in the History of Labour," in Celia Davies, ed. *Rewriting Nursing History* (London: Croom Helm, 1980).

while the medical staff interviewed the patient under assessment and, immediately after the patient was removed, the doctors interrogated the nurses about the patient's responses and conduct. Nurses were intended at that point to render observations and to venture diagnoses. While doubtless this represented a pedagogical technique and was intended to have a didactic purpose, one cannot but question whether the interrogation of the nurses, prior to any diagnosis being ventured by the medical staff, might have reflected the psychiatrists' desire to draw upon more than cursory observations, patient records and formal interviews in the diagnosis of patients.

Another anecdote which may provide further evidence of this phenomenon was related by Eleanor (Greene) Noakes, who recalled that at one time when acting as head nurse in the insulin room, she overheard one of the medical staff relating to a colleague *verbatim* a diagnostic observation that she had just made about a patient. Although intended as an observation about the remoteness of the medical staff ("I was surprised to discover that sometimes they do listen"), it served also to illustrate the extent to which the psychiatrist may in fact have depended upon the nurse as a source of diagnostic information.[89]

Whatever ambivalences and ambiguities may have been introduced by the adoption of more aggressive therapeutic régimes in the last half of the 1930s, these innovations had an appreciable impact upon the occupational culture of the second generation of trained mental nurses. The occupational identity of a knowledge worker is enfolded in the capacity to identify the work that one performs as requiring proprietary knowledge and skill, or to identify in one's work talents or skills that are unique or irreplaceable. By these standards

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[89]Eleanor Noakes interview.

it has been argued that the care that was delivered during the first decade of the School of Mental Nursing did not place the nurses securely in this category and that the nurses of the 1920s may have been more disposed to affiliate themselves with the Mental Hospital Workers Federal Union precisely because they did not possess the proprietary knowledge base akin to that claimed by general nurses.[90] By 1940, demographic changes within the nursing service and changing demands on the nurses created by new therapeutic régimes had created a context where the worker identity of the 1920s had been largely supplanted. Some of the difference must be seen to be rooted in the incipient notion that mental nurses were knowledge workers and that they felt themselves to have a set of skills that differentiated them from the less-trained male attendants and female support staff.

It has been argued above that occupational culture comprises the ideology which governs workers' identification with their conditions and that it is their collective intellectual understanding of their work that is the arbiter of autonomy and control over production. Central to the emergence of the consensus that allowed the élite of the third generation of hospital trained nurses to define their exclusive privilege within the nursing world was the ability to define, by laying claim to "technique" and the science of asepsis, a proprietary skill set and knowledge base that gave them some measure of personal control over the rhythms and intellectual content of their work.[91]

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[90]See Chapter 3.

[91]See Chapter 2. See also Susan Reverby, "The Search for the Hospital Yardstick: Nursing and the Rationalization of Hospital Work," in Susan Reverby and David Rosner, eds., *Health Care in America: Essays in Social History* (Philadelphia: Temple University Press, 1974); Barbara Melosh, *The Physician's Hand: Work, Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982); and

Some scholars have argued that there existed in the inter-war mental hospital an analogue to technique and the understanding of asepsis in the form of an understanding of patient management, and that in fact "discipline" constituted the defining skill of a mental nurse.[92] The present work challenges this view. It argues that the understanding of patient management was neither central enough nor was it sufficiently intellectually based to constitute a basic identity. Nurses from the 1930s, when asked about patient management, seldom used the language of skill and knowledge, instead invoking notions of caring, understanding and sympathy to describe how it was that they managed difficult or truculent patients. It will be argued, however, that by the late 1930s, the nurses at BHMD arrived at a collective understanding of their work that allowed them to call themselves nurses, and that gave them some measure of intellectual mastery over the work they performed. The skills that constituted the basis for this identity can be roughly divided into two categories. The first is caring, and the second is technique.

The motto of the training school -- "When love and skill work together, expect a masterpiece", attributed to Ruskin -- reflects a dichotomy that is at the very core of psychiatric nursing, and indeed may be argued to be at the core of all nursing. It is instructive to note the relative weight that is placed by mental nurses on the provision of personal service, patient management, and understanding as compared to specific clinical

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Kathryn McPherson, "Skilled Service and Women's Work: Canadian Nursing, 1920-1939." (Unpublished PhD Thesis: Simon Fraser University, 1989), Chapter 3.

[92]This is a central contention of Mick Carpenter. "Asylum Nursing Before 1914. See also Peter Nolan, *A History of Mental Health Nursing*, (London: Chapman and Hall, 1993).

skills. Several of the nurses interviewed for the present work showed a disposition to express the balance between personal service and skilled labour as a dichotomy, and to establish the work that they performed on a continuum between "personal care" and "nursing service." [93] It is further instructive to note that some (but not all) of those nurses interviewed who had received general training prior to coming to the hospital, or who had later gone on to perform nursing in an general hospital situated mental nurses very differently on this continuum, preferring to bolster their own identity as skilled practitioners by diminishing the skills of mental nurses, classifying the work performed by mental nurses as custodial care with few elements of skill.

Much has been written about the dichotomy between curing and caring that permitted general nurses to claim for themselves a sphere of work that was both distinct from that of the doctor and which conformed with notions of appropriate feminine behaviour.[94] This distinction was every bit as important for the mental nurses of the late 1930s at the Brandon Hospital for Mental Diseases, although the language in which it was articulated was slightly different. This can be attributed to the desire not only to create a sphere of endeavour that was separate from that of the doctors, but to differentiate the caring

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[93]These distinctions are difficult to make, because neither group tended to classify or quantify the personal service that they did as a skill, but saw it rather as an extension of their personality. Several, for example, cited a sympathetic disposition as the prime requisite of a good nurse, but were reluctant to identify the communication of sympathy as a skill.

[94]The role of the cure/care dichotomy in establishing the occupational culture of general nurses is central to the work of Susan Reverby. See Susan Reverby, *Ordered to Care: The Dilemma of American Nursing*, (New York: Cambridge University Press, 1987).

performed at the mental hospital from that at the general, in essence making a skill of custodial care. This may be seen as a second level dichotomy, one which separates the clinical functions of nurse from the personal ones.

Understanding this dichotomy is fundamental to understanding the occupational identity of the mental nurse in the 1930s. Simply put, there was little in the daily routine of the mental hospital that could be called curative or medical nursing care, except perhaps on the acute wards in the Unit and on the infirmary wards, where bed-care was prevalent. The absence of the requirement regularly to perform complex or highly ritualized procedures, the basis for what general nurses called "technique," was often employed by critics of mental nursing or those who wished to denigrate the skills of a mental nurse to illustrate that mental hospital nurses were not "real nurses." By separating the functions of clinical nursing and personal nursing, caring for individuals without an expectation of cure, mental nurses were able to lay claim to a specific skill set that differentiated them from the general nurse and which they employed to validate their work.

While much of the work at the hospital was very routine custodial care, it was not without perils that were foreign to the general hospital. Marjorie Anderson recalled that her nose was bloodied on the first day on the wards. Others related that it was fortunate that they were not required to pay for their uniforms, which were often rent, and that they all carried men's pocket-watches inside their bibs, since the standard nurse's wristwatch was not up to the demands of the mental hospital.[95] Katherine Weiermann related an incident which underscored the need for the nurses to be able to innovate and occasionally to imperil

[95]Jean Young interview.

themselves in the care of patients. She related that on one occasion the nurses were in the process of administering an inoculation to all of the patients in hospital. One women was paranoid about needles, and she managed to flee the ward to the room where the patients washed their personal laundry. There, she prepared to fend off the nurses with a washboard. Weiermann thought it highly inappropriate to ask a junior nurse to put herself in danger, and she took it upon herself, despite her diminutive size, to tackle the woman. She went to the nursing station where she removed her cap, her glasses and her watch and related what she told her nurses:

> Now come on, girls, have you got the needle? What I want you to do: I am going to rush her and I will be under the wash board. It won't hit me in the head, I'll see to that [indicating that it will strike her flat on the back]. You've got to follow me immediately and give her [the needle]... That's exactly what we did. No problem at all.

This anecdote reveals what many nurses identified to be a fundamental skill, and that was the capacity to adapt to changing situations and to take decisions rapidly. Of the above incident, Weiermann related what she felt to be the essence of working in the mental hospital:

> You just figure out what is going to save your hide and you get it done. It was all about practicality and common sense, and you did a lot of thinking on your feet and getting on with it.[96]

While general nurses were apt to be critical of the skills of the mental graduates, the mental graduates were in turn often critical of the general trainees, whose approach to patients they felt to be more prescriptive than adaptive. Of this distinction, Katherine Weiermann noted that "Mental nursing required a lot more ingenuity and the ability to think

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[96]Katherine Weiermann interview.

on the situation rather than the illness."

This dichotomy became most apparent when nurses were asked to differentiate the work that they did in the mental hospital from that which was performed at a general hospital, or to compare the defining skill of a mental and a general nurse. Typically, nurses used terms that reflected the value that they placed on the personal side of nursing, using words like "sympathy," "understanding," "sense of humour" and " empathy," to describe the most important skill they possessed. In contrast, the same nurses often cited technical proficiency as the prime requisite of a good general nurse. Mable Mills, for example, when asked to make the differentiation, named "a genuine interest in people" as a prime requisite for a mental nurse while general nurses needed to possess "just book knowledge."[97] Later she elaborated:

> In general nursing, everything was just cut and dried. There were your instructions and you just followed the rules. In psychiatric nursing, you didn't know what was going to come up next and every patient was entirely different. When it came right down to it, I enjoyed mental nursing more.[98]

This enjoyment came in part from the ability to separate the personal and the medical, and Mills, like many of the nurse interviewed, explicitly separated the two:

> You got more satisfaction seeing somebody go out of a mental hospital than you did seeing them go out of a general hospital because in the general hospital you expected them to get well and be discharged. In the mental hospital there was a little different feeling. There were a lot of patients you almost felt that you were a part of their getting better and being released.[99]

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[97]Mable Mills interview.

[98]Ibid.

[99]Ibid.

Distinction between the personal and the medical is inextricably wrapped up in perceptions of hierarchically ordered values. Many mental nurses were hostile to the characterization of their work as custodial care. Others, while they accepted this characterization, rejected the notion that custodial care had any less inherent value than clinical nursing care. One nurse made the distinction:

> They [general nurses] gave their care, but we gave loving care... our care.. was something voluntary. It was caring care.[100]

These nurses were anxious to have the work that they performed valued on par with that performed by general nurses and to be seen as requiring a comparable level of skill and commitment. They rejected the socially assigned hierarchy of value which placed custodial care at a lower echelon than medical care, and indeed some of them, like Mills, sought redress in the inversion of that relationship, arguing that her training in the mental hospital was actually superior to that at the general because it taught her to deal with patients on a personal rather than a clinical level.[101]

Others, generally speaking those who went into general nursing after they left Brandon, were more apt to accept a hierarchical ordering of skills which privileged their later training, and they could be very hard on the Brandon graduates. One nurse recalled that while she never lacked confidence while she was at BHMD, she realized upon entering the general hospital that her skills were entirely inadequate.[102] Madeline Whyte suggested that

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[100]Catherine Dennis interview.

[101]Mable Mills interview.

[102]Interview with anonymous nurse.

the nursing care that she provided while at Winnipeg General was "altogether different" from that which she provided at BHMD. While acknowledging the superior patient management skills that her years at Brandon offered her, she felt she was ill prepared to deliver the "real nursing care" of the hospital, having been grounded only in the routines of the Mental Hospital, which she distinguished as "just care."[103]

This is not to say that clinical nursing didn't occupy an important place in the minds of these nurses, and the second major area in which the mental nurses of the 1930s were able to claim some intellectual territory was that of technique. The mental nurses of the 1920s had few technical procedures around which they could construct an identity based on proprietary skills. Despite the best efforts of the post-War psychiatrists, there were few interventions and treatments, except for some limited forms of hydrotherapy, that had much effect. Given the chronic problems of under-resourcing facing the hospitals, even experimental treatments were few. By the late 1930s, however the landscape had started to shift and mental nurses had a few more demands placed upon them to do "clinical nursing."

The introduction of interventions like insulin shock therapy and Metrazol therapy provided some of this context. Although these therapies were offered only to several dozen patients at a time, they nonetheless formed an important part of the recollections of every nurse interviewed. Everyone who trained at the hospital was rotated every six to twelve weeks to a new ward, ensuring that over the course her career, each pupil had at least some exposure to every type of ward in the hospital. Every nurse did at least one rotation on "East

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[103]Madeline Whyte interview.

2," the second floor of the Unit where these treatments were offered. [104]

The introduction of these therapies had a profound effect on the whole hospital, allowing a greater optimism about the curability of mental illnesses. For many nurses, the optimism that the new treatments created, even if their efficacy was limited or the effect transient, overrode any qualms that they might have had about their potentially damaging effects. More importantly, they provided nurses with a technique that "we could hang our hats on."[105] Madeline Whyte captured the way in which this sense of optimism overrode some of the concerns for patients' welfare:

> I thought that it was wonderful that we finally had something besides paraldehyde and choral hydrate... We were all pleased that we were finally getting something. I know a little bit of what Dr. Cameron did in Québec, but nothing was done until he started something. Maybe he didn't do things right, but he was a clever man and he started a lot of these things... and he was the one who really started some sort of treatment for mental patients, and before that you just looked after them; it was just custodial. [106]

Insulin therapy was at once the most promising and the most demanding of the new interventions. Nurses were able to describe in great detail, even sixty years later, the precise procedures that they had to follow in the administration of insulin shock therapy. They recalled that they were responsible to prepare the patients and to engage in active surveillance when the patients were in the coma. This included clinical procedures like the regular taking of pulses and temperatures, drawing blood samples for laboratory analysis, and caring for and monitoring patients after they emerged from their comas. Eleanor

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[104]Lillian McLennan interview.

[105]Interview with anonymous nurse.

[106]Madeline Whyte interview.

Noakes, who as a mental graduate became supervisor of the insulin room, recalled that by the end of the decade, nurses performed nearly all of the clinical procedures, including the injection of the insulin and the insertion of the nasal alimentary tubes through which the glucose solution which brought the patients out of the coma were given.[107] Several nurses related that the insulin room was the most satisfying work that they performed. This satisfaction derived not just from its effect on the patients, but from the demands of the work itself. One nurse described work in the insulin room as "more challenging" and another said that "it required more skill."[108] Eleanor Noakes recalled that she probably would not have stayed at the hospital after graduation, save for the fact that she was offered a permanent posting in the insulin room.[109]

In the late 1930s, nurses also assisted in the administration of Metrazol and malaria, attended at surgeries and autopsies and assisted with the medical research and experiments performed by the doctors. Pupil nurses also performed clinical outreach work like administering intelligence tests and assisting in mental hygiene clinics in the schools which may be seen as public displays of their skill. This outreach was extended in 1938 to include work in public health. The province had laid off half of its public health nurses in 1932 and by the late 1930s, after successive wage cuts had further reduced the service and in light of the worsening social circumstances of the Depression , the province was unable to provide

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[107]Eleanor Noakes interview.

[108]Mable Mills interview; Eleanor Noakes interview.

[109]Eleanor Noakes interview.

adequate public health services.[110] To meet this need, pupil nurses at BHMD were employed as public health nurses, making house visits and delivering babies in Brandon and surrounding communities. Such "active" nursing, which required Brandon pupils to demonstrate that they possessed the basic clinical skills required to do home and obstetrical nursing, bolstered the sense on the part of the Brandon pupils that they had a credible claim to the title of nurse.[111] Thus by the latter 1930s, it may be argued that the nurses at the mental hospital were required to develop the technical skills that permitted them to cross the threshold from attendant to nurse in their own minds.

This sense of a proprietary skill set may have been strengthened or weakened by the perception of the relative skills of the male attendants. As the decade progressed, the second generation of trained mental nurses had a stronger basis on which to differentiate their work from that performed by the male attendants. To be sure, the work performed on the chronic wards was similar, and even on the acute wards male attendants discharged similar duties to the nurses. Notwithstanding, male attendants were not required to take the same training as female nurses, and there was a general sense that their training was more rudimentary.[112] More importantly, male attendants were excluded from the performance of several procedures that were reserved for senior students and graduate nurses, like the administration of hypodermic needles, giving medications and performing catheterizations. This

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[110]Pincock recalled this as an "opportunity" for the pupil nurses to demonstrate their clinical skills. Pincock memoirs.

[111]Lillian McLennan recalled in great detail the first time she delivered a baby without a doctor attending. Lillian McLennan interview.

[112]Interview with anonymous nurse.

placed the female nurses in a more secure position with respect to technique than the male attendants. One nurse recalled:

> Sometimes we were called onto the male wards if there was something that [they could not do] because the male nurses, they weren't really nurses at that time.[113]

A female nurse was placed in a supervisory position both on the Male Hospital and on the male wards of the Unit, and her authority was clearly established over the male attendants. Student nurses on these same wards controlled the administration of procedures, while the male attendants were relegated to the provision of basic personal care, like bathing and shaving.[114]

There is some evidence that not all male attendants were disposed to accept this hierarchy of skill. Although nurses tended to describe relations as congenial, the increased presence of a privileged élite of female nurses may have been perceived by the male attendants to have diminished their relative worth and skill, and there are intimations scattered in the institutional correspondence of a desire to reclaim this lost ground. Evidence of this phenomenon came in 1931, where an anonymous group of male attendants petitioned Pincock for a series of reforms at the hospital. This list is interesting on several counts. While most of the seven grievances dealt with details of improving the day to day life of the male population, several reveal a disposition on the part of the authors to self-identify as male nurses rather than as attendants. In the case cited earlier of the petition for a more secure male airing court, for example, it is the language of the requests that is

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[113]Catherine Dennis interview.

[114]Mable Mills interview.

most interesting:

> The attendant there is a custodian. He has to stand on the benches and watch the patients so that they do not run away. We feel that this is contrary to the *principles of occupational therapy*. Airing court should be a place where the patient can play games[,] enjoy themselves [sic], and where attendants can carry out their knowledge of *true psychiatric nursing* [emphasis added]."

Later in the same document, the attendants requested the appointment of a male clinical supervisor . Again, the language and stipulation of the request betray a disposition to regard the work performed by male attendants as nursing:

> *There must be a male clinical supervisor. That is a person with an R.N. Degree*, preferably with training in a mental hospital who will act as a liaison officer between the Nursing Office and the Attendant's [sic] office. and
> b) Will be able to supervise the male attendants so that they can carry out their *nursing art instructions* to the best of their abilities.
> This we feel is very important because as a rule the female nursing arts instructor cannot supervise the bathing of patients
> The nursing or rather clinical supervisor will be responsible for all of the nursing arts procedure. [sic][115] (emphasis added)

In a similar vein, an anonymous letter to Pincock, this one alleging misconduct by another attendant, was signed "Male Nurse," implying the currency of this form of appellation.[116]

These statements suggest that concurrent with the demographic change that was taking place in the nursing service, the male service was changing too, albeit in a more limited way. If the female nursing service at BHMD prior to the Depression had been an employer of last resort, the male service was even more so. Female nurses often spoke of the moral and intellectual superiority of the female service, and characterizations of the male attendants suggest that many wound up at the hospital because they were unable to find work

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[115]BMHCA SB3a F3, "From a Group of Attendants, 1931."

[116]BMHCA SB3a F3, Anonymous Male Nurse to Pincock, 4 November 1935.

elsewhere.[117] Although no doubt overstated as a means of elevating one's own credential, evidence to some extent bears out this argument. Pincock often complained of the intransigence and resistance to reform of the "old-style" attendants.[118] In many instances, male employees were farm labourers who were out of work, or even harvest excursionists who remained in Brandon after the work dried up. During harvest time, when work was plentiful, there were often shortages in the male service. Furthermore, many male attendants effected transfers once they has been at the hospital for a while, and often it was "inside" attendants who applied to work "outside" as gang supervisors on the farm or to work as maintenance or physical plant staff.[119]

By the early 1930s with the unemployment crisis in full swing, it appears that the male service experienced a demographic shift similar to that witnessed on the female service, although on a lesser scale, limited by the relative stability of the service. Several of the nurses interviewed recalled that a number of the attendants were in fact students at Brandon College who attended lectures during the day and supervised the ward at night. It was this group of attendants who in the second half of the decade would play a pivotal role in the agitation for better working conditions for employees and patients alike, and who

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[117]Lillian McLennan interview.

[118]Pincock memoir.

[119]BMHCA SB45a, File: "Correspondence Re: Staff," *passim*. The memories of several attendants who effected this change are preserved in the archives at the hospital. See especially SB2 F15, William Halley, Interview with Valerie Heppner, Brandon, 19 March 1973.

would be at the centre of a union organizing drive in 1937.[120]

Not all nurses defended their mastery of technique, and those with general training, received either before or after their mental training, were apt to be more circumspect in their evaluation of the clinical competence of the mental graduates. Katherine Weiermann recalled that when she came to BHMD in 1932, she perceived that the nursing care she encountered was not up to the standards to which she had become accustomed at Winnipeg General. She recalled that even as a student in the post-graduate program, before she became superintendent, she found herself giving a lot of informal instruction in the practical aspects of bedside nursing. As reported above, she recalled that the Brandon Graduates had very limited clinical experience, and that even in the training program "We taught the same things, although perhaps at a different level."[121] Other nurses were less charitable. Jean Young recalled that when she left BHMD for Winnipeg General in 1943, she felt very confident in her nursing skills but realized after a short time at the General that she knew very little.[122] Another nurse, who went on to take her general training recalled that although

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[120]At least two of the officers of the Association were Brandon College students. The correspondence of the Association shows a much higher level of literacy than had been the norm in letters received from attendants in the past. Of particular note was a brief presented to the Public Accounts Committee in 1939 which contained a detailed actuarial analysis of the staffing costs of the hospital as well as a proposal for the introduction of a new wage schedule. This almost certainly represents the work of Harry (H. Clare) Pentland, Secretary of the Association, who later became a noted university economist. BMHCA SB3b F1, "Brief Presented by Representatives of the Brandon Mental Hospital Attendants' Association Before the Public Accounts Committee, 11 April 1939."

[121]Katherine Weiermann interview.

[122]Jean Young interview.

she had felt that she had left Brandon with good clinical skills, she revised the opinion on her arrival at the general hospital: "We called ourselves psychiatric nurses, but it was quite different from having general training."[123]

Lillian McLennan, who went on to become a certified lab technician, and therefore felt little need to lay claim to the other credential, was similarly critical:

> We really shouldn't have been called nurses, we should have been called caretakers. You can't be giving nursing care when you have one hundred and thirty patients. You are really a custodian... The only nursing care you did outside of female hospital was bed making, bed panning and bathing and preventing bed sores.[124]

Just as there was a strong separation between female nurses and male attendants, there was also a strong separation between the graduate general nurses, the graduate mental nurses and the pupil nurses. Several nurses interviewed noted that it was the general hospital graduates that tended to be the most defensive of their position, both while on duty and off:

> The grads were a bit different. They were more aloof and kept to themselves, but I was friendly enough with some of them too.[125]

Another nurse observed that some general graduates often showed a great deal of respect for the patient management abilities of the mental nurses:

> Some of them felt they knew a lot more than we did, although others would react that they didn't know as much about mental hospital patients as we

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[123]Interview with anonymous nurse.

[124]Lillian McLennan interview.

[125]Mable Mills interview.

did...[126]

This degree of stratification may have reflected the ambiguity and insecurity felt by nurses at all levels about their skills. Nurses who went on to work in other hospitals commented on the fact that despite the more permissive environment and the apparent diminution of class distinctions off-duty, Brandon was a much more hierarchical and stratified hospital than others they had experienced. One nurse noted that "you were never friendly with your supervisor in Brandon."[127] Another characterized the relationship with the head nurses at Brandon as "distant" and "unsupportive," "It was not a learning situation."[128] This aloofness may also have had something to do with the occupational solidarity of subsets of nurses in a context where other levels of ward attendants were not present. There were no nurse's aides or untrained ward attendants at BHMD until after the Second World War, and in the absence of any clearly inferior class of ward staff the senior staff, may have sought to reinforce to their advantage the levels of hierarchy that did exist.[129]

Hierarchy was reinforced by ritual. One nurse recalled the importance of ritual respect:

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[126]Interview with anonymous nurse.

[127]Mable Mills interview.

[128]Jean Young interview.

[129]Although untrained ward staff, principally married women, were employed for three years after 1942 in response to the labour shortages at the hospital during the war, permanent ward aides, called practical nurses, were not employed until 1947. The exceptions were what were called in the 1930s "dining room nurses," whose only role was to supervise the patients at meals while the ward staff took their own meals in the nurses residence. Madeline Whyte interview.

> In those days you were taught a lot of respect for senior staff. For example we were supposed to stand when one of our seniors, even from the class above, entered the room. You were expected to open doors for doctors and you didn't go ahead of a doctor through a door.[130]

Nurses were expected to leap from their seats and stand at attention when a doctor or a senior nurses came on the ward, and they were never to precede a doctor or a senior through a door or onto an elevator. These rituals were important to all levels, including the psychiatrists. One nurse recalled a patient who, prior to her admission, had been a nurse at the Neepawa General Hospital and who used to stand rigidly at attention during rounds. She recalled Dr. Pincock pointedly observing, "Now that is a nurse... she has lost a great deal, but she has not lost her courtesy to the doctors."[131] Another recalled that she was once severely reprimanded for having violated this code by the simple act of holding a door for a nurse who was her junior.[132]

As in the previous decade, many of the rituals that were practiced replicated those seen in general hospitals. Marjorie Anderson recalls that "capping day was a big day." A nurse's status was codified in her uniform. Pupil nurses were issued a blue uniform on enrolment. About six months after they commenced their lectures and upon passing their first round of exams, nurses were promoted to "junior." With this label came a pleated cap, a bib and cuffs. The change of identity was significant, underscoring the class distinction that coloured all relationships at the hospital. Katherine Weiermann recalled that one of

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[130]May Smeltz interview.

[131]Hazel Wright interview.

[132]Interview with anonymous nurse.

the most effective sanctions that could be applied to a pupil nurse was the loss of her cap, a symbolic demotion to probationer status. That such a sanction was effective reveals the strength of the affiliation that many women of this generation felt to the school, and it also revealed their lack of power in relation to the institution. It underscored the fact that a nurse's credential came only at the pleasure of the school. The removal of the cap was a reminder that the decision to withhold the credential could come at any point in the nurse's training.[133]

One of the most important ritual events was medical rounds, which occurred daily on the Unit and less frequently, usually once or twice a week, on the chronic wards. On rounds, the psychiatrist was accompanied by the supervisor of the ward, or sometimes the nursing superintendent, and nurses stood at attention, speaking only when spoken to. "You practically broke the desk standing up when the doctor came on the ward," one nurse recalled.[134] Another remembered, "When Dr. Pincock and the superintendent were making rounds that was when you put your cuffs on."[135]

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[133]Katherine Weiermann interview; See also Charles Rosenberg *The Care of Strangers: The Rise of the American Hospital*, (New York: Science History Publications, 1979).

[134]Interview with anonymous nurse.

[135]The act of rolling down one's sleeves is imbued with an important double meaning. On the surface, one is transforming oneself from manual worker to something else, but at another level, one is crossing a threshold between a male world of manual work and a more appropriately feminine world of domestic orderliness. Scholars have long debated the contradictions that the nature of their work posed for nurses. There were many instances where their work challenged them to contemplate not only their relationship to work, but in a culture so deeply imbued with symbols of respectable femininity, with the gendered dimensions of their work. It may be argued that this challenge was even more

Privilege was apportioned in many ways. At the top of the hierarchy were the medical officers who were generally distinguished as the only staff who were both trained and male, and generally came from what one nurse described as "established families."[136] The social separation that was presumed to exist between the doctors and the rest of the hospital was amply illustrated in a rather trivial incident wherein the wife of a doctor was refused cream for a coffee party. The incident prompted Pincock to write a memo to the medical staff in which the class privileges of the medical officers were clearly articulated:

> In order to avoid any embarrassment, if you require extra supplies from the stores or kitchens, will you kindly send the messenger accompanied by a note to the dietician... I may say that there is every disposition on my part to recognize that physicians are entitled to extras for the purposes of entertaining their friends, as I know that in the past none of these privileges have been abused, but it will overcome petty annoyances and embarrassment if this method of requisition is followed. You will readily recognize that it is not dignified to have your wives subject to refusal of supplies from [sic] those in subordinate positions.[137]

Hierarchy was also reflected in the privileges accorded to nurses and doctors which were not available to male attendants, like the wider beds mentioned above. One such privilege was that of a lunch break. While the nurses, in oral testimony, referred frequently to the coffee breaks that they took while on the wards (and indeed the provision by the hospital of special utensils separate from those used by the patients for that purpose), attendants were not

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powerful for the nurses working at the mental hospital, both because they were required to do more manual work and because their job required them to participate often in the physical domination of a patient. Lillian McLennan interview.

[136]May Smeltz interview.

[137]SB3 F11, Memo from Pincock to Drs. Schultz, Little, Creasy and Stephens, nd.

permitted to take any food or drink while on duty.[138] In an unsigned letter to Pincock, one attendant aired his grievance with the apparently discriminatory treatment:

> Do you think it justice to place that restriction on the male attendants only. How would you feel about it if you were an attendant who could enjoy a cup of hot tea when you came in from airing court on a cold day or a hot drink before facing a walk of two and a half miles home on a bitter night. Again I ask how would you like it if you saw the nurses and the doctors enjoying that privilege an [sic] you left out in the cold. I believe that you would agree with me that you were being discriminated against.[139]

A perhaps surprising and potent symbol of the existence of hierarchy and privilege within the hospital was the asparagus patch. Asparagus was named by no less than half of the nurses interviewed by the author. This delicacy was grown only in small quantities and was served only in the doctors' and staff nurses' dining rooms. The nurses resented this privilege, and asparagus raids became a symbolic means of subverting the authority of the hospital hierarchy. Nurses recall that they routinely raided the asparagus garden and hosted "asparagus parties" in the nurses' home, cooking it on contraband hot-plates. So intense was the asparagus poaching, that in about 1936, a parole patient was placed in charge of guarding the asparagus patch against the nurses' raids.[140]

One of the places where hierarchy was reinforced was in the dining room, where class distinction was the dominant organizing construct. Nurses sat at assigned places, and

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[138]Madeline Whyte interview. Whyte recalled her disapproval of the fact that the nurses were required to eat with different utensils than those used by the patients: "It was like they were all infected or something."

[139]BMHCA SB3 F3, " a Male Attendant" to Pincock, nd.

[140]Lillian McLennan interview. Lillian McLennan used to recall that as lab technician in the later 1930s, she was the designated thief, as she got off shift an hour earlier than the nurses and could go down to the garden while "Mrs. H." was at supper.

each class was served in order of precedence.[141] The staff nurses, who included the superintendent and her assistant, the surgical nurse, the lab technician, head nurses and instructresses, as well as the personal secretary of the medical superintendent dined in a separate dining room and were served the same fare as the medical staff.[142] This type of distinction, and especially the special menu was recalled with resentment by many of the nurses interviewed, but for Kay Weiermann who was an assistant superintendent and superintendent of nursing for most of her career there, the separate dining room served an entirely different function. Weiermann acknowledged that student nurses at the hospital were under constant scrutiny, and that this was a highly stressful environment. For her, the presence of the separate dining room offered her an opportunity to consciously and predictably separate herself from the nurses. In doing so, she felt that she offered them freedom from the sense of always being watched and an opportunity to cultivate ties in a more relaxed and informal environment.[143]

In other instances, strict observance of hierarchies was forsaken in the interest of keeping the hospital running. Katherine Weiermann recalled that as superintendent, she was largely an administrator, but cautioned: "Not that you ever got to where you kept your hands clean and looked down your nose." She commented that in order for her to be able to expect that her nurses were to go "above and beyond," she had to earn their favour by allowing the

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[141]Hazel Wright interview.

[142]Lillian McLennan interview.

[143]Kay Weiermann interview.

strict division of labour to break down sometimes.[144] She recalled that she would frequently assist junior nurses, especially with complicated procedures, knowing that they would at times be called upon to do things that were not reasonable to expect of them, and that they were more likely to comply if they "had a sense they knew you." Of this technique, she reflected:

> It was amazing how much they liked me; I figured that better they liked me... perhaps they'd try to please me, which they usually got around to.

The same technique was employed by the female nurses on the male wards, who relied on the male attendants for assistance and sometimes to secure their personal safety. Mable Mills, for example, recalled that as charge nurse on Male Hospital, she frequently assisted with shaving patients when things were slow. In return she came to be able to expect a greater degree of assistance and co-operation from the male attendants when she was performing her prescribed procedures.[145]

Essential to the health and function of the nursing service was the existence of homosocial networks that permitted nurses close contact and support from their peers. Indeed, this may be what Kay Weiermann was trying to create when she perpetuated the tradition of the segregated dining room and discouraged her staff nurses from entering the students' dining room after the meal had started. Many of the nurses who worked at the hospital cited the camaraderie and companionship that characterized life at the residence,

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[144]For a reflection on the inter-dependence of levels of the nursing hierarchy and on the break-down of the strict division of labour, see the introductory chapter of Sarah Jane Growe, *Who Cares*?, (Toronto: MacLellan and Stewart, 1991).

[145]Mable Mills interview.

noting that one was seldom without companionship when it was desired.[146] "If you were in your room alone, you were never there long before there were two or three others in."[147] This served several functions. Not the least was that it contributed to the education of the nurses and assisted them in coping with the day to day travails of working at the hospital.

Life in the nurses' home was sometimes more permissive than life without. Within the context of the homosocial relationships, seen from the outside as proper and safe, the hospitals permitted a degree of latitude and laxity. This relaxed environment contributed to the overall health of the institution and limited the impediments to the formation of strong, mutually supportive networks. One nurse, for example, recalled her first Hallowe'en at the hospital, where nurses were required to appear at the party clothed only in items from their rooms like curtains and sheets.[148] Another nurse recalled that Mrs Little, the house mother, always extended the courtesy of loudly rattling her keys before she came onto a dormitory so as to permit the nurses sufficient time to hide their hot-plates, radios and other contraband.[149] In some instances, this laxity extended beyond the walls of the hospital, and some nurses recall that they enjoyed more freedom and less often experienced the paternalistic "protection" of the hospital while at Brandon than in their general training.[150]

Sports and recreation played an important part in the life of the hospital. They

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[146]Ibid.

[147]Ibid.

[148]Kay Dennis interview.

[149]May Smeltz interview.

[150]Interview with anonymous nurse.

offered opportunities to transcend the rigid class distinctions that permeated everyday interaction on the wards, and the athletic field was one of the few places at the hospital where hierarchies seemed to be cast aside. Nurses recalled, for example, playing tennis with psychiatrists, curling on mixed teams, and that the intramural softball league consisted of three teams, nominally an attendants' team, a nurses' team and a doctors' team, but that these names indicated only the captain of the team, and that each included members of all three services. One nurse recalled that despite the pervasive presence of hierarchy and ritual that reinforced class distinction, even the superintendent's staff became part of the community on the sporting field. When asked about their relationship with the senior nurses, Eleanor Noakes, who had commented critically on the depth of the class distinction commented: "It was 'speak when spoken to,' You did not initiate a conversation [with senior staff], but off duty you could play tennis with them."[151]

Time off also created opportunities go to Brandon, about two miles to the south. It is apparent that the BHMD was considerably more lax when it came to the free time of the nurses than Winnipeg General or any of the other general hospitals to which Brandon graduates went. In some respects, this may be taken as a sign, much like the higher wage paid to a mental nurse as compared to a general nurse, that the Hospital recognised the relatively low value of the parchment that the nurses received on graduation was to be compensated with a slightly more relaxed social environment. Indeed, many of the nurses reported that in months when they did not have afternoon lectures, they went to town on an almost daily basis, mostly to escape the food of the institution and to take a meal either at

[151]Eleanor Noakes interview.

the home of their parents or with the family of a classmate.

In many respects the residents of the Mental Hospital, staff and patients alike, existed on the periphery of the Brandon community, both socially and geographically. Prior to the 1930s, the women who worked at the hospital were isolated from the broader community of Brandon by the rhythms of their work, which permitted only one day off in three weeks, and by the restrictive rules of the institution, which required them to be on the grounds of the hospital even when off-duty. Although the principle of one-day's-rest-in-seven was only implemented for the female service in 1938, a relaxation of the stringent rules about daytime leave and the advent, in about 1931, of regular bus service between Brandon and the Hospital, broadened the scope of interaction between the nurses and the community. By the late 1930s, Brandon nurses used to go to town very regularly. Lillian McLennan's account that on payday most nurses used to buy two bus tickets, sufficient for twenty four round-trip rides to town, gives some sense of the frequency of these visits.[152]

Recollections of the reception the nurses received in Brandon were mixed. They reveal both the ambivalence of the relationship the nurses enjoyed with the community of Brandon and the ambivalence that they themselves felt about their identity. There is no question that from an economic point of view, the nurses were very welcome. The Mental Hospital remained one of the largest employers in the area and at the onset of the Depression, the twenty-five dollars per month that a nursing student received was a considerable sum of money. That room and board were not deducted, and that there were no assessments for breakages or uniforms from this twenty-five dollars, meant that a great

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[152]Lillian McLennan interview.

deal of this money could be discretionary. As a consequence, the nurses generated a fair bit of economic activity. One nurse acknowledged the primacy of the economic relationship when she observed, "there was a dress shop on 9th street that wouldn't have survived the depression without us."[153]

Nevertheless, association with the hospital carried with it the stigma of association with the mentally ill, and for many in the community of Brandon, the Hospital was regarded as an employer of last resort. Kay Dennis recalled in 1983 that "opinion around town was that it was a terrible place.. that people were really wild.. and that people who worked there didn't have a good reputation. They were considered second class."[154] Lillian McLennan recalled that, "Some mothers were reluctant to let their sons come up to the dances," and Mable Mills recalled that during her youth in Brandon, "I never dreamed that it was a place where they were trying to help people."[155] Dennis went on to recount that after she took employment at the hospital, she experienced a certain degree of shunning by her neighbours, and that although she attended regularly, she was no longer made to feel welcome at her church in town. She recalled one incident:

> ...[A] good friend of my mother told her not to let me go there - I'd just go to the dogs. After I went, when she came to visit my mother she would ask about the rest of the family, but I was a cast-out after that.[156]

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[153]Marjorie Anderson interview; Eleanor Noakes identified this as Mona's Dress Shop.

[154]BMHCA SB2 F32. Kay [Catherine] Dennis, interview with Eveleyn McKenzie and Lloyd Henderson, Brandon, 26 April 1983.

[155]Lillian McLennan interview; Mable Mills interview.

[156]Kay Dennis interview.

One of the typical responses to this kind of shunning was to invoke a sense of moral superiority over the previous generation, by which is meant the nurses of the 1920s. These women were variously described as "lower class," as "untrained scrub maids," and as having loose morals. Some nurses levelled these accusations against male attendants who were their contemporaries, praising their diligence and commitment while on the ward, but assigning them a lower class identity. Lillian McLennan invoked a "Sarah Gampish" notion of the earlier generation of mental nurses when she attributed the reception that she got in Brandon to the loose morals of her predecessors:

> They had a poor reputation prior to us. Earlier nurses in mental hospitals had a reputation of being low class and fast women or something... I shouldn't say because they weren't educated, but they really were a poorer type...
> We had a very good class. One of us had been to university and there were two B.A.s in the year ahead. We were very respectable, but apparently years before they had fast women - which meant that they drank and smoked... but none of our gang drank and smoked.[157]

Scholars of nursing have pointed out that subsequent generations of nurses have defined themselves in relation to previous ones, and that the invocation of the moral and or disciplinary superiority of the present generation has often been a linchpin of occupational identity, whether it be Registered Nurses asserting their superiority over untrained ward attendants, or university trained nurses asserting their superiority over hospital trained nurses.[158]

Thus by the end of the 1930s, one can see in the Mental Nursing Service at BHMD many of the hallmarks of general nursing culture. The last half of the 1930s were years of

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[157]Lillian McLennan interview.

[158]See Barbara Melosh, *The Physician's Hand*, 177-82.

renewed hope and optimism in the mental health community. The development of new interventions and therapies finally carried the promise of a cure for mental illness. This shift to interventionist treatments gave the nurses that worked in the mental hospitals of the late thirties a sense that they were delivering curative care, indeed that they were actually nursing.

It is acknowledged that the administration of these new therapies constituted only a very small part of the mental nurses' actual work and that the care remained largely custodial, but this was not necessarily relevant to the formation of occupational identity. Susan Reverby's analysis of the content of nursing work has demonstrated that indeed general nurses expended the larger proportion of their work time engaged in unskilled domestic tasks, not in performing tasks which manifestly required the application of specific scientific knowledge. Kathryn McPherson has argued that the adoption of scientific management in the 1930s stripped nurses of much of the intellectual control that they had over their work. Nursing superintendents traded this control away to the medical profession in return for their own security as a managerial élite. What was left behind when many of the skills were stripped away was ideology in the guise of science. While the language of nursing remained the language of science, it may be argued that science was largely supplanted by ritual and prescriptive procedure, and that the element of cohesion became identification with an ideological construct and affiliation with an élite social group. [159] Such an understanding makes it easier to understand the behaviour of the second generation of trained mental nurses.

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[159]Kathryn McPherson, *Bedside Matters*, Chapter 3.

Thus while the introduction of new therapies and new technical demands on the mental nurses of the late 1930s was important to creating the perception of a set of proprietary skill for mental nurses, this factor was secondary to the arrival at the hospital of a cohort of workers disposed to affiliate to such an ideology. For this purpose, the key change from the 1920s to the 1930s was demographic. The peculiar economic circumstances of the Depression brought into the service of the hospital a larger number of better educated native born women from more affluent backgrounds. Many of these women saw their affiliation with the hospital as impermanent. Like general hospital nurses, who tolerated rigid discipline and hard work in return for the promise of future social and economic security, they were able to project forward and to see that future benefits might accrue from their experience at the mental hospital. Unlike the nurses of the late 1920s, therefore, who were disposed to take job action to improve their immediate circumstance, second generation mental nurses saw improvement in their circumstance in co-operation with, not resistance to the agenda of the psychiatric community. Union activity, for example, was anathema to these women. Jean Young, when asked whether she had ever considered affiliation with a union, retorted, "I couldn't spell the word."[160]

Mental nurses still existed on the margins of the general nursing community, and eligibility to write the Registered Nurses' Exam eluded them until 1942, when an affiliate arrangement was finally struck with Winnipeg General Hospital. Nurses were reminded in their daily encounters with the residents of Brandon that by their association with the mentally ill, they remained on the margins of respectable society. At their obstetrics and

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[160]Jean Young interview.

gynaecology lectures at Brandon General, they were even more directly reminded of their marginal relationship with the registered nurses' community: "They thought of us as glorified scrub maids."[161] This marginal relationship had another consequence, and that was the formation of a unique occupational identity apart from the general nursing community. Willing to affiliate with an ideology of nursing and to identify themselves as skilled workers, mental nurses at Brandon compensated for their rebuff by the general nursing community by developing a sense of their own skills that were separate from those of the general nurse. In so doing they introduced a second level to the cure/care dichotomy that separated nurses and doctors. They asserted that the care they delivered was "caring care" in contrast to the prescriptive "curing", or clinical, care of general nurses (which was "just care" in the lexicon of one of the nurses interviewed). Ironically, this may have moved mental nurses further from the locus of power. If, as Susan Reverby has argued, general nurses were politically disabled by "the order to care in a society which refuses to value caring," then mental nurses were perhaps more disabled by their assertion that they delivered "more caring care" to people who were not valued by society.[162] Nonetheless, personal service, buttressed by a basic understanding of clinical nursing, became by 1940 the core of a discrete occupational identity.

This identity was imperilled in the 1940s by the severance of the vast majority of the nurses of the second generation from the service of the hospital. One might argue, however,

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[161]Madeline Whyte interview.

[162]Susan Reverby, "A caring dilemma: Womanhood and nursing in historic perspective," *Nursing Research* 36:1 (January/February, 1987): 5.

that it remained in those who stayed behind, and in those who returned to the hospital as senior staff following general training, and that it was the existence of this unique identity which helped to shape the future of mental nurse training in Western Canada.

Chapter 5 - Conclusion - Persistence and Change, 1939 - 1946

It has been argued in the preceding chapter that the conditions that prevailed in the latter half of the 1930s contributed to the formation of an occupational identity for the second generation of trained mental nurses at the Brandon Hospital for Mental Diseases that set them apart from the preceding generation. It has been argued that this identity was created by a combination of specific economic circumstances and more general changes in the care of the mentally ill. While there was a basic continuity in the medicalization of mental health care, the economic conditions of the 1930s were impermanent, and the hospital landscape changed dramatically in the early 1940s. Specifically, the hospital experienced a staff exodus after 1939 as the end of the Depression and the transition to a wartime economy re-configured the labour market in Brandon and surrounding communities.

A large proportion of the women who had come to work at the mental hospital in the 1930s had aspirations to go on to other forms of paid work that carried a higher status and were more portable. Some certainly felt that their social and economic backgrounds and their prior educational attainment made them better qualified for other forms of work, and indeed this sentiment was sometimes shared by hospital administrators. The mental hospital was never regarded as a place of permanent employment by these women, but rather as a transitional workplace which would provide economic security through the worst of the Depression. As the economy improved and other employment opportunities presented, the surplus labour supply that the hospital administration had celebrated in the early 1930s evaporated. While the desk of the superintendent of the training school was "piled high"

with applications for much of the 1930s, and while nurses who trained in that period reported long waiting lists to get in, the availability of other work in the early 1940s created critical labour shortages at the hospital, indicating that in the eyes of the broader community, mental hospital work was not yet a vocation, but an employment of last resort.[1]

Nurses left the hospital to take up a variety of other activities. Many of the second generation nurses had always intended to pursue general hospital training, and for them, mental nursing had been a form of interim employment that would bolster their credentials and provide gainful employment with room and board until they reached the age of admission into a hospital training program. Canadian hospitals in the early 1940s were on the cusp of a period of renewed growth and development as the inter-war models of private duty nursing, charity institutions and home medicine were shed in favour of the large public institutions that were to become the hallmark of the modern welfare state. These women discovered that the new hospitals valued their patient management and administrative skills, and that placements were readily available to them. [2] While no hospital was yet willing to make such concessions as reduced training time, the rewards of general nursing, which included greater prestige and portability, made an additional two to three years' training worthwhile.

Other women left the hospital for domestic life. Several former nurses reported that they were involved in long courtships or engagements through the 1930s. These couples had

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[1]Mary (Churcher) Smeltz. Interview with the author, Brandon, 14 February, 1996.

[2]Anonymous Nurse, Interview with the author, Winnipeg, 16 November 1995.

delayed marriage and family life pending the economic security of the future breadwinner.[3] Until the late 1940s, married nurses were not employed by any major Canadian hospital or mental institution. Thus, marriage was clearly proscribed for any mental nurses whose future husband did not have secure employment.

Some of the reasons for severance were specific to the Brandon Hospital for Mental Diseases, and these caused much discord not only at the hospital itself, but between the hospital and the government of the day. As early as his Annual Report for 1938, submitted in July of 1939, Pincock warned his political masters that the failure to restore cuts to the civil service wage schedule were having a very detrimental effect on the nursing service. He reported that many of the nurses were leaving the employ of the hospital to seek similar work at other mental hospitals in Canada and the United States: "We regret the loss of some of our nurses recently to other mental institutions offering greater monetary inducements."[4] Over the course of the decade, the employees at the hospital had endured three successive pay cuts, and by 1939, unadjusted salaries had been reduced to 1924 levels.[5] Although the pay for pupil nurses remained well above the standard offered by other institutions, the mental graduates could do much better elsewhere. Chief among the "other mental institutions" mentioned by Pincock above was the one at Ponoka in Alberta. Ponoka had no training school of its own, and employed only graduate nurses and graduates of mental

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[3]Eleanor Noakes, for example, had been delaying marriage since before she commenced her training in 1935. Eleanor Noakes, Interview with the author, Brandon, 12 February, 1996.

[4]BMHCA SB23b F7, *Annual Report for 1938.*

[5]Ibid.

hospital training programs. This institution had long historic ties with BHMD, having been superintended by Baragar until the time of his death in 1937. The matron at Ponoka in the mid-1930s was Catherine Lynch, former superintendent of nursing at the Brandon Mental Hospital (who later went on to become superintendent of nurses at Winnipeg General), and it is not surprising that a number of Brandon graduates were recruited to work at Ponoka.[6] By no means did all of those who left go to Alberta though. Other nurses reported that they or their colleagues readily found work elsewhere, chiefly in New England, where the demand for trained mental nurses was high, and in Ontario, where they were able to find employment at private mental institutions such as the Homewood retreat in Guelph[7]

By 1939, it was apparent that the failure of the hospital to keep pace with economic change was having a detrimental effect on the institution's ability to retain its best staff and to maintain its programs. Mathers and Pincock sent a series of letters to the Minister and to Bracken himself protesting the government's failure to restore the pay cuts and warning that the hospital's ability to continue to deliver modern scientific therapies like insulin were imperiled.[8]

These losses were not confined to the female nursing service, and in 1939 the hospital lost four of its staff doctors, prompting Pincock to write to the Minister:

A great deal of genuine dissatisfaction exists because of the present lack of

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[6]Mable Mills, Interview with the author, Winnipeg, 2 October, 1995.

[7]Madeline Whyte went on to nurse at Homewood. Madeline (Ballard) Whyte. Interview with the author, Selkirk, 5 January, 1996. See also Katherine (Wilkes) Weiermann, Interview with the author, 11 December, 1995.

[8]BMHCA SB3a, *passim.*

> security and guarantee of the future and this is seriously affecting the morale of the staff and threatens the disintegration of a trained, experienced and conscientious group of men whose primary interest has been the development of an efficient service.[9]

Pincock went on to make the case for a reasonable schedule of remuneration of the medical staff, but apparently the call went unheeded, as two years later, his successor, Stuart Schultz made the same plea:

> One can endure losses to essential war services with equanimity and even encourage enlistment for such purposes, but the loss of intelligent and experienced staff because of justifiable dissatisfaction over working conditions is difficult to condone.[10]

The multiplication of options available to mental graduates was attested to by one nurse, who confessed that at the time she left the hospital to be married in 1939, she would probably not have recommended enrollment in the training school to a friend as a career choice, "because there were so many more options then."[11] It should be noted that not all of these options implied severance from the hospital. Even at their home institution, mental nurses without general training were not eligible to become head nurses, and they could not be promoted above the level of supervisor, which despite the promising sound of the title, carried little better salary and perquisites than being a senior student. As a consequence, several mental graduates went into occupational therapy, where the lack of a credential did

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[9]BMHCA SB23b F8. *Annual Report for 1939.*

[10]BMHCA SB23c F1. *Annual Report for 1941.*

[11]Eleanor Noakes Interview.

not hamper their advancement in the same way.[12] In a similar vein, Lillian McLennan, who was a mental graduate, went to work in the laboratory, where she eventually obtained a credential as a lab technician. Like occupational therapy, this offered McLennan the opportunity for career advancement where the lack of a general nursing credential did not serve as an obstacle.[13]

Depopulation of the nursing service by 1940 had precisely the effect that Pincock had earlier predicted, and the shortage of trained staff compelled the hospital to discontinue its insulin therapy program. Although several attempts at reinstatement were made, this program remained substantially dormant for three years. The closure of the treatment rooms in 1940 was but one indicator of what has been described as a generalized decline in the level of patient care and the quality of the staffing. The diversion of economic resources and the changing employment market created by the War interrupted the steady process of reform that had characterized the 1930s. The mental hospital fell even lower on the Bracken government's list of priorities than it had been in the previous decades, and there was a considerable regression in the quality of care offered.[14] With a lesser trained and perpetually short-handed staff, Pincock reported in 1942 that "the liability to accidents shows a marked

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[12]Two of the nurses interviewed in the preparation of the present work took this route. See Katherine Dennis, Interview with the author, Brandon, 11 December, 1995; and Marjorie Anderson, Interview with the author, Brandon, 1 April 1996.

[13]Lillian McLennan. Interview with the author, Winnipeg, 11 April 1996.

[14]BMHCA SB1a F3. Robert McGarva, "From Prison to Community: The Development of Care and Treatment at the Brandon Mental Hospital, 1918 to the late 1950s. (Unpublished paper, 1986), 42.

increase with willing but untrained personnel."[15]

In place of trained nurses, which since the middle of the previous decade had formed more than half of all the ward staff, the hospital was forced to rely on untrained staff. On the male wards these took the form of men on National Selective Service - conscientious objectors.[16] The female wards were staffed primarily with married women of varying skills from the City of Brandon.[17] Even the addition of these new nurses was insufficient, and in 1945, the superintendent of the hospital (Stuart Schultz, as Pincock had left to assume the position of Provincial Psychiatrist in 1942), reported that there were twenty-seven vacancies on the female service in a total staff of one hundred and seventeen. Of the ninety nurses on the service, forty three were nurse-attendants or part time workers.[18]

The "nurse-attendants" referred to in the above tally represented a new and subordinate class of female employee that was introduced in 1942 as an expedient to address some of the staff shortages. These women received the same course of lectures as the male attendants, and were eligible for the same Certificate in Mental Nursing. The purpose of this course was purely practical: women enroled in the shorter and less demanding course of

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[15]BMHCA SB23c F2. *Annual Report for 1942.*

[16]The mental hospital was accorded low priority under the Selective Service program however, and the hospital was able to secure the service of only forty-four men, still short of the required complement.

[17]Not all of these women were entirely without skills. Opening the door to married women allowed some former mental nurses, like Eleanor Noakes for example, to re-enter the hospital workforce. Eleanor Noakes interview. Katherine Weiermann, who was Superintendent of Nursing between 1941 and 1946 offers some perspective on the impact of these women on the nursing service. Katherine Weiermann interview.

[18]BMHCA SB23c F5. Annual Report for 1945.

training were more available for ward work. It had the ancillary effect of creating another level of hierarchy within the walls of the institution, and one which probably benefitted the mental graduates.

1942 was a watershed year of the hospital nursing service. In that year the School of Nursing became affiliated with the Winnipeg General Hospital. Much as was envisioned in 1929 when the three year training program was devised, the affiliate program provided that Brandon pupils who had successfully completed two years of training would be admitted into the Winnipeg General Training program at the second year level. At the end of a further two years of training, successful candidates would receive a Diploma in Mental and General Nursing, and they would be recommended by Winnipeg General to write the Registered Nurses' Exam.[19]

Coincident with the opening of the affiliate program, the Diploma of Mental Nursing course reverted to a two year course, and considerable investment was made in the School of Nursing, with new instructresses being hired and the Nursing Library expanded significantly.[20] Investment in the School of Nursing at a time of staff crisis is best seen as a recruiting tactic, and indeed the hospital did expend considerable effort on recruiting new nurses, even to the point that nurses delivered testimonials about the benefits of affiliating with BHMD in radio addresses.[21]

The establishment of the affiliate program can also be seen as the culmination at the

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[19]BMHCA SB23c F2. *Annual Report for 1942.*

[20]Ibid.

[21]Ibid.

beginning of the 1940s of several processes that had been underway for twenty years. In the early years of the century, and especially after the First World War, psychiatrists had existed on the margins of the medical profession, isolated both figuratively and literally by the nineteenth century emphasis on moral treatment and the asylum system. They sought to bring psychiatry and the treatment of mental illness back into the medical world by transforming their asylums into hospitals. As the case of the Brandon Hospital for Mental Diseases suggests, they were met with several fundamental obstacles in this quest. The first obstacle was medical. Despite the early attempts at heroic intervention, the optimism of the early 1920s quickly evaporated as scientific medicine was neither able to deliver a cure for mental illness, nor even to provide an explanation for many of its common manifestations. Through to the mid-1930s, beneath the veneer of the hospital lay the old asylum, existing on the margins of society and warehousing the mentally ill away from the sight and minds of the populace. For those who worked there, the title of nurse was insufficient to disguise the fact that the intellectual content of their work was limited, and in fact the vast majority of the effort they expended was in providing routine maintenance and custodial care.

The second obstacle was cultural. This doctor-driven model of care was at odds with the ambitions of the increasingly influential élite of the general nursing community, who were aggressively asserting control over the discipline of nursing by propagating an ideology of professionalization. As scholar Eliot Friedson has argued, the most important aspect of professionalization is neither the standardization of work nor the intellectual control over

its content but the establishment of the gatekeepers of the professionalised system.[22] Marginalized within the medical community and frustrated by the general hospital tradition of semi-autonomous nursing schools, the psychiatrists could not compel the recognition of their nurses, and mental nurses were shut out of general nursing. Given the resistance of the general nursing community, the questionable credentials and intangible rewards of mental nursing were insufficient compensation for the low wages, poor working conditions and the lack of economic mobility presented by mental hospital work. It is no surprise that when the Mental Hospital Workers Federated Labour Union formed in 1926, women in the employ of the hospital were quick to sign up.

The near collapse of the training school in 1926 underscores the fundamental failure of the doctor driven model of nurse training of the 1920s. Nursing historians have observed that nurse training was far more about cementing an affiliation to an ideology than about imparting specific scientific knowledge. In Reverby's words, nurse training "was more work than learning" reflecting what Christopher Maggs called "the political economy of the hospital apprenticeship system."[23] Nursing apprentices typically spent more time performing basic domestic tasks than taking lectures or engaging in active tutorial learning. George Weir's exhaustive study of nursing education in Canada discovered that instruction was consistently given short shrift by nursing schools, and that nurses frequently skipped

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[22]This is the central contention of Eliot Friedson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge*, (New York: Harper and Row, 1970).

[23]Susan Reverby. *Ordered to Care: the Dilemma of American Nursing*. (New York: Cambridge University Press, 1987), xvii; and Christopher Maggs. *The Origins of General Nursing*, (London: Croom Helm, 1986), *passim.*

lectures to complete ward work and meet the basic economic needs of the hospital. He concluded that as much as 37% of a nurse's day was spent engaged in unskilled domestic labour.[24]

In this context, the importance of ideology, reinforced by ritual, becomes clear. Nurses endured the rigorous restrictive life of the training school and tolerated the hard and often dirty work not for its own rewards, but for the intangible benefits of admission into a privileged community. To be successful, this model of initiation had to be supported by a basic economic rationality: compliance with the demands of the nursing school and the embrace of its cultural norms had to lead ultimately to financial independence and membership in a respectable sector of society. The mental nurses of the 1920s rejected the strictures of the training school and evolved a culture of resistance, which included affiliation with a trade union, precisely because that basic economic rationality did not underlie the rituals of the training school. By the end of the next decade, the context had shifted just enough that when another union organizing drive started in 1938, women were not involved. Certainly some of this absence can be attributed to the historic marginalization of women within the Canadian Union movement, but this is insufficient.[25]

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[24]George Weir, *Survey of Nursing Education in Canada*, (Toronto: University of Toronto Press, 1932), 193. Weir's definition of unskilled domestic work was very narrow, and "all work involving an elementary knowledge of the principles of hygiene and sanitation" was excluded, including disinfection and bedmaking. Weir acknowledges that were these duties also to be interpreted as domestic work, the percentage would be increased to over 75%. Ibid., 192.

[25]The historic role of women in the Canadian labour movement is beyond the scope of the present work. See Ruth Frager, "No Proper Deal: Union Workers and the Canadian Labour Movement, 1870 - 1940." in Union Sisters: Women in the Labour Movement. Linda Brisken and Lynda Yanz, eds. (Toronto: Women's Educational Press, 1983); and

The challenge is to locate the cultural change of the interceding ten years. Two sources of fundamental change must be identified. The first is demographic, and is rooted in the changing employment patterns created by the Depression. The second relates to the growing technical demands imposed by the medicalization of care, which had the effect of creating for the nurses of the 1930s the perception of an identifiable skill-set and allowing them to differentiate themselves from the other employees of the hospital.

To understand the interplay of these two factors, it is useful return to Celia Davies' observations about the content of nurse training.[26] If nurse training is primarily about affiliating with a cultural norm, and if it is therefore partly independent of the work performed, the behaviour of the nurses of the 1930s is better understood. Despite the overwhelming persistence of custodial care, the beginning of new treatments in the 1930s created sufficient perception of a proprietary skill set that the nurses were able to set themselves apart from the rest of the hospital staff and to stake out some intellectual territory of their own.

This was in part because many of these nurses were disposed to seek out this territory. They came from cultural backgrounds which were favourable to credentialism, and many of them had aspirations to go on to further education or training. Mental nursing was an interlude or a stepping stone to something else. Most embraced a fundamental optimism that things would get better, and that advancement was possible. By the end of

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Irene Goldstone, "The Origins and Development of Collective Bargaining by Nurses in British Columbia, 1912 - 1976." (Unpublished MA Thesis, University of British Columbia, 1981).

[26]See Chapter 4.

the 1930s, this potential for advancement was already manifest in the multiplying opportunities to enrol in general training, to go into occupational therapy, to take a job elsewhere or to move into married life. Unlike the nurses of the 1920s, whose imperative was the melioration of their immediate circumstance, these women saw their greatest personal profit in affiliation with the ideology of the school. Quite simply, the hoped that the training would assist them in finding something better.

While the affiliate program signified in some measure the ultimate legitimation of the project that began with the opening of the school of nursing twenty-one years earlier, the first attempt at a program was less than an unequivocal success, underscoring in part the persistence of the desire on the part of the general nursing élite to marginalize the mental hospital nurses. Jean Young, a student in the second class of the affiliate program, recalled that the Brandon nurses were treated poorly at Winnipeg General. Her status as a mental nurse was signified throughout her affiliation by the difference in her uniform. She recalled that the Brandon pupils arrived and remained as a group, and that they "treaded lightly" and were treated as "foreigners" for the duration of their training.[27] Perhaps the most difficult was that even though their names appeared on the graduation rolls of Winnipeg General, they were barred from attending the graduation ceremony at the Hospital, and they had to settle for a separate ceremony in Brandon where they were presented with a parchment and pin different from the rest of the graduates.[28]

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[27]PAM C-1769-98. Jean Young. Interview with Kathryn McPherson, Winnipeg, 8 May 1990.

[28]Ibid.

The affiliation with Winnipeg General was to last for only a few years, and in 1946, the affiliation was switched to Brandon General. Taking advantage of geographic proximity, the new course was more integrated and took only three years to complete.[29] This new course was to chart the future for psychiatric nursing in Western Canada. Whereas elsewhere in Canada and the United States, psychiatric nursing came to be more closely integrated into programs of general nursing, the Brandon program, as well as companion programs elsewhere on the prairies, continued to be offered at freestanding mental hospital schools of nursing. This situation prevailed in Manitoba until 1996, when the last class of mental nurses completed their course of studies at the Brandon Mental Health Centre.

The persistence of these models can be seen in part to reflect the ongoing influence of the second generation of mental hospital trained nurses. In spite of the fact that many of them left the service of the hospital when other opportunities presented, they left a cultural legacy within the institution, and that was an occupational identity apart from that of general hospital nurses. By invoking their superior ability to care and their learned capacity to function in the unpredictable environment of the mental hospital, they elevated the custodial care that they gave to a higher echelon. In so doing, they created for themselves the intellectual basis for a distinct occupational identity.

In 1948, the federal government intervened for the first time in mental health care by extending special operating grants to mental hospitals. By 1952, mental hospitals were included in the National Health Grants program that was to mark the emergence of the

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[29]BMHCA SB23c F6, *Annual Report for 1946.*

modern welfare state in Canada.[30] At this time, the influence of the nurses of the second generation was still strongly felt at the Brandon Hospital for Mental Diseases. Some of these women remained in the service of the hospital as ward supervisors or occupational therapy instructors. Several others returned to the hospital as instructresses or administrators after completing a course of general training at a general hospital, and still others returned after 1945 as graduates of an affiliate program. These graduate nurses brought with them an ethos which combined the ideology of general nursing with that of mental nursing. Although further research is required, preliminary evidence, including oral testimonials from some of these nursing administrators themselves, suggests that this dual affiliation played a role in the adherence in Western Canada to the system of freestanding training schools.

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[30]The special operating grants are mentioned in BMHCA SB23c F8, *Annual Report for 1948*. See also Anne Crichton. "The Shift from Entrepreneurial to Political Power in the Canadian Health System." *Social Science and Medicine*. 10, 59-66.

List of Abbeviations

BGH	Brandon General Hospital
BGNA	Brandon and District Graduate Nurses' Association
BHI	Brandon Hospital for the Insane
BMH	Brandon Mental Hospital
BMHC	Brandon Mental Health Centre
BMHCA	Brandon Mental Health Centre Archives
BHMD	Brandon Hospital for Mental Diseases
MAGN	Manitoba Association of Graduate Nurses
MLL	Manitoba Legislative Library
NCMH	(American) National Committee for Mental Hygiene
PAM	Provincial Archives of Manitoba
CAMC	Canadian Army Medical Corps
CNCMH	Canadian National Committee for Mental Hygiene
RAMC	Royal Army Medical Corps
SHMD	Selkirk Hospital for Mental Diseases
WGH	Winnipeg General Hospital

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[1]The manner in which the BMHC Archives are organized would require the names of more than eighty discrete shelf boxes to be reported here. All documents, operating records and correspondence created before 1950, plus more recent records relating to the Archives, the Library and the Centennial Book Project were examined. Also examined were photographs, newspaper clippings, vertical file materials, unpublished papers and oral history collections.

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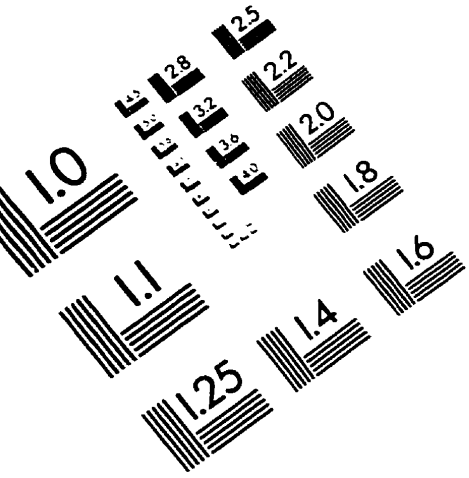

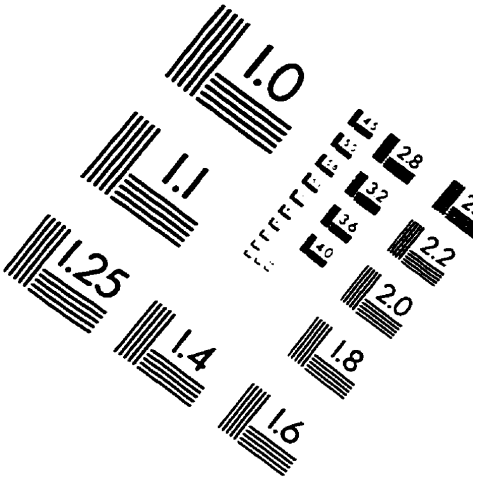

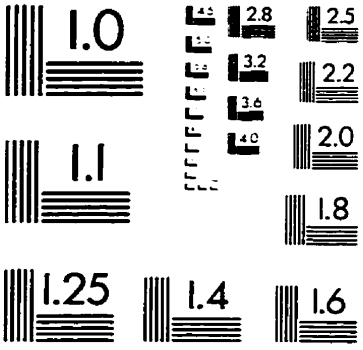

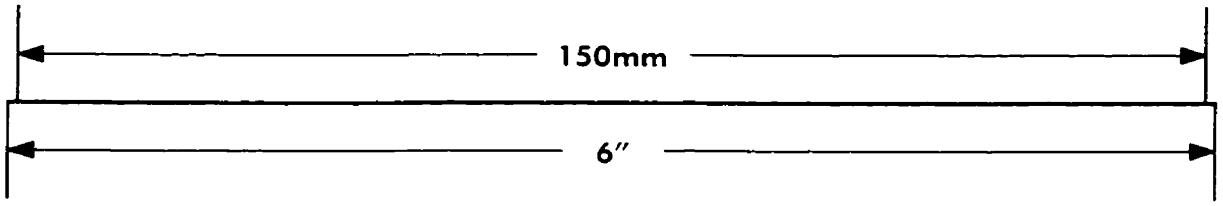

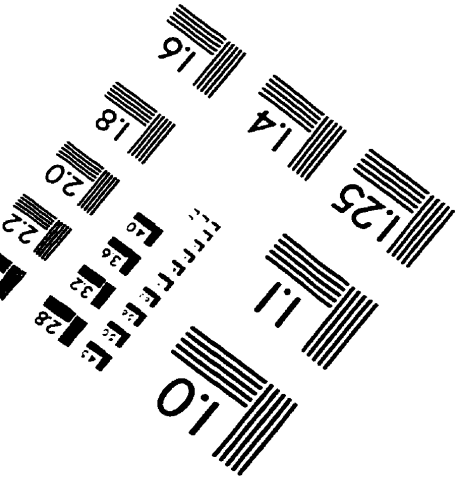

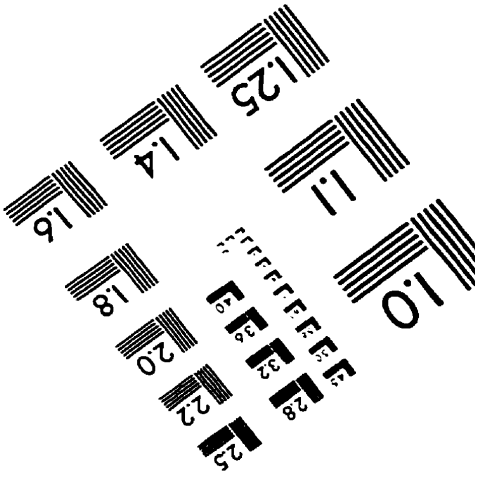

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