

Class Difference and the Reformation of Ontario Public Hospitals, 1900-1935: "Make Every Effort to Satisfy the Tastes of the Well-to-Do"

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Article abstract

At the beginning of the 20th century, charity hospital governors in Ontario began to explore the possibility of admitting paying patients to help offset the costs of providing medical charity. This transformation entailed changes in administration, as well as concerted publicity and marketing campaigns to rehabilitate the image of the hospital and to attract affluent health consumers. The subsequent construction of new hospital facilities, exclusively for the use of paying customers, was informed by an ideology that mandated the physical separation of social classes and the identification of deserving and less deserving recipients of health care services. This paper examines aspects of the design, management, marketing, and staffing of a number of southern Ontario public hospitals to illustrate how the transformation of these institutions in the years between 1900-1935 actively shaped class inequality within and outside their walls.

ARTICLES

Class Difference and the Reformation of Ontario Public Hospitals, 1900-1935: "Make Every Effort to Satisfy the Tastes of the Well-to-Do"

James M. Wishart

ACCOMPANIED BY THE MUSIC of Romanelli's orchestra, Ontario Lieutenant-Governor W.D. Ross used a gold key to open the doors to a marvelous new structure at the corner of Gerrard Street and University Avenue in Toronto on 24 April 1930. Mary L. Burcher, one of the first of over 2000 visitors who came through the doors "by invitation only," was thoroughly impressed by the opulent scene before her:

Attendants dressed in mulberry and gold uniforms are stationed at the door to direct the visitor.... The furniture and furnishings of the rotunda are luxurious in the extreme. The terrazzo floors with copper stripping in block effect are covered with handsome rugs in rose, gold, and blue tones. The long windows are covered with ecru net glass curtains and draped with rose and gold broca.... Table and floor lamps with parchment and Chinese embroidered silk shades cast a warm glow ... [and] on each side of the rotunda there are hung oil paintings of various benefactors.... Behind this, and extending the whole length of the north corridor, are the executive offices.... The Board Room is also located in this corridor. It is softly carpeted in rose and blue and furnished in walnut and blue Spanish leather.¹

¹Mary L. Burcher, "Many Unique Features Are Incorporated in New Private Patients Pavilion," *Canadian Hospital* (May 1930), 28; "New Wing Opens to Make Hospital Continent's Best," *Toronto Daily Star*, 24 April 1930.

James M. Wishart, "Class Difference and the Reformation of Ontario Public Hospitals, 1900-1935: 'Make Every Effort to Satisfy the Tastes of the Well-to-Do'," *Labour/Le Travail*, 48 (Fall 2001), 27-61.

Burcher, an executive member of the Canadian Hospital Association, remarked that the new structure was "suggestive of a palatial and exclusive hotel." In reality, it would serve no such mundane function; this monument was none other than the new Private Patients Pavilion of the Toronto General Hospital (TGH). Billed as the *pièce de resistance* of the hospital building effort, the nine-story structure confirmed the TGH's standing as "The Largest Single Hospital, Medical, Education Unit on the Continent."²

Hospital Superintendent Chester J. Decker, fairly bursting with pride, explained that "Every conceivable device, every possible arrangement or system has been installed that patients may be as comfortable and happy as possible during trying times." Confirming Burcher's impressions, the building did incorporate a "Hotel Wing" and "Hotel Dining Room" on the first floor for the convenience of visiting relatives and friends. Meanwhile, below the floor, in concealed elevators, and on back stairways, human and inanimate machinery alike laboured to ensure that no discomfort would impede the convalescence of the patients on the upper floors. For the price of twelve dollars per day (roughly two weeks' wages for a hospital maid), the private patient could enjoy all the health-improving service their money could buy. Toronto's Mayor Wemp, speaking to the assembled press, enthused, "Fortunate is the unfortunate patient who will have to be treated in this building."³

A century ago, public hospitals stood on the periphery of the medical economy. As municipally-owned, philanthropically-funded, technologically-unsophisticated institutions housing the aged, the unemployed, and the indigent ill, they were at best tangible symbols of the privilege of the paternalist elite and of the abject dependence of the urban poor. At worst, they acted as "instruments for social control ... better equipped to promulgate Victorian social virtues than to treat sickness."⁴ But by the 1930s, these same organizations had emerged, in their own propaganda, as "shining examples of service, science, and success," that efficiently dispensed care and cure to *all* members of society.⁵ Historians have often understood this development as virtually inevitable and inevitably progressive: the advances of scientific medicine and the demands of medical professionals gave rise to wholesale changes in the provision of institutional health care. In such formula-

²"The Largest Single Hospital, Medical, Educational Unit on the Continent," *Canadian Hospital* (May 1930), 25.

³Burcher, "Private Pavilion," 27; "New Hospital Wing Opened by Lieutenant-Governor," *Toronto Daily Telegram*, 25 April 1930.

⁴David Gagan, "For Patients of Moderate Means: The Transformation of Ontario's Public General Hospitals, 1880-1950," *Canadian Historical Review*, 70 (1989), 152. For histories of the 19th-century charity hospital that seek to complicate this standard portrayal, see Charles Rosenberg, *The Care of Strangers: The Rise of the American Hospital System* (New York 1987) and S.E.D. Shortt, "The Canadian Hospital in the Nineteenth Century: An Historiographic Lament," *Journal of Canadian Studies* 18 (Winter 1984), 3-14.

⁵"Special Industrial Hamilton Number," *Hamilton Spectator*, 13 November 1926.

tions, hospital bureaucrats — whether professional administrators or philanthropic overseers — emerge as humanitarian individuals who did the best they could with limited resources until government saw fit to assume more responsibility for the medical needs of its citizens.⁶ Continuing inequity in the distribution of the benefits of medical science thus occurred in spite of the best efforts of philanthropists.

Yet such an understanding does not account for the appearance of structures like the TGH Private Pavilion. The grand opening of the new building at TGH epitomized an early 20th-century trend in the provision of health care in Ontario, and throughout North America more generally. Beginning just before World War I, hospital governors re-formed their charity hospitals to attract and accommodate a paying clientele. In so doing, they did not always seek to expand the curative potential of their facilities, nor did they meekly bend to the will of an increasingly powerful medical profession. The facilities that emerged, of which the Private Patient Pavilion at TGH was but one, embodied an ideology that mandated the physical separation of social classes and the identification of deserving and less deserving recipients of health care. Indeed, discussions of medical efficacy and cost were at times used both explicitly and implicitly to *justify* class segregation. Thus, the hospital as a modernizing social institution did not inadvertently mirror existing injustices in early 19th-century society, as some historians have concluded.⁷ In this paper I examine aspects of the design, management, advertisement, and staffing of a number of southern Ontario public hospitals to illustrate how the transformation of these institutions in the years between 1900 and 1935 actively shaped class inequality within and outside their walls.

Repositioning the Charity Hospital

In mid-19th-century Ontario, health services were organized according to an ideological and spatial segregation, in which the quality of care and the skill and training of caretakers were most often directly proportional to the social position of the patient. Alongside the charity hospital, which served the indigent and insolvent, was a system of health care provision catering to the paying customer — service was provided in the comfort of one's own home by paid, relatively skilled, doctors and nurses. In this environment, access to private health care was a clear marker of respectability, while treatment at a publicly-funded health institution

⁶G. Harvey Agnew, *Canadian Hospitals: A Dramatic Half-Century* (Toronto 1974) and Gagan, "Patients of Modern Means," 152; Rosenberg, *Care of Strangers* and Rosenberg, "And Heal the Sick: The Hospital and the Patient in 19th-Century America," *Journal of Social History*, 10 (1977), 428.

⁷I refer specifically in Canadian literature to David Gagan, "*A Necessity Among Us*": *The Owen Sound General and Marine Hospital 1891-1985* (Toronto 1990); Gagan, "For Patients of Moderate Means," 152; and Mark Cortiula, "Social Class and Health Care in a Community Institution: The Case of Hamilton City Hospital," *Canadian Bulletin of Medical History*, 6 (1989), 133-145.

symbolized financial and moral bankruptcy.⁸ At the end of the 19th century, however, as it appeared increasingly possible to cure or ameliorate ailments that had plagued humankind for centuries, physicians and surgeons began to envision the local charity hospital as a convenient, publicly-subsidized "doctor's workshop."⁹ Aseptic practice had taken hold in medicine, and doctors convinced themselves that the home, tainted as it was by dirt and disruption, was an unfit location for the care of the sick, whatever their socioeconomic position. Furthermore, the profusion of new medical technologies increased the overhead costs of private practice, and the geographical expansion of urban centers made "house calls" less and less practical. Physicians urged hospital trustees to open their institutions to paying patients, in order to reduce the need for individual physicians to make major purchases of equipment. Such a move would also require patients to make the trip to the doctor, rather than vice versa.¹⁰

Nevertheless, the desire by medical practitioners to improve their efficacy and profitability was only one of several considerations in the transformation of Canadian hospitals in the early 20th century. Hospitals existed as discrete corporate entities with goals, prerogatives, and problems often separate from those of medical practitioners. Chief among their tribulations was a chronic lack of funding. At Kingston General Hospital (KGH) between the years 1902 and 1917, the "per diem cost" of patient care, the gold standard by which hospitals judged their efficiency, rose from \$0.66 to \$1.52. During this period, KGH finished the year "in the red" about half of the time.¹¹ Similarly, at Hamilton City Hospital (HCH), this per unit cost jumped from \$0.94 to \$2.04 between 1890 and 1905.¹² Income was erratic, depending heavily upon the benevolent contributions of the local elite and the often politically contentious stipends provided by municipalities for care of their sick poor.

By 1900, many hospital governors throughout North America began to explore the possibility of admitting affluent patients to help offset the ballooning costs of medical charity. In the forefront of this movement in Canada, KGH received about half of its 1907 income from a relatively small number of paying patients. This was an uneven development, however; in the same year HCH covered only 25 per cent

⁸Cortiula, "Social Class and Health Care"; Gagan, "Patients of Moderate Means," 152.

⁹There is a substantial literature that highlights the professional ambitions of doctors in the shift to institutional practice: Charles Rosenberg, *The Care of Strangers*; Morris Vogel, *The Invention of The Modern Hospital* (Chicago 1980), Ch.3; and in Canada, David Gagan, "A Necessity Among Us": *The Owen Sound General and Marine Hospital 1891-1985* (Toronto 1990), Ch. 2; David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966* (Montreal 1986).

¹⁰Gagan, *Necessity*, 28-29; Agnew, *Canadian Hospitals*.

¹¹Queen's University Archives (hereafter QUA), Kingston General Hospital Fonds (hereafter KGH) B103 Board of Governors Annual Reports, 1902-1918.

¹²Mark Cortiula, "Houses of the Healers: The Changing Nature of General Hospital Architecture in Hamilton, 1850-1914," *Histoire Sociale/Social History*, 55 (1995), 39.

of costs in this manner, and every major expenditure on maintenance or new facilities threatened to send the hospital into a downward economic spiral.¹³ The HCH Governors were forced annually to climb the stairs to the City Council chambers, hats in hand, to beg and bully politicians for more funds to carry on hospital work. Desperate to be free of these obligations and uncertainties, hospital overseers formulated expansion plans and marketing schemes to attract more paying patients to their institutions and thereby increase hospital revenues.

Serious pitfalls had to be negotiated before these ideas could be enacted. Charitable hospitals were dark places in the popular imagination, associated with death, disease, and disenfranchisement. In 1905, a Montreal doctor described the bad old days of the 1880s to a group of graduating nurses: "It was with the greatest difficulty that patients could be induced to go into a hospital. It was the popular belief that if they went in they would never come out alive."¹⁴ Even if this stigma could be lifted, and the wealthy persuaded to seek out the hospital when they were ill, there remained the problem of the unwelcome and unhealthy mixing of social strata within the hospital institution. Poverty, in the perceptions of hospital trustees, doctors, and their prospective bourgeois clients, often brought to mind a dangerous moral and physical degeneracy.¹⁵ The apparent solution to this problem came in a reformulation of the time-tested policy of health service segregation *within* the walls of the hospital institution. Separate spaces and "grades of care" were created for patients who were sorted according to ability to pay.¹⁶ These spaces were constructed with the assumption that the needs, wants and *rights* of patients from differing class categories were fundamentally different. University of Toronto

¹³"Hospital Costs and Revenues," *Hamilton Herald*, 10 July 1913.

¹⁴Dr. F.J. Shepherd, to the Montreal General Hospital Nurses' Club, in J.J. Heagerty, *Four Centuries of Medical History in Canada*, Vol. 2 (Toronto 1928), 144. It is noteworthy that hospital publicists later used these same dark images to highlight the drastic improvements made to modern facilities.

¹⁵A representative primary document that well-illustrates the "scientific" foundations of this enduring tripartite correlation of disease, immorality, and poverty, is R.L. Dugdale's *The Jukes: A Study in Crime, Pauperism, Disease, and Heredity* (New York 1888). A sociological case study, this book analyses an extended family of 500-some members in order to establish the aggregate "social damage," in dollars and cents, wreaked by their combined criminality, disease, and institutionalization. It makes for fascinating reading in the context of governmental reports in recent years which raise panics over the rising cost of supporting the socially "unproductive." For a more recent theoretical analysis of the "myth of the barbaric, immoral, and outlaw class which ... haunted the discourse of legislators, philanthropists, and investigators into working-class life," see Michel Foucault, *Discipline and Punish: The Birth of the Prison* trans. Alan Sheridan (New York 1995), Part 4, Ch. 2. Angus McLaren has explored this in the Canadian context in *Our Own Master Race: Eugenics in Canada, 1885-1945* (Toronto 1990).

¹⁶The term "grades of care" was suggested by hospital consultant Charlotte Aikens, in *Hospital Management* (New York 1911), 64.

President C.S. Blackwell noted in 1930 that the moneyed class “*naturally* feel a disinclination to occupy a public ward,” so, he explained, hospital corporations were duty-bound to address this problem.¹⁷ The opening of the Private Patients’ Pavilion in Toronto, with its twelve-dollar-per-day rooms (plus extras), was a clear and public statement of this principle. While disease has been romantically pictured as a great social leveler, in the case of the modernizing hospital, it became yet another occasion for a *restatement* of class hierarchy.

Opening the charity hospital for business required some rhetorical sleight-of-hand, since Progressive-era hospitals were firmly rooted in the notion of *noblesse oblige*. As Rosemary Stevens explains, “clubwomen, clergymen, bankers, and business leaders came together [in the mid-19th century] to establish hospitals as part of their commitment to ideals of Judeo-Christian obligation, to class and group solidarity, and to civic duty, that is, a positive act of charity.”¹⁸ Hospitalization was, with few exceptions, for poor people. But with the possibility of solving their mounting financial shortfalls seemingly laid out before them in the image of the wealthy health consumer, hospital Boards of Governors and their supporters formulated a shift in perspective. Publicly and in their private meetings, they began to frame the maintenance of voluntary hospitals for the provision of health care to *all* classes of patients as humanitarian duties in and of themselves. In Hamilton, the governors of the Mountain Sanatorium organized their annual fundraising campaigns around this principle. “The Sanatorium,” they wrote in a widely-distributed flyer, “is an institution belonging to the citizens of Hamilton, and it is therefore the privilege of every man, woman, and child to contribute to its maintenance and development. It is caring for the victims of infectious disease and in this way is affording protection to every home in the City.”¹⁹ Julius Rosenwald, a well-known New York philanthropist who had in his long career “brought new philosophy to the science of giving,” explained at the 1930 meeting of the American Hospital Association in Toronto that the real function of voluntary hospitals was to help first those who helped themselves. “Self-respecting citizens do not want charity,” he remarked; rather, they preferred to pay to the best of their ability.²⁰ “Scientific” charity, then, would maintain the self respect of recipients by subsidizing the contributions of the “worthy” poor patient, while expecting full payment from the solvent. Logically, those who contributed more, ought to receive more and better

¹⁷Italics mine. “Golden Key Opens Door to Hospital’s New Wing,” *Toronto Evening Telegram*, 25 April 1930.

¹⁸Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York 1989), 27.

¹⁹“How Big is Your Heart?” Promotional Flyer, Hamilton Health Association, 1915, Chedoke-McMaster Health Sciences Archives (Hereafter CMH), Hamilton Health Association Fonds (hereafter HHA) Publications Box 1, Folder 16.

²⁰“Canadian Delegates to AHA Convention Press Claims of Toronto for 1931 Meeting,” *Canadian Hospital* (December 1930), 21.

service. This repositioning reversed the longstanding paternalist commitment to free hospitalization for the sick poor that had been the prime directive of the voluntary hospital. Suffering souls, throwing themselves upon the mercy of the hospital became customers, who purchased the services provided by a community-run and -supported institution. But although the community ostensibly worked as a whole to support its hospital, the best services provided therein were to be sold to the highest bidder.

The drive to cultivate new consumers of enhanced hospital services and the rhetoric of scientific charity was also welded to the orthodoxy of efficiency that inundated public life at this time. As trustees of the voluntarist spirit (and funds) of the community, it behooved hospital boards of governors to produce their public service as economically and systematically as possible. Scientific management and cost accountancy, modeled after techniques used in the world of business, would ensure that not a penny of the benevolent contributions or patient fees — hospital profit — was misspent.²¹ As architectural consultant B. Evan Parry explained, "While hospitalization cannot be commercialized, it is nevertheless a business ... which ought to produce the maximum amount of service per dollar."²² Parry and his contemporaries were quite clear on the idea that efficiency was not to be achieved at the cost of reduced privileges for the paying customer. In effect, the new standard for hospital management was to be "efficiency for the poor, and service for the wealthy."

Managing Class: The Hospital's Administrative Overhaul

Prior to the turn of the century, hospital organization was relatively uncomplicated. Mundane concerns like food provision, cleaning, the management of domestic staff, and nursing training and labour, were all handled by the Matron, or Lady Superintendent, who was typically a senior nurse. This division of labour left matters of finances, plant maintenance, medical services, and community relations to the board of trustees and the chief of the medical staff. One of the Board members was often an accountant, another a lawyer, another a factory owner, and it seems likely that such men had little difficulty in pooling their resources to complete these

²¹ On how scientific management came to the modernizing hospital, see for example Edward T. Morman, ed. *Efficiency, Scientific Management, and Hospital Standardization: An Anthology of Sources* (New York 1989). In Canada see George M. Torrance, "Hospitals as Health Factories," in Davis, Coburn *et al.*, *Health and Canadian Society: Sociological Perspectives* (Toronto 1981), 479-500 and Katherine McPherson, "Science and Technique: Nurses' Work in a Canadian Hospital," in Dianne Dodd and Deborah Graham, eds. *Caring and Curing: Historical Perspectives on Women and Healing In Canada* (Ottawa 1994), 71-101.

²² B. Evan Parry, "Report of the Sub-Committee of the Canadian Hospital Council on General Problems of Construction and Equipment," *Canadian Hospital* (December 1932), 8.

tasks.²³ The fact that the vast majority of patients were among the least valued cohort of society meant that their perceived needs were simple and easily met. In 1907, for example, it was seen as appropriate to house charity patients at the Hamilton Sanatorium in tents and wooden shacks, and for the more able-bodied to work on the hospital's farm to produce much of their own food.²⁴ The entry into hospitals of a type of patients who were thought to require better grades of food, accommodation, nursing care, and medical technology, however, necessitated major changes in institutional shape, organization, and day-to-day functioning. By the mid-1910s the numbers of beds, the variety of services provided in hospitals, and the sheer quantities of money, materials, and personnel expanded rapidly. Between 1902 and 1917 the annual number of patients treated at KGH more than doubled, and the number of employees nearly tripled.²⁵ Total yearly expenditures in this period rose from \$18,000 to over \$75,000, and by 1921 had topped \$150,000. Hospital trustees, as unpaid overseers of the charity project, had neither the time, inclination, nor skill to effectively negotiate the resulting morass of administrative minutiae. As one frustrated hospital official complained, "the sum total of ignorance on the part of members of hospital boards, of hospital methods and practice is something that cannot be lightly regarded."²⁶

Hospital Boards of Governors gradually came to the realization that a new managerial system was required to facilitate the expansion of hospital activities. In Hamilton, this issue was placed at center stage in 1913, after a report by the Inspector of Prisons and Charities revealed that conditions in the City Hospital were far below the standards required for provincial subsidization. Accusations of patient neglect and high-level corruption appeared in local newspapers, and a number of heated debates ensued in the City Council chambers.²⁷ Alderman Willoughby Ellis, after tactfully thanking Medical Superintendent Dr. William Langrill for his dedication in the face of a "tremendous increase" in the work of the hospital, suggested that "it might be advisable to take the business management entirely out of the hands of the Medical Superintendent and place it in the hands of a business manager."²⁸ In making this recommendation he was following the lead of Canadian industry which, as Paul Craven has shown, found it necessary to redevelop its administrative style in the boom years of 1900-1910. Craven notes that "modern

²³The Board at KGH, for instance, had representatives from all three of these occupations at various times, who included their individual expertise as part of their philanthropic contribution.

²⁴CMH HHA Annual Reports Box 1, 1907.

²⁵QUA KGH B103 Board of Governors Annual Reports, 1902-1918.

²⁶"Canadian Delegates," 21.

²⁷Hamilton Public Library Special Collections (Hereafter HPLSC) RG1, Hamilton City Council Minutes, May-June 1913. This report occasioned an editorial skirmish between the *Hamilton Herald* and the *Hamilton Spectator*. See, in the *Herald*, "Spectator Story 'Yellow' as Usual," 24 June 1913.

²⁸"Council Puts Board of Control on Trial," *Hamilton Herald*, 11 June 1913.

management," by which he means a bureaucratic command hierarchy headed by "scientifically" trained professional administrators, "emerged first in those industries characterized by technological innovation and expanding markets."²⁹

Most hospitals did not systematically enact this type of managerial overhaul until just after World War I, by which point their own rapid technological sophistication and market expansion, anchored to unwieldy and chaotic authority structures, had made scandals like the one at HCH in 1913 relatively commonplace. A significant number of the new breed of business managers engaged by desperate hospital boards were officer-class war veterans or engineers with substantial training and experience in the systematic management of people and materials. They were characterized by their relative youth, ambition, and creative problem solving abilities, and by their manifest respectability. One such executive was R.F.A. Armstrong, whose tenure at KGH coincided with the inauguration of a "comprehensive building scheme" that greatly expanded the hospital's capacity to treat private patients. A report commissioned by the KGH Board of Governors in 1924 indicated that the new orientation towards paying customers, already well under way, required a new form of authority at the helm of the hospital, one based on job-specific training and experience rather than medical skill or philanthropic pedigree.³⁰ Dr. Horace Brittain, head of the KGH Administration Committee, argued that a number of large Canadian hospitals were already "efficiently managed by such professional men, who have greatly increased the prestige of the hospitals."³¹ Kingston General, he implied, was in danger of falling behind. This comment by Brittain was the crux of the matter, and it confirmed the centrality of the new professional administrator in the creation of a new image and new client base for the hospital. As long as the hospital remained merely a custodian of the sick poor, managing it could be a part-time philanthropic hobby. But once payment and profit were involved, it was time to turn the task over to administrative experts. Armstrong, who had distinguished himself as an Army engineer in France and as Town Manager of Woodstock, Ontario, met the Committee's requirements perfectly.³²

²⁹Paul Craven, *'An Impartial Umpire.' Industrial Relations and the Canadian State 1900-1911* (Toronto 1980), 94, and Ch. 3 in general.

³⁰KGH had gone without a permanent superintendent for some time before hiring Armstrong, and the years 1913-1924 were characterized by conflicts among nursing managers, doctors, and trustees. See James M. Wishart, "Producing Nurses: Nursing Training in the Age of Rationalization at Kingston General Hospital, 1924-1939," MA Thesis, Queen's University, 1997, 35-36, and Margaret Angus, *Kingston General Hospital, A Social and Institutional History* (Kingston 1973), 107-109.

³¹QUA KGH B104.6, Dr. Horace Brittain, "Report of Administration Committee/Survey," Minutes of the Committee of Management, 29 December 1924.

³²By diverting a river to flood German trenches in France, Armstrong had saved the lives of Allied soldiers and millions of dollars worth of equipment. He also had two university

It is noteworthy that the transfer to an expert leadership often came at the expense of women's authority and occupational status in the hospital. Especially in larger, more prestigious facilities like Toronto and Kingston, Lady Superintendents, once the primary authority in most day-to-day hospital functions, found themselves directly subordinated to salaried male administrators. That women were once able to hold these positions of considerable responsibility spoke to the comparatively low status and perceived simplicity of hospital management prior to the large-scale movement of private patients and medical technology into hospitals. Hospitals as low-budget shelters for the sick poor might be supervised by women; "The Largest Single Hospital, Medical, Education Unit on the Continent" apparently could not. At the same time, smaller hospitals in Brantford, St. Catharines, and Peterborough, among others, employed women superintendents until well into the 1930s and 40s.³³ Some held important positions in administrators' professional associations, and contributed regularly to professional publications.³⁴ By all accounts, they were considered among the most capable of hospital managers. Yet even where women retained a high level of executive power the longest, the scope of their authority was often limited by prevailing expectations regarding appropriate women's activities. Emily McManus, author of *Hospital Administration for Women*, assumed that the Lady Superintendent would oversee the "women's work in a Hospital," namely, nursing, laundry, kitchen, cleaning, and volunteer labour.³⁵ "Men's work," relating to purchasing, funding, management of the medical staff, building projects, and political lobbying, ought to be handled by male accountants and the trustees in consultation with the (primarily male) Medical Committee. Lady Superintendents who transgressed the boundaries of their traditional bailiwick in

degrees and a variety of managerial experience. In his first year as Superintendent, he received a salary of \$5000. QUA KGH B202. R.F.A. Armstrong, "An Exercise in Occupational Therapy," 1952. For a study of the training and nascent professional development of hospital superintendents, see Morris Vogel, "Managing Medicine: Creating a profession of hospital administration in the United States, 1895-1915," in Lindsay Granshaw and Roy Porter, eds. *The Hospital in History* (London 1989), 243-256.

³³See James Clark Fifiield, ed. *American and Canadian Hospitals* (Minneapolis 1933). This was especially true among hospitals like St. Joseph's that were run by religious sisterhoods. Canadian religious hospitals are outside the scope of the present paper, and in most cases still await concerted historical study.

³⁴Of particular note is Muriel McKee, who served as Superintendent of Brantford General Hospital in the 1930s, as well as Vice President of the American Hospital Association. Despite (or perhaps because of) these accomplishments, an editor for *Canadian Hospital* felt it necessary to assure her readers in 1931 that Miss McKee was still a "womanly woman." Mary Burcher, "A Programme for A Successful Hospital Day," *Canadian Hospital* (June 1931), 11.

³⁵Emily McManus, *Hospital Administration for Women* (London 1934), 1. This comprehensive British manual, according to a stamp in the flyleaf of my copy, could be found in the HGH library by 1935.

the hospital often found themselves at odds with their male superiors, or, as in the case of Miss E. Grantham at HCH in 1905, looking for alternate employment.³⁶

Like most other 20th-century industrial magnates, trustees seeking to modernize their hospitals came quickly to endorse the project of scientific management. In defining the tasks of the new hospital management experts, trustees and medical industry commentators acquired the fetishes of efficiency and cost accountancy that captivated so many of their capitalist contemporaries. R.F.A. Armstrong began his tenure as Superintendent at KGH by sponsoring a contest for the nurses, providing a cash prize for the best annual suggestion for "controlling waste." From this benign beginning, he went on to institute a strict accountancy system for hospital consumables, in which items like linen and cleaning supplies were kept in a locked room and signed out by a clerk.³⁷ Moreover, Armstrong and his colleagues took great interest in applying the suggestions made in medical industry journals for increasing production through the Taylorization of hospital activities.³⁸ Nursing tasks in particular were broken down into component parts and systematized, to allow nurses to complete them more quickly and thus administer to greater numbers of patients.³⁹ Increasingly meticulous record-keeping allowed managers to track the productivity of employees, and to effect speed-ups when necessary.⁴⁰

But increasing "production" and reducing operating costs were only two of the new administrative imperatives. Superintendent Armstrong and his colleagues, modern men with modern ideas, were the well-run, *modernized* health care facility incarnate. Symbolically and literally, they assured paying customers that they could safely commit themselves, their loved ones, and their charitable contributions to the hospital institution. The prescriptive literature for superintendents in this period clearly indicates the importance of this particular function. An influential manual of hospital management first printed in 1913 explained:

³⁶Grantham's unwillingness to be a scapegoat in intra-hospital conflicts resulted in her resignation in 1905, under a cloud of controversy. See "Her Version of the Trouble," *Hamilton Spectator*, 1 June 1905. For a detailed case study of another contest between female and male hospital executives, see Linda White, "Who's in charge here? The General Hospital School of Nursing, St. John's Nfld., 1903-30," *Canadian Bulletin of Medical History* 11 (1994), 91-118.

³⁷"News of Hospitals and Staffs," *Canadian Hospital* (June 1925), 26.

³⁸See especially Susan Reverby, *Ordered to Care: The Dilemma in American Nursing, 1850-1945* (Cambridge 1987) for a discussion of scientific labour management that is applicable to both American and Canadian hospitals. In Canada, see Wishart, "Producing Nurses," Ch. 2.

³⁹For example, "A Time Study," *American Journal of Nursing*, (January 1929), 79-83, and QUA KGH RG 504 Box 1 Louise Acton Fonds, "Nursing Techniques and Procedures."

⁴⁰QUA KGH N302.3 KGH Nurse Training School Nurses' Time, Monthly, and Record Books.

The superintendent will recognize as a most serious and important part of his duty is his attitude toward the public [sic]. Upon his careful and discreet conduct in this direction will depend very largely the success of his administration. To a degree which it would be difficult to exaggerate, the hospital is dependent for its success upon the good will and favourable regard of the public, and the superintendent is, in large measure, its representative in this direction.⁴¹

An even more blunt statement of this same concept in a 1931 issue of *Canadian Hospital* illustrated the consistency of the ideal over this period:

Every hospital superintendent should do everything in his power to sell his hospital to the public. This can be done in many ways; by means of proper publicity, seeing that the grounds, buildings, equipment, etc., are kept looking as attractive as possible, and above all by seeing that the patient is properly treated once he gets within the hospital itself.... A satisfied patient is the best advertisement you can have.⁴²

This boosterism was emphatically *not* directed at the indigent patient, whose "satisfaction" concerned the hospital very little. Professional superintendents sought, first and foremost, to attract customers who were financially solvent and could afford to pay well for the new line of products and services produced by the hospital.

Administrators of the re-formed hospital also applied their expertise to the management of bodies: those of personnel, patients, and visitors. As in the Taylorized factory, the general principle that each person in the institution had an assigned place and function structured the organization of personnel. The hospital ran best, according to the views expressed in prescriptive literature and practice, when these places were well-defined and their boundaries policed by a command hierarchy. R.F.A. Armstrong, who in the course of his tenure at KGH became a highly influential figure in the hospital industry, was a great proponent of this administrative model. In a speech to the American Hospital Association, he opined that "Misunderstandings are a great source of trouble. The establishing of definite lines of supervision constitutes the lines of authority along which the orders flow. Lack of definite lines of supervision develops overlapping or gaps in the service that inevitably cause friction. Some one must be made responsible for each task, no matter how small."⁴³ To illustrate his point, he published a flow chart annually outlining the authority structure of the hospital, dividing the management and staff into departments and sub-departments according to their function. But occupational

⁴¹George P. Ludlum, "The Superintendent," in Charlotte Aikens, ed. *Hospital Management* (New York 1911), 83.

⁴²A.J. Swanson, "The Hospital Superintendent — His or Her Job," *Canadian Hospital*, (March 1931), 13-14.

⁴³QUA KGH B202 R.F.A. Armstrong, "The Effects of the Present Economic Conditions on Hospital Operation," Speech to American Hospital Association Meeting, Toronto, 1931.

content alone did not determine these positions and the hierarchy into which they fit. Relations of class, combined with those of gender and ethnicity, clearly separated nurses from orderlies, doctors from maids, and perhaps most importantly, public ward patients from private patients. As chief executive officer of the hospital, the Superintendent oversaw and mediated between these distinctions in order that "misunderstandings" as to place did not occur.

*Marketing Class: "Science, Service, and Success"
at the Fee-for-Service Hospital*

Recent historical treatments of the 20th-century hospital agree with Morris Vogel's contention that many North American hospitals were "regularly admitting middle-class [and affluent] patients by the 1910's."⁴⁴ There is a tendency, however, to portray this migration of patients from bourgeois home to public institution as a relatively seamless transition that unproblematically paralleled the hospital's shift from a purely charitable institution to a business-like provider of scientific medicine for all classes. In fact, despite the increasing proficiency of doctors in treating illness, and the measurable improvements made to hospital facilities, suspicion still coloured public attitudes towards the hospital institution well into the 20th century. Also significant was an undercurrent of critique amongst certain sectors of the public regarding the apparent abandonment of the hospital's charitable mandate. These factors combined to make "selling the hospital" a more complicated task.

Mistrust was sometimes expressed in muckraking newspaper articles that raised questions about the competency of surgeons, the quality of care in hospitals, the tendency of nurses to give wrong medications, and so on. The *Hamilton Herald*, for instance, ran an article in 1914 under the headline, "Some Ghastly Tragedies Concealed Under Garb of Surgery." The article extensively quoted a Dr. L.W. Cockburn, who had claimed in a letter to the editor that many, if not most, doctors were unqualified to perform the increasingly specialized procedures of modern interventionist medicine.⁴⁵ This sobering news came only three months after the Hamilton City Hospital had been investigated (and eventually cleared) on a number of charges of negligence and malpractice first brought forward by the *Hamilton Spectator*. The newspaper had alleged physical abuse of a child patient by an HCH nurse, unsanitary conditions in the nursery, and the accidental death of a man who fell out of bed and broke his neck.⁴⁶ It is obvious that certain journalists engaged in fear mongering to sell papers; nevertheless, the frequency of this sort of article seems to indicate a persistent unease with hospitals and the medical practice within them.

⁴⁴Vogel, "Managing Medicine," 244.

⁴⁵*Hamilton Herald*, 10 January 1914.

⁴⁶"The Hospital Inquiry," *Hamilton Herald*, 20 August 1913; "Inspector Bruce Smith Places Blame Squarely," *Hamilton Spectator*, 25 September 1913; "Much Rejoicing at the City Hospital," *Hamilton Herald*, 3 October 1913.

This persistence may be illustrated by editorial commentary in the *Vancouver Sun* in January 1930 that combined a strong suspicion of hospitals with a paranoia around surgery and vaccination. The article is worth quoting at some length:

More ridiculous than the ancient practice [by doctors] of opening up the heads of their victims... is the modern practice of opening up bodies, cutting out appendices and tonsils and the unnecessary human mutilation that is everyday in hospitals going on in the name of modern surgery... Health, or immunity from disease will never come from surgery, or from injecting into the body filthy pus contained in serums.⁴⁷

The *Sun*'s editors condemned the "commercialization of surgery," and asserted that in "nine out of 10 cases, [surgery] is unnecessary." Popular suspicion arose particularly as medical and nursing practice became increasingly specialized and incomprehensible to the average patient.⁴⁸

A tension also existed between the "open for business" aspect of the modern hospital and the voluntarist legacy with which administrators continued to festoon the institution. A behind-the-scenes incident that occurred early in the "reformation" of KGH offers clear evidence that at least some members of the philanthropic community itself were unimpressed by the subversion of their "Good Samaritan" intentions. In 1918, the hospital Board of Governors received a letter from Nickle, Farrel, and Day, Solicitors, on behalf of the deceased Ellen Nickle. Mrs. Nickle, in 1903, had agreed to fund the construction of a wing of the hospital, with the express condition that "no part of the [Nickle] Wing shall ever be closed to any patient on account of inability to pay, but on the contrary, that it shall at all times be accessible to the sick poor."⁴⁹ Fifteen years later, this accessibility clause was either forgotten by the Board, or else they had decided that it had expired along with its originator. In either case, the hospital made plans to renovate the Nickle building to accommodate private patients. Nickle, Farrel, and Day consequently politely informed the Board that "In order to avoid any unpleasantness ... we expect the contract entered into in 1903 to be observed, and Mrs. Nickle's intentions regarding the original endowment ... duly regarded."⁵⁰ Stymied, the Board of Governors was

⁴⁷"Editorial — Surgery: Ancient and Modern," *Vancouver Sun*, 11 January 1930.

⁴⁸The frequency with which nurses were accused of malpractice or incompetence is, I believe, partially reflective of a societal discomfort around women's possession of medical/technical knowledge, and of the increasing distance between professional nursing practice and popular notions of "the soothing hand on the fevered brow." See Janet Muff, *Socialization, Sexism, and Stereotyping: Women's Issues in Nursing* (London 1982) and Philip Kalisch and Beatrice Kalisch, *The Changing Image of the Nurse* (Menlo Park 1987).

⁴⁹QUA KGH B308.8, Ellen Nickle to KGH Board of Governors, 18 June 1903.

⁵⁰QUA KGH B303.9, Nickle, Farrel, and Day, Solicitors to KGH Board of Governors, 26 December 1918. W.C. Nickle was also a trustee of the hospital, which indicates that not all trustees were enamoured of the new business of hospital care.

forced to reconsider its expansion plans, or else be subjected to a potentially embarrassing lawsuit from one of its own benefactors.

Such conflicts indicate that, although the early 20th-century hospital was increasingly viewed by physicians and governors as the most logical place for all social classes to go for medical treatment, it had not necessarily won over the hearts and minds of potential customers. In this context, the professional administrator's role as public relations agent, and media damage control officer, was critical. Hospital revenue depended upon bringing health consumers and their friends and families into the private wards of the hospital, and sending them home as "satisfied patient[s] ... to become real friends and boosters for the institution."⁵¹ The image of the hospital as technologically sophisticated and medically efficacious, yet homelike and benevolent, needed to be cultivated in the minds of the paying public. Likewise, in order to placate disgruntled benefactors and maintain the flow of financial endowments, the "community service" face of the institution had to be kept clean.

T.H. Pratt, Chairman of the Board of Governors at HCH, offered his opinion in 1924 as to how this ought to be accomplished. "I believe in publicity," he announced to the assembled board members and city aldermen, "I have great faith in the power of printers' ink."⁵² Hamilton's Mountain Sanatorium, a tuberculosis hospital, had a direct tap into this power. Founded in 1906, the "San" was heavily supported by soon-to-be newspaper mogul William J. Southam, then owner of the *Hamilton Spectator*. In the spring of 1907, the *Herald*, a rival paper, ran the headline "Former Inmates Live in Tents," accusing the new institution of callous neglect of its indigent patients.⁵³ Outraged, Southam personally drove several *Spectator* reporters to the new hospital site and toured them through the facility. The next day, a headline in Southam's paper read: "Directors of the San Are Suing the Herald: Former Patients Deny the Statements the Herald Made About Them Yesterday." Throughout the following week, the *Spectator*'s editors defended the intrinsic morality, necessity, and efficiency of elite philanthropic endeavours, which were allegedly under attack by "the enemies of the Sanatorium."⁵⁴ Faced with litigation brought by some of Hamilton's sharpest lawyers (who also happened to be members of the Sanatorium Board), the *Herald* backed down and published an apology.

⁵¹ A.J. Swanson, "The Hospital Superintendent," 11.

⁵² "Charges Made by Ald. Wythe Contradicted," *Hamilton Spectator*, 1 May 1924.

⁵³ *Hamilton Herald*, 29 May 1907. The *Herald* was correct — in its early years the Sanatorium sent charity patients home after three months of treatment, to avoid having the hospital become a shelter for "incurables." The patients mentioned by *Herald* correspondent had arranged with the hospital governors to set up shelters in a backwoods area of the hospital property, and were occasionally visited by the Sanatorium's doctor or nurses.

⁵⁴ *Hamilton Spectator*, 30 May 1907; Editorial, *Hamilton Spectator*, 8 June, 1907. One might wonder at the alacrity with which the tent-dwelling patients supposedly retracted their statements of the previous day.

Incidents like these encouraged hospital executives to take publicity very seriously. Hamilton City Hospital, after World War I, maintained a policy whereby all contact with the press would be handled by the superintendent alone. This was no toothless directive — student nurses at most hospitals could be summarily dismissed for “discussion of hospital affairs outside the hospital,” and some training schools reserved the right to censor nurses’ mail.⁵⁵ It is significant that these policies appeared just as hospitals began to focus systematically upon a new bourgeois clientele. The “right to privacy” was part and parcel of the service being sold to these respectable men and women, who had no wish to have the particulars of their illnesses spread about town. By contrast, indigent patients were commonly subjected to intrusions by welfare investigators, medical students, reporters, and a bevy of municipal and provincial inspectors, and might find their names, pictures, and financial status gracing the pages of hospital annual reports and local newspapers.⁵⁶

The control of information by management meant that through press releases and scheduled public tours of the campus, hospitals could strive to ensure that a flattering image was the only one shown to the public. A full page taken out in the Kingston *Whig-Standard* in 1931 to publicize the opening of the newly expanded Empire Private Patients Wing, boasted that “The new fire-proof section provides accommodation of the very best ... while every advance in medical science has been incorporated.” To prospective out-of-town patients who still felt that their private doctors knew them best, the ad advised that “skilled surgeons, obstetricians, and medical men are here ready to associate themselves with your family physician.”⁵⁷ Comfort, flexibility, and the best of medical technology and expertise were what paying patients were taught to expect for themselves and their loved ones in the modern hospital. In Hamilton, the heavy industry center of the nation, hospital growth was tied, in hospital propaganda, to Progress, Enterprise, and Civic Pride.⁵⁸ In a piece entitled “Hamilton’s Hospitals Among the Best on Continent,” hospital boosters proclaimed that “The humanitarian side of Hamilton’s progress is nowhere more strikingly shown than in her hospitals, which are shining examples of service,

⁵⁵For example, see KGH Training School for Nurses, *Rules and Regulations for Student Nurses*, 1922 (possession of author). This was also recommended by Aikens in *Hospital Management* (see p.195, “Press and Hospital”). Nurses were usually required to sign contracts to the effect that they would not give their opinions on hospital administration or internal affairs to the press.

⁵⁶The annual reports of various hospitals are illustrative of this tendency. For example, pictures of private rooms are invariably uninhabited, while images of public wards show patients either sitting in well-scrubbed rows in their beds, or engaged in various productive and therapeutic activities. See, for example, CMH HHA Annual Reports Box 1, 1915.

⁵⁷“Kingston General Hospital Commemorating the Completion of a Fifteen-Year Building Plan,” *Kingston Whig-Standard*, 1 May 1931.

⁵⁸I use the term “propaganda” because hospital governors themselves used it to describe their strategies for “educating the public.” See “Some Needs at City Hospital,” *Hamilton Herald*, 21 December 1922.

science, and success." Reflecting Chairman Pratt's belief in "proper publicity," the special issue also made reference to the debacle of 1913, assuring those who remembered it that "the hospital governors have worked a great transformation ... and instead of a hospital that was constantly being subjected to criticism of government inspectors.... Hamilton now has one of which every citizen may feel proud."⁵⁹ It was the fond hope of administrators that this civic pride would translate into patronage, and that financially solvent citizens would choose to purchase their health services from HCH.

In boosting the hospital, administrators were prepared to stop at virtually nothing to tug at the heart- and purse-strings of customers and benefactors. Just prior to Christmas, 1929, the *Spectator* proposed that if Jesus had happened to be born in Hamilton, Mary would likely have taken advantage of the hospital's well-appointed maternity ward.⁶⁰ Even the Son of God was apparently not too good to make use of the services of the modern public hospital. Another marketing technique common to hospitals across Canada and the US was Hospital Day, celebrated the first Sunday of every May, on or about Florence Nightingale's birthday. Begun in 1921, this ritual was adopted to educate potential customers, and to solicit philanthropic funds through sentimentally calling attention to the good work being done for the city's sick poor. Hospital administrators were unapologetic about the functionality of the occasion. *Canadian Hospital* editor Mary Burcher, describing an ideal Hospital Day celebrated at Brantford General Hospital in 1931, commented that the whole event was "calculated to make the lay visitor hospital-minded."⁶¹ The scene she described is reminiscent of a county fair, with games and activities for every age of visitor. A week prior to the celebration, special inserts in local papers reminded citizens that the big day was approaching, and donated radio spots were procured to increase the exposure even further.⁶² Children could enter an essay contest about the wonders of the hospital. Politicians, heads of local philanthropic organizations, and other affluent representatives made self-congratulatory speeches on the front steps. The occasion itself was a carnival of consumerism, as local merchants vied to show their allegiance to the hospital in advertisements, giveaways, and special sales that dedicated a percentage of earn-

⁵⁹"Special Industrial Hamilton Number," *Hamilton Spectator*, 13 November 1926.

⁶⁰"Today Birth of Jesus Might be in a Hospital," *Hamilton Spectator*, 14 December 1929. Joseph and Mary were, of course, penniless refugees, and thus would have undergone a relief investigation before Mary was permitted to give birth at Hamilton City Hospital.

⁶¹Mary Burcher, "A Programme for A Successful Hospital Day," *Canadian Hospital* (June 1931), 11. Preparations for the 1931 celebration may have been especially frenzied, since the American Hospital Association had promised to award a prize to the "best Hospital Day" among North American hospitals.

⁶²On 14 May 1928, for instance, KGH commissioned a 10-page "Special Hospital Day Section" in the Kingston *Whig-Standard*, which included a comprehensive (and deeply positivist) history of the institution showing its steady progress over the past 100 years.

ings to the hospital fund.⁶³ But the highlight of the whole project was the organized tour of the hospital. Visitors were taken “behind the scenes” in a choreographed effort to prove that there was nothing to fear and everything to commend about the institution. The logic was straightforward: if it could be demonstrated that no vestige of the Victorian poorhouse remained, and that the general hospital was in fact superior to the middle class home as a place to be sick, the customers would beat a path to the door.

Hospital propaganda was not solely dedicated to generating new business and to bourgeois self-glorification. The notion of the hospital as a bulwark against disease in the community gained currency throughout this period, and served in part to justify calls for philanthropic financial and political support. Disease and the poor were still inextricably linked in the minds of administrators and trustees, especially during periods of heavy immigration. Whereas illness among the wealthy was “tragic,” the sick poor as an aggregate were a “menace to the health of the community.”⁶⁴ Foucault’s description of the Revolutionary hospital in France seems remarkably transferable to this context: “A structure had to be found, for the preservation of the hospitals and the privileges of medicine, that was compatible with the principles of liberalism and the need for social protection — the latter understood somewhat ambiguously as the protection of the poor by the rich and the protection of the rich from the poor.”⁶⁵

The promise of medical philanthropy as prophylactic for Canada’s wealthy was frequently made in the context of hospital-sponsored anti-tuberculosis campaigns. Dr. J.H. Holbrook, medical superintendent at the Hamilton Sanatorium, speaking in 1912 to a gala gathering of Hamilton’s “beauty and chivalry,” begged his audience to “safeguard the lives of *our* children” by supporting the institutionalisation of the tubercular poor.⁶⁶ “The poor,” he explained, “if left to themselves, will grow steadily worse.” Warming to his subject, he thundered, “We must recognize that tuberculosis ... is a manifestation of SOCIAL DISORDER, ECONOMIC DISTRESS, AND SOCIOLOGICAL BLUNDERING, as well as DEBILITATED AND DE-

⁶³Purchases of consumables and construction of buildings by hospitals generated an entire economy of specialized suppliers and contractors. While I have seen little direct indication of graft, it is clear that affiliation with the hospital could bring tangible benefits for merchants and service providers. In 1938, for instance, Hamilton millionaire Charles Seward Wilcox donated \$250,000 to the Hamilton Sanatorium to build a new infirmary in his name. Wilcox’s Deed of Trust insisted that W.H. Cooper, a long-time member of the hospital Board of Governors, friend of Wilcox, and construction magnate, be given the building contract, thus circumventing the usual practice of competitive bidding. CMH HHA Construction Box 1, Folder 9, “Details and Invoices of Construction.” I will consider these issues more thoroughly in my PhD thesis.

⁶⁴CMH HHA Annual Reports Box 1, 1915.

⁶⁵Michel Foucault, *Birth of the Clinic: An Archaeology of Medical Perception*, trans. A.M. Sheridan Smith (New York 1975), 82.

⁶⁶Italics mine.

PRAVED INHERITANCE, INADEQUATE NURTURE and HYGIENIC LAWLESSNESS.”⁶⁷ Rather than an unspecific notion of altruism or social justice, then, wealthy supporters of the community hospitals (and of local public health services more generally) could expect a tangible return on their investment, in the form of social order and hygienic discipline among the diseased classes. The results of such investments were calculated numerically and presented annually on spreadsheets comparing death rates, quantities of institutionalised indigents, and the total number of individual applications of the medical gaze to the diseased bodies of the disenfranchised. Reading these reports, hospital-minded philanthropists could rest assured that potent medical institutions, shaped according to their class interests, surveilled “every home in the City.”⁶⁸

Building Class: Private and Public in the Voluntary Hospital

Bourgeois patients who elected to patronize the re-formed hospital as a result of the massive hype could hardly have been disappointed. The affluent health service consumers who passed through the doors of the increasing numbers of private patient wings and buildings could not help but feel welcome and comfortable. A stiff competition existed between Canadian hospitals in the inter-war period that continually raised the bar on private room standards and fee-for-service facilities. Monthly issues of *Canadian Hospital*, a professional journal for administrators, contained one article after another relating the latest technique for “creating a home-like atmosphere.” In the process of transforming large sections of the hospital into sickrooms for the bourgeoisie, hospital builders strengthened class boundaries and exhibited disdain or even disregard for the impoverished patient.

The most obvious indicator of class distinctions was the segregation of patients in sections of the institution designed around their social standing. Hospital architectural ideals changed significantly in the years between 1900 and 1940, shifting from an emphasis on long, open wards for 24 or more patients, to a penchant for multi-story buildings honeycombed with semi-private (2-4 patients) and private units. The new spatial organization was accompanied by differing levels of service offered to patients. The suggestions in hospital literature as to how this ought to be executed provide a clear picture of the ideological imperatives that shaped this project. In 1911, before any but the largest urban charity institutions had inaugurated their ambitious service-for-profit schemes, Superintendent John Elliot Brown of TGH sent a survey to hundreds of North American administrators soliciting their opinions on the “ideal hospital.” With reference to the problem of multiple grades of service, Brown concluded, simply, that “When all classes of patients must be accommodated under the same roof, it is better to have all private ward patients ministered to on a separate floor from the public ward patients.” Even more

⁶⁷CMH HHA Annual Reports, Box 1, 1912, pp.20. Upper-case emphasis is Holbrook’s.

⁶⁸CMH HHA Annual Reports, Box 1, 1912.

preferable in his view were the facilities at the St. Luke's Hospitals in New York and Chicago, where "separate pavilions" were provided for each classification of patient. But according to Brown, "the question has been best solved ... in Muskoka and in Weston, ... [at which] one building is used for free patients only, ... and the other is remote only half a mile and takes paying patients." The need for this segregation was taken for granted by Brown, and had the distinct advantage of being economically viable: "The profits from the latter institutions are applied to the maintenance of the former."⁶⁹

One tenet of the policy of segregation by class was that paying patients should not have to encounter their impoverished co-residents in the institution. At times this was expressed the other way round — it was unjust that the poor should have to see the sumptuous meals, the tastefully decorated sitting rooms, and the special privileges and medical attention given to wealthier hospital inmates. HCH Superintendent W.G. Langrill, making a plea to City Council for funds to expand the accommodations for paying patients, implied that the existing private and public sectors of the hospital were too close together. Referring to the china-plate food service afforded paying patients, he worried: "These meals are far superior to those served to the public patients, and it must be very humiliating to see the superior food going past them into the semi-private wards."⁷⁰ The solution was not, to be sure, to even out the quality of food served to all patients — it was, after all, the hospital's duty to "make every effort to satisfy the individual tastes of the well-to-do."⁷¹ Instead, patients in different income brackets should be separated sufficiently so that no humiliation would be experienced by the poor, nor twinge of conscience by the rich.

The quality of care and living conditions in the public wards could vary dramatically from one institution to the next, and over time at the same hospital. At KGH, thrice-yearly visits were scheduled by a rotating committee of hospital trustees, elite men and women who had donated time and money to the institution. "Visitors" were charged with assessing the general condition of the hospital, and reporting back to the other governors, whose day-to-day responsibilities often kept them from making regular appearances at the facility they sponsored. We can get

⁶⁹ John Elliot Brown and Edward W. Stevens, "A General Hospital for One Hundred Patients," in *Transactions of the American Hospital Association*, 1911. Brown was Secretary of the AHA, and Stevens was an architect who was making his name and fortune as a "specialist" in hospital design. Their "model hospital" design was reprinted in virtually every hospital management journal, and was still influential in the 1930s.

⁷⁰ *Hamilton Times*, 10 June 1913, in Cortiula, "Houses of the Healers," 47.

⁷¹ This obligation of the hospital was spelled out in an editorial article in *Canadian Hospital* in December 1930. The subject of the article was the creation of the position of a "Director of Special Trays" at a California facility. The woman filling this job was responsible for catering to the individual culinary wants of patients who were paying from \$8-20 per day for hospital care.

an idea of the tenor of these visitations from a report given by the KGH Visiting Governors in 1926: "We visited the Public Wards and after questioning some of the patients we are satisfied that they are receiving good care and treatment."⁷² Judging by their comments, the visitors were most concerned to see that the wards, patients, and staff were clean, and that staff appeared to be working efficiently. The benevolent "satisfaction" of these men and women was not altogether difficult to inspire. The patients in the public wards were, after all, receiving health care at no cost to themselves, and would likely have received none without the efforts of the philanthropic elite. Moreover, marginalized indigent patients were probably disinclined to raise any objections to these well-dressed dignitaries, for fear of being denied access to further treatment.

A somewhat different picture emerges from the above-mentioned 1913 Report of the Inspector of Prisons and Charities. Dr. Bruce Smith, after touring Hamilton City Hospital from top to bottom, commented to an inquiry board that "The conditions of some of the public wards as I saw them today brings them almost up to the shade of being criminal." He found that these wards were overcrowded and poorly ventilated: "I was met with air so foul as to be disgusting, and only the good constitutions of the inhabitants will enable them to withstand it." Recommending that the provincial stipend to the hospital be withdrawn until conditions were remedied, he noted that only a new hospital with greatly expanded accommodation for those who were sick and impoverished would entirely solve the problem.⁷³

In a move that reflected the general trend of hospital-building in this era, the Hamilton City Council did indeed approve a new hospital, though apparently not what the Inspector had in mind. In 1917 the Mountain Hospital for private patients opened amid much fanfare. A mile distant from the immigrant neighbourhood in which HCH stood, the Mountain Hospital was physically and symbolically inaccessible to the city's poor; it perched at the brow of the Niagara Escarpment overlooking the city. The furnishings and décor of this new facility reflected the class status of its prospective customers and, following the latest advice in hospital design literature, sought to "avoid the institutional aspect and provide a home-like atmosphere."⁷⁴ Press releases described the custom-built furniture accented with "gay chintz," the state-of-the-art electric lighting, and the high-quality beds. Visitors were encouraged, and could, for a fee, stay overnight in empty rooms to more conveniently support their ailing friends or relatives. Although the lack of a decent road up the Escarpment kept the building only partially full for several years, by 1926 another 100-bed wing had been added to keep up with demand. Of the newly completed structure, the *Herald's* correspondent raved, "the modern hospital room

⁷²QUA KGH B105. "Report of the Visiting Governors of Kingston General Hospital," 23 November 1926.

⁷³HPLSC R362.9713 ONT, Ontario Inspector of Prisons and Charities, Annual Reports, 1913.

⁷⁴"New Mountain Hospital for Private Patients Opened," *Hamilton Herald*, 21 March 1917.

is just as comfortable and pleasant as the bedroom of the finest home, certainly a decided contrast to the cold white finish formerly thought necessary for a hospital."⁷⁵ The "institutional aspect" was reserved for the main campus of HCH, where cosmetic renovations, fresh white paint and expansion into the abandoned private sectors eventually brought the public wards up to par.

Like the well-appointed bourgeois home, profit-oriented hospitals retained staffs of domestic servants, commonly called "the help" to distinguish them from medical professionals. The influx of high-maintenance patient-customers caused a rapid expansion in the number of unskilled hospital labourers. In 1928, KGH mustered 140 "help" for 306 total beds, a nearly 10-fold increase in servants over only 10 years, during which time the patient population had only doubled.⁷⁶ Leon Fink, in one of the very few historical accounts of this workforce, refers to them as "involuntary philanthropists," an appropriate term given that these men and women remained largely without union representation or minimum wage protection until well after World War II.⁷⁷ Unlike the student nurses, who were selected, trained, and disciplined to act as "proper" women, auxiliary workers were socially situated below even the public ward patients, and were frequently drawn from the ranks of recent immigrants. In order to facilitate discipline, the hospital required them to live on campus. "Servant quarters" were typically located either in the basements and attics of larger hospital buildings, or in residence-style structures located well to the rear of the hospital property.⁷⁸ The condition of these accommodations, as with those for public ward patients, reflected the relative value placed on auxiliary workers as human beings. KGH Visiting Governors in 1927 were appalled to find nursing students housed in tiny, unventilated, attic and basement rooms "not even suitable for the ward servants."⁷⁹ Within a year, a new Nurses' Residence was completed, whereupon the help were transferred to the "unsuitable" quarters vacated by the student nurses. The attitudes that gave rise to poor living conditions for unskilled workers were common among hospital consultants, executives, and sponsors. A few years earlier, describing the plan for a "proposed help's building," renowned hospital architect Edward Stevens advised that "it is sometimes possible to give the maximum amount of convenience at the lowest cost by making this

⁷⁵ *Hamilton Herald*, 8 December 1926.

⁷⁶ QUA KGH B103 Board of Governors Annual Reports, 1928, 34.

⁷⁷ Leon Fink and Brian Greenberg, *Upheaval in the Quiet Zone: A History of the Hospital Workers' Union, Local 1199* (Chicago 1989), 16. For similar analysis with reference to asylum attendants, see James Moran, "The Keepers of the Insane: The Role of Attendants at the Toronto Provincial Asylum, 1875-1905," *Social History/Histoire Sociale*, 55 (May 1995), 51-76.

⁷⁸ Edward Stevens, in his treatise on hospital architecture, includes several hospital plans which followed this latter arrangement. E. Stevens, *American Hospital*.

⁷⁹ QUA KGH B105 Reports of the Visiting Governors, 1927.

section of the institution non-fireproof.”⁸⁰ No reasons were given for these comments — bourgeois class ideology obviated the need for explanation.

The moral and logistical problems posed by the presence of a large number of lower-class and immigrant men and women (both patients and workers) may be illustrated by a series of complaints from the KGH Visiting Governors. After several oblique references were made in the annual reports for 1925 and 1926, they tersely noted in their 1927 summary that “There is a condition, which has been brought to your attention before, in regards to the close proximity of the dining room for the help ... we feel that it would be desirable to have the help provided for in some section not so close to the nurses’ dining room.”⁸¹ With this structural change, nurses, the hospital’s “daughters,” would presumably be better protected from corruption by low-bred employees. Other architectural considerations reduced the degree to which paying patients would see or hear hospital servants. New hospitals were built with sound-proofed service elevators, back stairways, basements, and tunnels linking the main buildings, in which the unskilled labour of the auxiliary staff could be carried on out of sight and hearing of the paying patients. Like domestic servants in private homes, these men and women were required to wear uniforms identifying them as subordinates and classifying them according to their function.⁸² They were expected, on threat of dismissal, to show absolute deference to their social betters, especially paying patients. Given the existence of these attitudes and regulations regarding the “help,” the boast by HCH in 1925 that their auxiliary employees “live[d] to serve” was less an indication of the voluntary spirit of these workers than a classification of their lifelong function.⁸³

To facilitate discipline of the movements and behaviours of all patients and staff, regulations were drawn up and posted liberally about the hospital. George Ludlum, Superintendent of the New York Hospital, prescribed distinctly different directives for “ward” (public) versus private patients. In a widely-reprinted article written in 1913, he felt it necessary to bar indigent patients from smoking, “using profane or obscene language,” “engaging in an immoral act,” or accepting food and drink from visitors. Private patients had no such explicit prohibitions. In Ludlum’s opinion, visiting hours for ward inmates should be strictly curtailed, while paying patients ought to be permitted to entertain friends and family from 9 to 9 “without

⁸⁰E. Stevens, *American Hospital*, 184.

⁸¹QUA KGH B105, Reports of the Visiting Governors, 1926-27.

⁸²An exhibit at the 1930 Ontario Hospital Association displayed “uniforms for every member of the hospital staff,” reflecting the need to visually signify an individual’s place in the hospital hierarchy. *Canadian Hospital* (November 1930), 31.

⁸³At the Hamilton Sanatorium, as at most hospitals, administrators fought a constant battle to “get and keep good help” due to the extremely poor wages and inhuman work conditions offered by the hospital. They were able, however, to draw on a very large pool of immigrant labour throughout this period. CMH HHA Administration Boxes 1 through 9, Minutes of the Finance Committee, 1911-1939. See also Moran, “Keepers of the Insane.”

restriction other than that imposed by the patient's condition."⁸⁴ So that the recipients of charity health care might "earn their keep," and also to prevent them from sinking into moral and physical lethargy, Ludlum directed that "Convalescent patients shall render such help in the general work of the wards as their condition will warrant, in response to the demands of the nurses." At the Hamilton Sanatorium, "free" patients were expected to work on the hospital's farm, as babysitters for child patients, or in various other tasks as their medical status permitted. This practice was a source of great pride among the hospital's directors, who reported annually on the increasing sophistication and profitability of patient-labour initiatives.⁸⁵

Some policies for the control of public patients recalled the carceral function of the old poorhouse/hospital, and exemplified the inherently disciplinary spirit of 20th-century "scientific philanthropy." A version of "The Rules" drafted in 1922 at KGH mandated that ward patients could not leave the institution without the permission of the superintendent, a regulation which, if broken, could result in the dismissal of the student nurse on duty.⁸⁶ At Hamilton Sanatorium, where the unsupervised tubercular poor represented "social disorder" according to Superintendent Holbrook, "free" patients who failed to fill out "Form 7" before exiting the hospital were designated as "AWOL." Each incident of illegal absence was recorded on their permanent record, and was reported to a surveillance network consisting of the Municipal Health Officer, the Relief Department, and the provincial Division of Tuberculosis Prevention.⁸⁷ Form 7, itself a technology of surveillance, demanded the patient's reason for leaving, and required the resident doctor to determine whether the stated excuse was "reasonable or unreasonable," or whether the patient "should be forced to enter a Sanatorium."⁸⁸ Such coercive powers wielded by voluntarist hospital administrations, often in cooperation with provincial and municipal authorities, are important evidence of what Mariana Valverde has described as the "full and active cooperation" between state and bourgeois voluntary organizations in creating and maintaining a social order.⁸⁹ Significantly, in the case of the Hamilton Sanatorium, medical policing of the indigent ill was not an initiative of an elected government, but emerged from the ambitious efforts of Superintendent Holbrook and other interested citizens.⁹⁰

⁸⁴George Ludlum, "The Superintendent," in Aikens, *Hospital Management*, 95.

⁸⁵CMH HHA, Box 1 Annual Reports, 1907-1933.

⁸⁶KGH Training School for Nurses, Rules and Regulations, 1922 (possession of author).

⁸⁷CMH HHA Patient Records, Boxes 1-5, *passim*.

⁸⁸"Notice of Patient Leaving Sanatorium Without Approval of Superintendent," CMH HHA Miscellaneous, Box 1, Folder 3.

⁸⁹Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925* (Toronto 1993), 25.

⁹⁰The details of Hamilton's anti-TB campaigns are beyond the scope of this paper, but serve to illustrate the hospital's efforts to expand its power and influence beyond its walls. My larger project on Ontario hospitals will consider more closely what Foucault in 1963 called

In view of the obvious structural disparities between public and private facilities, and the class prejudice that informed internal hospital organization, it would be logical to assume that hospitals failed to live up to their moralistic claims that class status or ability to pay had no bearing on the quality of medical treatment. Some historians who have examined the hospital in this era have assumed that wide gaps in quality of care existed, based on negative reports by external observers. Cortiula, for example, cites only the 1913 Inspector's Report in concluding that "the poor of Hamilton languished in the unsanitary public wards" throughout this period.⁹¹ Such blatantly unsanitary conditions, however, were not the rule for all voluntary hospitals, nor did they exist at all times at HCH. In 1922 the Board of Governors could at least say that the provincial Inspector had given a passing grade to the accommodations for indigents, which had achieved a minimum standard of cleanliness and organization.⁹² Similarly, comments from a former nursing student at KGH make clear that the nursing matron there had exceedingly high expectations for aseptic practice in all regions of the hospital, and that lapses were severely punished.⁹³

More importantly, medical workers did not necessarily internalize the hospital mandate of efficiency for the poor and comfort for the affluent. Nurses in particular often acted as a sort of feminine buffer between the charity patient and the disciplinary, bottom-line mentality of hospital economics. Indeed, hospitals subsidized and humanized their health care delivery by requiring a mostly-unpaid, mostly female, labour force to shoulder the burden of chronic underfunding and understaffing of charity wards. The manifest injustice of differential treatment required many nurses and some doctors to sacrifice their own health and well-being for that of their indigent patients. Jean, a former student nurse at KGH, explained in an interview that inexperienced, unpaid, understaffed students had to make choices between spending more time with particular sufferers, and ministering to all of their assigned patients. She related an incident in which she had been assigned night watch over a ward of 26 patients. Of these, six had typhoid and were quarantined in isolation rooms, requiring a complete change of uniform and five-minute disinfection with every visit by the attending nurse. She relates:

"a generalized presence of doctors whose intersecting gazes form a network and exercise at every point in space, and at every point in time, a constant, mobile, differentiated supervision." Michel Foucault, *Birth of the Clinic: An Archaeology of Medical Perception*, trans. A.M. Sheridan Smith, (New York 1975), 31.

⁹¹Mark Cortiula, "Social Class," 143.

⁹²HPLSC R362.9713 ONT Ontario Inspector of Prisons and Charities, Annual Reports, 1922.

⁹³'Jean,' R.N. (pseud.) Interview by author, 15 November 1996, Kingston, Ontario. Tape Recording in possession of author. See also McPherson, "Science and Technique."

While I was in the Isolation, there was a lady in the women's wing who started hemorrhaging. And I couldn't get to her. We lost her. That is a memory that will never leave me. You could only be in one place at a time. And another man, with a broken back, had fallen out of bed onto the floor ... and there he was — I couldn't do anything until I finished scrubbing. You had to go through and struggle with it. It was inhumane, really, for us and the patients.⁹⁴

Doctors could also work to reduce the imbalance between paid and charity health care. David Naylor estimates that urban general practitioners in the inter-war years provided as much as 25 per cent of their services without hope of remuneration, a proportion that increased substantially during the Depression.⁹⁵ Some physicians faced disciplinary action by hospital administrators for their compassionate tendency to admit too many non-pay patients, or for their contravention of hospital policy in using pay-patient facilities to treat the indigent ill. In Hamilton in 1921, for instance, a physician found himself defending himself in front of City Council for having assigned a semi-private room to an impoverished child in hopes that the child would recover more quickly.⁹⁶ Hospital governors were often unsympathetic to these efforts, and took steps to reduce the admission of patients whose support could not be guaranteed in advance by a municipal relief officer. In 1919, the Hamilton Sanatorium business manager moved that "all applicants for admission to the Sanatorium who are not admitted through the regular channels must have their case passed by the Chairman of the Board and the Chairman of the Finance Committee, and that proper forms for admission be drawn up in order that payment of maintenance be guaranteed."⁹⁷ Henceforth, doctors who wished to admit indigent patients without submitting them to a relief investigation were required to personally guarantee payment to the hospital.

Despite the efforts of concerned health professionals, however, there is substantial evidence that paying patients received significantly more attention than that of indigents. One piece of evidence is the nature of the accommodations themselves. By the first decade of the 20th century, the germ theory of Pasteur and Koch had achieved predominance in medical practice. It was generally accepted that long, open wards with 24 patients — previously the standard unit for public accommodation — were conducive to the spread of disease, due to excessive human traffic and unimpeded airborne cross-infection.⁹⁸ Frequent changes of air, considered paramount in the convalescence of the sick, were considerably more difficult to achieve in large, high-ceilinged spaces.⁹⁹ One theory in the US insisted that wards

⁹⁴"Jean," interview.

⁹⁵Naylor, *Private Practice*, 64.

⁹⁶"Defends Hospital: T.H. Pratt Makes Reply to Medical Health Officer," *Hamilton Spectator*, 7 February 1921.

⁹⁷CMH, HHA, Minutes Box 1, Board of Directors Monthly Meetings Minute Book, 20 February 1919.

⁹⁸Taylor, *Architecture*, 63.

⁹⁹E. Stevens, *American Hospital*, 198-200.

should not exceed 6 beds in size, and most superintendents and doctors agreed that this was the most healthful arrangement. Notwithstanding this consensus, Superintendent John Brown of TGH, in designing his model hospital, took the position that "in view of the present-day economies demanded, ... a [public] ward of twenty patients is best."¹⁰⁰ Most other Canadian administrators agreed, and the "free" wards in Toronto, Vancouver, Ottawa, Hamilton, and Kingston maintained occupancies of 16 to 24 beds at least until the 1950s. Florence Nightingale, in her 19th-century efforts to design a more health-inducing hospital, recommended that each patient in a public ward have a minimum of 1500 cubic feet of air space, usually achieved by a floor space of 10 by 15, and a ceiling height of at least 10 feet.¹⁰¹ At the Hamilton Sanatorium during periods of peak occupancy, the standard for "free patients" was 700-1000 cubic feet, and "two to a bed" was not an uncommon situation until the late 1920s, especially on the children's ward.¹⁰²

By contrast, patients in the new wards at HCH could expect to be housed in private and semi-private rooms in which the latest in ventilation equipment flushed out and replenished the air the recommended 40 times per hour. Private or semi-private rooms (2 or 4 patients) were assigned with an eye to preventing cross-infection, and contagious patients were segregated in single rooms for "special cases."¹⁰³ While Isolation wards also existed outside the main hospital building for public ward patients, the generally overcrowded conditions and overworked nursing staff meant that contagion sometimes went unidentified, resulting in epidemics. Consequently, if we consider room arrangements as they were seen by hospital architects, as a technology of medical practice, then it is clear that public ward patients failed to benefit from the "latest in equipment" that was so much a part of hospital self-promotion.

More directly, most private patients exercised their option to have their personal physicians attend them at the hospital. Ward patients were required to accept whatever doctor was providing services *pro bono* that day. At KGH, unpaid student interns on rotation, who according to surreptitious remarks by the student nurses were likely to pay closest attention to the "interesting" cases, provided the bulk of the public ward medical service.¹⁰⁴ The quality and expertise of nursing treatment was also determined by the hospital class hierarchy. Former nurses are

¹⁰⁰Brown, "General Hospital," 118.

¹⁰¹Taylor, *Architecture*, 69.

¹⁰²"Inspector Bruce Smith Places Blame Squarely — City Hospital Not in Any Way Suitable to Requirements," *Hamilton Herald*, 23 September, 1913. See also Cortiula, "Houses of the Healers," 42.

¹⁰³"New Mountain Hospital for Private Patients Opened," *Hamilton Herald*, 21 March 1917.

¹⁰⁴QUA KGH R500, Nurses "Comment." This remarkable document is a journal kept clandestinely by succeeding classes of nursing students at KGH. The fact that the journal was kept hidden encouraged students to write frankly and anonymously about hospital authority figures, their work, their social lives, etc.

adamant that they "treated all the patients the same, no matter if they were poor, or rich, or red or green."¹⁰⁵ But their ability to provide effective care was severely limited by the fact that public wards were chronically understaffed. "Claire," for example, a student nurse at TGH in the 1930s, was regularly assigned to single-handedly supervise a 24-patient public ward overnight. Private patients had the alternative of hiring "specials" — private duty nurses — or could share a hospital nurse's services with 4 to 6 other patients. While most nursing labour was performed by students with various levels of training, the affluent customers in the Private Patients Pavilion at TGH were attended by graduate nurses only, and were provided with bedside telephones and buzzers to communicate their needs.¹⁰⁶

It seems likely, then, that paying customers could expect a higher minimum standard of medical and nursing care than lower-class hospital inmates. If they had money to spend, the gap could increase even further. As hospitals continued to seek new forms of income, fee-for-service schemes appeared around particular technologies. The X-ray and radiotherapy were particular favourites in this line. In 1925, the Board of Governors at KGH arranged a system of profit- and expense-sharing with radiologist Dr. William Jones, who, like most radiotherapy practitioners at this time, possessed his own minute supply of astronomically expensive radium.¹⁰⁷ The agreement netted Jones \$7300 in fees in the first year, a higher salary than even that of the hospital superintendent. The hospital took in a similar amount after expenses, and its X-Ray Department figured prominently in publicity campaigns.¹⁰⁸ It has been impossible to ascertain the degree to which "free" patients could avail themselves of the then-miraculous treatments performed in this department. Yet it seems reasonable to conclude that the owner of the machine would seek to keep this practice to a minimum in order to maximize his profit margin.¹⁰⁹

¹⁰⁵'Claire,' R.N. [pseud.] Interview by author, 18 December 1995, Peterborough, Ontario. Transcript in possession of author.

¹⁰⁶"Many Unique Features Incorporated in the New Pavilion," *Canadian Hospital* (May 1930), 30. The practice of using student nurses as labour persisted until the 1950s in Canada. Students were often assigned to provide direct care for patients after completing only three months of a two- or three-year training program. "Specials" were graduates of the hospital training school who worked as private nurses, usually in patients' homes during convalescence. As hospitals became the preferred site for health care, "specials" came to form a reserve nursing labour force which could be called to attend to patients by request, thus saving the hospital the trouble of hiring them full-time. Through the 1920s and 30s, the typical rate for a private nurse was \$4-6 per day. See Wishart, "Producing Nurses," *passim*.

¹⁰⁷The Ontario government created a provincial radiotherapy program beginning in 1931 which sought to eliminate this unregulated use of radium. My thanks to Dr. Charles Hayter for this information. See Charles R.R. Hayter, "The Clinic as Laboratory: The Case of Radiation Therapy, 1896-1920," *Bulletin of the History of Medicine*, 72 (1998), 673.

¹⁰⁸QUA KGH B104 Reports of Special Committees, "Memoranda of Agreement: Kingston General Hospital and William A. Jones, M.D."

¹⁰⁹Charles Hayter has found, in the case of Halifax, that even "publicly-owned" radium was infrequently used to treat indigent cases; only 10 per cent of treatments in 1926-36 were

In a further qualification of the foregoing analysis, it must be recognized that the re-formation of the voluntary hospital did result in distinct improvements in the treatment of indigent patients. Despite the strenuous attempts to maintain physical separation of class groups, hospital overseers could not blatantly ignore their charitable mandate, nor did they wish to. Most, if not all, of the members of trustee organizations appear to have had a genuine interest in helping the poor, and in ameliorating the problems created by rampant urban growth and industrialization. As hospitals raised their standards to meet the influx of middle-class patients, the quality of care for indigents tended to follow. Likewise, the introduction of new medical techniques and technologies eventually benefited the sick poor, if not always directly, then through a "trickle-down" effect. In any comparison with the carceral 19th-century charity hospital, the public wards in 20th-century hospitals come out favourably. Then, as today, however, in the frequent periods of fiscal restraint the poor bore the brunt of hospital economizing, and were the first to face restricted access to health services.

Regulating Class: "Protecting the City Against Imposters"

As part of the provision of "scientific charity," and as a necessary accompaniment to the cultivation of a larger paying clientele, hospital administrations sought new ways to exclude free patients from their wards, or to find more efficient means of extracting payment. Officially, public hospitals could not turn away anyone who needed health care, regardless of their ability to pay. This "right to treatment" was made law by provincial governments and by individual municipalities, both of which contributed to the upkeep of the sick poor. But state funding seldom covered the full cost of indigent care, a fact that was a great source of bitterness among hospital bureaucrats.¹¹⁰ The following exchange was recorded at a Hamilton City Council Meeting in 1916:

Alderman: Can't you refuse to admit these [free] patients?

Sup't. Langrill: We daren't. The government makes it necessary that we take in a man if he is sick... If we don't do it, we lose the grant. I have been keeping out as many as I can, though.¹¹¹

free. See Hayter, "'To the Relief of Malignant Diseases of the Poor': The Acquisition of Radium for Halifax, 1916-1926," *Journal of the Royal Nova Scotia Historical Society*, 1 (1998), 139-140.

¹¹⁰In 1928, these rates were set by the Royal Commission on Public Welfare in Ontario. The provincial government was assigned to contribute \$0.60 per day for indigents, with the home municipality of the patient chipping in another \$1.75 per day. Even with the "utmost economy" being practiced, R.F.A. Armstrong calculated that public ward patient service cost \$2.60 per patient day at KGH, for a "net loss" of \$0.30 per patient day. QUA KGH B103 Annual Reports, 1928, 31-33.

¹¹¹*Hamilton Times*, 18 March 1916.

The reporter did not indicate whether anyone present was taken aback by the Medical Superintendent and an alderman, pillars of their community, discussing the possibility of breaking the law to avoid having to provide charity care for needy patients.

Hospital executives went to great lengths to demonstrate just how much it cost the institution to treat non-pay patients in the hospital, a practice that often included accusations of fraud on the part of the poor. R.F.A. Armstrong, a great believer in dollar figures, included in every annual report a precise calculation of the "Extent of Free Service Given." In 1931, as the Depression deepened, he reported that \$25,945.58 worth of "free public ward service" had been provided by the hospital, outside and above the costs covered by the municipality and the province.¹¹² This represented a 5.8 per cent increase on the previous year, exacerbated by a 14 per cent drop in revenues from paying patients. The trend continued until well after economic conditions began to improve. KGH Governors watched their annual "free" patient attendance rise from 50 per cent of all admissions in 1930 to nearly 64 per cent in 1934, compelling Superintendent Armstrong to comment that, "More and more there seems to be an expectation on the part of patients in the Public section that the service should be extended to them absolutely free.... There are many of these patients who should at least pay something."¹¹³ In making these claims, Armstrong and his colleagues were in lock step with trends in Canadian social welfare. Speaking to a group of "public-spirited citizens" in Hamilton a decade earlier, J.A. Dale, Head of the Department of Social Service at the University of Toronto, proclaimed that undisciplined charity had created "a mendicant class ... who would live without work."¹¹⁴ This class of persons was physically degraded due in part to its members' moral turpitude and poor work ethic, and needed to be disciplined lest it corrupt the hard-working "worthy" poor whose moral standing was already weakened by their neediness. Refusal of health services and/or extraction of payment would teach the "unworthy" lessons that might set them back on the right track.

A development that aimed at reducing public ward attendance while living up to the letter of medical relief law was the "Outdoor Patient Department."¹¹⁵ Outdoor

¹¹²QUA KGH B103 Annual Reports, 1931

¹¹³QUA KGH B103 Annual Reports, 1934.

¹¹⁴"Central Bureau of Social Agencies Doing Noble Work; Needy People who are Worthy are Always Helped and Unworthy Refused," *Hamilton Spectator*, 1 April 1924. More generally, see James Struthers, *No Fault of Their Own: Unemployment and the Canadian Welfare State, 1914-1941* (Toronto 1983).

¹¹⁵For a very good collection of primary documents outlining the movement to create Outdoor Departments or Dispensaries, see Charles E. Rosenberg, ed., *Catering for the Working Man: The Rise and Fall of the Dispensary - An Anthology of Sources* (New York 1989). See also George Rosen, "The First Neighbourhood Health Movement — Its Rise and Fall," *American Journal of Public Health*, 61 (1971), 1620-7.

patients were primarily poor, with acute ailments that could be treated quickly and the sufferer sent home. An article in the *Hamilton Spectator* advertised the manifest benefits of this department in 1922:

The outdoor department of the hospital is where people who cannot afford to pay for medical treatment ... receive free advice and treatment by the best medical men and specialists in the city, all of whom give their services gratis. As a result not only are the misery and sufferings of these people reduced to a minimum, but in many cases they are prevented from becoming a menace to the health of the community and incidentally, from becoming a greater financial burden to the community.¹¹⁶

Supporting the image of the hospital as a responsible dispenser of charity, the *Spectator* assured its readers that such free services were not given out "indiscriminately." All free patients had first to be cleared by the City Relief Officer, who, after an investigation, pronounced the "need and worthiness of the applicant." In this way, the hospital and its benefactors were "protected against imposters." One can imagine that, faced with the ordeal of yet another means test by civil authorities, some poor persons might have elected to live with their ailments. Those who did not — in 1924 HCH reported nearly 20,000 outpatient visits — may have preferred the comparatively quick treatment and home convalescence to the repressive and cramped conditions on the public wards. This was surely an ironic turn of events: the campaign to woo paying patients away from the comforts of their own homes worked to push the sick poor *out* of the hospital and into their often far from healthy home environments for convalescence. It seems likely that the burden of this process was carried by female homemakers, whose traditional gendered association with caring made them nurses-by-default.¹¹⁷

Hospitals placed considerable stock in this outdoor service, since the sheer numbers of patients treated were hard evidence of a commitment to the health of the poor. Moreover, as Rosenberg has noted, the need by medical students for "clinical material" upon which to learn their trade meant that hospitals could staff their outpatient departments primarily with interns who cost only the price of their upkeep.¹¹⁸ Administrators nevertheless insisted that these patients received "treatment and attention... that is the equal of that obtained by the wealthiest people from their private physicians."¹¹⁹ But the wealthy, they neglected to add, did not have to

¹¹⁶"Some Needs at City Hospital," *Hamilton Spectator*, 21 December 1922.

¹¹⁷For a discussion of Canadian working-class women's responsibility for their families' health which generally confirms my speculations here, see Bettina Bradbury, *Working Families: Age, Gender, and Daily Survival in Industrializing Montreal* (Toronto 1993), 159 and *passim*.

¹¹⁸Charles E. Rosenberg, *Catering for the Working Man*, 2. Guidelines for intern practitioners insisted that they "shall not receive any fee for any service rendered in the hospital." "What Hospitals Expect of Interns," *Canada Lancet and Practitioner*, (April 1925), 185.

¹¹⁹QUA KGH B103 Annual Report, 1919.

sit in groups of 50 or more in cramped waiting rooms in the hopes of seeing a doctor before the department closed at 4:30 in the afternoon. Nor were they subjected to means testing before receiving treatment, although by the time of the Great Depression, most pay patients were encouraged to remit the first week's fees in advance, "to avoid misunderstandings." The emphasis on Outdoor Departments for poor patients thus served as another marker of class status in the hospital. By treating indigent patients quickly and sending them home to convalesce, the hospital reduced the pressure on its public wards, and freed up space for the installation of new revenue-generating private rooms.¹²⁰

Individual "imposters" were not the only deadbeats supposedly attempting to take unfair advantage of the hospital's humanitarian service. Under the 1912 Hospitals and Charities Act, municipalities whose sick poor were treated at voluntary hospitals were required to contribute substantially to their upkeep. As might be expected, few cities and towns were eager to admit responsibility for indigents, who were construed as rootless. In attempting to recoup "losses" on charity patients, hospital accountants went to great effort to force cities to pay their "bills" for charity service. In 1919, for instance, HCH sued Barton Township over a \$200 outstanding debt, after Barton refused to pay on the grounds that the patient-in-question's emergency admission had not been approved by the reeve.¹²¹ Similarly, one of the more remarkable documents in the KGH Archives is a letter from Superintendent Armstrong to a Kingston City Council member, dated 3 September 1926. In the letter, Armstrong relates the results of an extensive investigation he had personally conducted regarding the previous residency of one John A. Newman. Newman, a war veteran, had the misfortune to contract tuberculosis while in jail in Guelph, and made his way to Kingston, where he worsened and was admitted to KGH. After sixteen weeks he was still ill, and had accumulated charges close to \$300. According to Armstrong's rough notes, Newman had "resided" in dozens of different places since 1917. In what looks like something of an end run, Armstrong claimed that the three days Newman spent in Kingston prior to being admitted to hospital, constituted residency, and thus Kingston ought to put up its share of the upkeep.¹²²

Overdue bills were a cause of great concern among hospital authorities, and they were not above resorting to callous and even inhumane action to ensure compliance in matters of monies owed. In 1921, an irate Hamilton doctor appeared at City Council to criticize the hospital for having refused to allow a child to go home with his mother until the \$21 bill for semi-private service was paid. Chairman T.H. Pratt, in his defence of his administration's actions, neither denied nor apologized for holding the child as collateral.

¹²⁰"Some Needs at City Hospital," *Hamilton Spectator*, 21 December 1922. Langrill, quoted in the article, is unequivocal in his support of this function of the Outdoor Department.

¹²¹"Hospital Will Sue Township," *Hamilton Times*, 28 November 1919.

¹²²QUA KGH B202, Armstrong to W.H. Herrington, Esq., 3 September 1926.

This patient was placed in a semi-private ward by the parents, and the family doctor was in attendance. The hospital authorities maintain that they have a perfect right to charge in this instance. The people concerned are property owners. It is the rule of this institution that where people are able to pay, we ask them to do so. In cases where they say they cannot, we investigate the circumstances, and, if they are unable to pay for their care, we do not charge them.¹²³

Langrill, the Superintendent, offered to refund the charge (and, presumably, return the baby) "if the family procured an order from the relief officer" as evidence that they were truly destitute. He believed that the family should sell whatever property they owned in order to pay their child's medical expenses, and that they would do so only when faced with the abduction of their son. The entire sorry scene indicates just how far the voluntary hospital could stray from its humanitarian mandate in the service of its bottom line.

The larger role that hospitals played in the administration of relief in the inter war period deserves more study, especially in their function as community bases for public health work. For my purposes here, it is enough to note that in vigorously drawing distinctions between the deserving and undeserving recipients of its services, the "modern" hospital reified the ages-old stigma attached to poverty. Correspondingly, the hospital trustees, by continuing to style themselves as the dispensers of humanitarian aid to the poor, "defined and ratified social structures in the community through creating a visible, beneficent upper class with its own continuing institutions."¹²⁴

To conclude, some assessment of the success of the "open for business" campaigns is in order. When considering the financial statements of public general hospitals, one is struck by the fact that, despite the fervent expansion programs and the utter devotion with which hospitals pursued moneyed customers, the proportion of revenue contributed by paying patients tended to level off rather quickly. KGH, despite more than tripling its fee-for-service capacity, never managed to raise pay patient revenues higher than 65 per cent of total receipts between 1907 and 1935. In fact, this oft-quoted statistic usually hovered around the 55 per cent mark for other hospitals as well.¹²⁵ While the Depression had much to do with declining revenues in the early 1930s, it is likely that the cash flow generated by structures like the TGH Private Patients Pavilion was barely enough to maintain them and to offset their depreciation. Hospital managers appear to have been conflicted over this problem. On the one hand, it was their economic mandate to run the hospital as cost-effectively as possible. On the other, both marketing common sense and

¹²³"Defends Hospital: T.H. Pratt Makes Reply to Medical Health Officer," *Hamilton Spectator*, 7 February 1921.

¹²⁴R. Stevens, *Sickness and Wealth*, 26

¹²⁵I base these estimates on a survey of annual reports, press releases, and Board of Governors Minutes from KGH and St. Catharines General and Marine Hospital, and from the monthly reports given to the Hamilton City Council by the governors of HCH.

their class ideology required that they provide customers of their own station with the most luxurious quarters possible. At times, the two were incompatible, and it is instructive to observe which side most often won out. In 1926, KGH found itself short of fee-for-service accommodations, and invited tenders to build a 24-room extension on the existing private wing. In accepting the lowest bid of \$67,000, Superintendent Armstrong commented in his personal notes that he felt it was much too expensive, but that without this new building, "conditions in the private wards will soon become unsuitable."¹²⁶ In a nutshell, money was no object when ensuring the comfort of their peers. The 321-bed Private Patients' Pavilion at Toronto General, which cost in excess of \$2 million, demonstrates this point all the more concretely. In the "unit cost" parlance used by administrators at the time, the Pavilion was constructed for the patently non-economical price of over \$6000 per bed.¹²⁷ By comparison, a 67-bed extension to the public ward building at KGH a few years earlier set the hospital back only \$1179 per room. "Efficiency" was a relative term when the comfort of the bourgeois patient was concerned.¹²⁸

Finally, to return briefly to the beginning of this discussion: the opening of the Private Patients' Pavilion in Toronto on a cool spring day in 1930. While Toronto's elite moved from the opening ceremonies to a reception at the Royal York Hotel, homeless men at the Longbranch barracks on the outskirts of town bedded down for the night. This moment was in some ways the beginning of the end of an era, the culmination of an expensive game of one-upmanship between groups of wealthy philanthropists. The rise of the exclusive hospital ward in Canada contained within it the seeds of its own destruction, as costs for new facilities and technologies spiraled upwards out of control. By the mid-thirties, private room rates had moved beyond the reach of all but the most rarified levels of society, and administrators found themselves converting private wings into spaces for partial- or no-pay patients.¹²⁹ Most significantly, the movement to create large-scale health insurance schemes, whereby the cost of illness could be divided amongst large numbers of healthy subscribers, took on a new urgency. Hospital authorities, along with some doctors, led this movement, recognizing that their institutions would quickly go bankrupt if none but the insolvent attended them.¹³⁰ By 1935, hospital administrators began to coordinate provincial Blue Cross insurance plans and, following World War II, these influential men could be found at the forefront of the lobby for federal health insurance. Their efforts worked to effect a gradual democratization of hospital health care that allowed most (urban) patients access to high quality medical practice.

¹²⁶QUA KGH B305, Tender for Addition to Empire Wing

¹²⁷"Many Unique Features..." *Canadian Hospital*, (May 1930), 30.

¹²⁸QUA KGH B305, Tender for Additions to Nickle Building.

¹²⁹Gagan, "For Patients of Moderate Means," 175.

¹³⁰Naylor, *Private Practice*, Ch. 5. See also Agnew, *Canadian Hospitals*.

The decline of fee-for-service hospitalization was, for the optimistic, a victory of humanitarianism and socialization. Yet it is important to note that the notion that wealth and status ought to allow greater privileges in the health care system never fully died out in Canada, and democratization was partial at best. Higher grades of accommodation, special services and luxuries, and a more complete range of medical techniques and technologies, remained the province of the wealthy and influential in the public hospital. At Ottawa Civic Hospital, for example, patients were still classified as "public" and "private" in the early 1970s, and student nurses were restricted to "practicing" on the less privileged patients in the 16-bed wards.¹³¹ Today, as all levels of government seek to scale down their responsibility for and investment in universal health care, we are faced with the officially-sanctioned re-emergence of a so-called "two-tiered" health system. Wealth and power increasingly provide preferential access to the best health care on the market, much of which is provided by profit-seeking corporations invited to compete by conservative provincial governments. One can identify a return to a rhetoric in which health care "tiers" are once again justified in terms of efficiency of service and medical efficacy. In a remarkable turn of events, publicly-run hospitals have found themselves relying more and more heavily upon professional and third-party fundraising administrators to generate new forms of private philanthropic funding, thus recreating the explicitly paternalistic gift relation that defined health care at the turn of the century. Indeed, Ontario premier Mike Harris has gone on record as saying that this structure is both natural and to be desired. "Hospitals have always relied on private donations," he stated recently. "This is not something that is new, but I can tell you that it is perhaps more important than ever."¹³² I cannot help but feel that some lesson has been forgotten, or perhaps was never learned.

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¹³¹My thanks to my colleague Jayne Elliot for this information. "Private" accommodations have, of course, always been available for those with expanded insurance coverage or sufficient funds.

¹³²"Donor gives Toronto hospital \$5.2m for lab," *Hamilton Spectator*, 14 October 1999.

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