

The Professionalization of Medicine in Ontario
during the Nineteenth Century

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ABSTRACT

The nineteenth century was the most striking period in the history of Canadian medicine because it progressed from a relatively low-status occupation to a relatively high status profession. Canadian medicine was able to reach this goal as much on the basis of political maneuverings as justifiable merit. This thesis is an attempt to "secularize" medicine (Freidson 1970a:24); to see it as a human creation. Owing to limitations of time and space I have decided to concentrate on one of the provincial forefathers of Canadian medicine, Ontario; with reference to the other progressive province, Quebec.

I have used three theoretical perspectives to help me organize the tremendous amount of data I accumulated. The majority of my discussion revolves around Terence Johnson's perspective in Professions and Power. Johnson looks at occupations within a socio-political milieu and on the basis of the latter suggests why certain occupations achieve or do not achieve professional autonomy. This approach is attractive because he does not examine professions in terms of innate characteristics but rather as an occupation that has been able because of the socio-political milieu to convince the State to transfer control over all administrative affairs to the profession. This includes any policing or disciplinary matters and therefore leaves the profession free from external scrutiny and control.

In order to analyze medicine's climb to autonomy in Ontario I have borrowed two occupational career stages from Johnson and devised one of my own. In the first stage medicine comes under Oligarchic control.

Johnson suggested that when a client oriented occupation is in a situation where the power elite constitutes the sole consumer group then the occupation is controlled by the elite and is not free to manoeuvre for more independence. The second stage in medicine's career is simply a transitional period when medicine comes out from under Oligarchic control and proceeds towards autonomy. The final stage is the achievement of occupational autonomy.

Eliot Freidson has also been used, but to a lesser extent in the analysis. He concurs with Johnson's definition of profession. Freidson's emphasis on the factor of technical competence is particularly useful in the transitory stage of medicine's status as one reason why medicine is unable to achieve occupational autonomy.

Johnson's theoretical perspective becomes a little less helpful in analyzing Canadian data towards the last third of the century because of his emphasis on the growing homogeneity of the occupation. It did not coincide with Canadian data. Thus I added Strauss and Bucher (1961) to keep the historical analysis in line with events. Their appreciation of the importance of conflict and differences of interest to the progress of occupations helped generate worthwhile hypotheses from what appeared superficially to be rather unimportant occurrences.

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INTRODUCTION

1) Intent

The intention of this paper is to examine the process of professionalization for the profession of medicine in nineteenth century Canada. The question to be asked is how did medicine establish itself as an occupation with the power to supervise and regulate itself and maintain a monopoly over services?

To narrow the scope of this paper I will deal in depth with Ontario and refer to developments in Quebec because these provinces led in the development of the profession of medicine. The Maritime Provinces were cut off from the main part of their country and occupation and therefore experienced a different history. Provinces to the west of Ontario developed at a much later date than Ontario and Quebec, which meant that, during its process of professionalization, medicine in the western provinces had to contend with different conditions than medicine in Ontario and Quebec.

The first task at hand is to define the term profession. I have chosen to use the definitions of Terence Johnson (1972) and Eliot Freidson (1970a) because both define this kind of occupation in terms of its legitimate power to supervise occupational activities and members rather than defining it in terms of inherent characteristics. Johnson and Freidson view the special characteristics of the

doctor-patient relationship as amenable to the creation of a situation of autonomy for the doctors. Medicine deals with acute problems of uncertainty, where client judgement is seen as ineffective and where help may involve violation of the person or mind (T.J. Johnson, 1972:43). The less knowledge the patient and doctor share and thus the greater the social distance, the greater helplessness of the client, the greater the chance of exploitation and the greater the need for social institutionalized control. (T.J. Johnson, 1972:44) However, it should be noted that the social distance between client and practitioner and the perceived value of the service are not the same for all occupations.

Professionalism is one way of controlling an occupation which is perceived as potentially threatening to the consumer. The type of control which an occupation comes under depends more on the era and socio-political situation during which it was establishing itself than on the inherent characteristics of an occupation. This explains why occupations with similar characteristics in the producer-consumer relationship may not gain the same degree of autonomy. This may not be a static condition for the occupation may undergo changes in its skill content and society may be persuaded to redefine the importance of its work. As a consequence its potentialities for autonomy may also vary. (T.J. Johnson, 1972:44) Johnson and Freidson have concluded that medicine's occupational status is due less to its unique characteristics than to its ability to persuade those in power that it needs autonomy to function properly. I am partial to Johnson's definition because it places the process of professionalization within a temporal and cultural context.

To Freidson, a profession is defined as a special kind of occupation because it has been given the right to control its work (i.e., legitimate, organized autonomy); the autonomy to determine who can do work and how it can be done; and the recognized right to declare "outside" evaluation illegitimate and intolerable. (Freidson, 1970a:71) He goes on to say that a profession attains and maintains its position by the protection and patronage of an elite segment of society which has been persuaded that there is some special value in its work. The elite uses political and economic influence to maintain the profession's position. This drives competing occupations out of the same area of work and discourages others from entering because of the competitive advantages conferred on the chosen occupation. Other related competing occupations are subordinated to the profession. (Freidson, 1970:72) While it is not essential in the beginning for the profession to reflect the beliefs or values of the average citizen, to survive, a profession must establish some sort of rapport with the average citizen. To maintain its professional status it must cease to draw only upon the elite for clients. The doctor, then, has to win favour with clients who do not share the same values and beliefs because they come from different social classes, are outside of the occupational community of medicine, and therefore may not be familiar or sympathetic with the occupation's ideas and practices. (E. Freidson, 1970a:74)

Because there are many variables to consider when one places the professionalization of medicine in a social context, I have divided

the nineteenth century into three time periods. The divisions were made on the basis of changes in the power base of Canada. If it is assumed that the power elite transfers power to the occupation in the process of professionalization, then any changes in the elite's power will probably be reflected in the occupational structure of medicine. Therefore I have used political and economic conditions, to break the analysis into sections.

The first time period is 1800 to 1840. I stopped at this point because in the 1840's relations between Britain and Canada began to change and this led to a weakening of the power of the few who directed the political and economic affairs of Canada. This oligarchy depended on contacts with prestigious Britons for appointments and commercial interests in Canada. While the Rebellion of 1837 was an indication of the dissatisfaction of the average citizen with the oligarchical form of government, the essential erosion of power came with Britain's withdrawal of supervision.

The second date marks the beginning of the Union of Canada, a different form of government with a changing power base. The second time period, 1840 to 1867, was a time of political uncertainty. During these years Britain withdrew favourable trade agreements, regular troops and other forms of financial support from Canada. To survive economically, Canada entered into trade relationships and thereby increased interaction with the United States. This was also a time of trial and error and uncertainty for Canada's political structure. Confederation, 1867, marked the beginning of increased

stability in governmental affairs. It also marked the beginning of the Canadian Medical Association. For these two reasons the year 1867 was chosen to introduce the last time period. I chose to end my investigation at the beginning of the twentieth century because medicine had finally reached the status of profession by that time. Advances in medical research led to improved results in practice and helped medicine establish itself as a successful profession. It was also helped by the improvement in the education of the public which helped harmonize the patients' ideas and knowledge with those of the doctors. It became easier to convince those in power to grant autonomy and to maintain it by virtue of the support of the public. (E. Freidson, 1970:75) As an indication of the prestige accorded to it, medical men were called upon to give learned opinions in areas not directly associated with their regular duties.

Professionalization is essentially a political and social process wherein those concerned employ certain arguments to persuade the State of a profession's right and need of autonomy. Illness, birth and death are vital concerns of people and each bring out feelings of helplessness on the part of the emotionally involved individual. This leaves them particularly vulnerable to those who offer help. Those in the medical occupation have used these concerns to enhance their position. I would hasten to add, though, that their motivations were probably well intentioned because they believed that the medical care they were giving was the best available. When physicians generally

were not well paid why would so many work themselves to exhaustion or ride through snowstorms, wilderness and rivers to reach people in distress? Ample description of the trials and ordeals faced by pioneering medical doctors is provided in William Bull's From Medicine Man to Medical Man (1934). Another good reference is Canniff's Medical Profession in Upper Canada. (Heagerty, 1928:235)

The image of a service orientation can also be created to help persuade politically important figures of the virtue of the occupation. (Freidson, 1970a:82) A service orientation is another way of saying that the physician's first motivation is to serve others to the best of his ability. The pecuniary aspect of his services is played down. Throughout the nineteenth century there are hints of a deliberate creation of a service orientation image. Doctors of the medical establishment frowned upon the use of advertisements for doctors' practices and eventually brought about legislative sanctions against practitioners who persisted. In addition, one finds hints of a service orientation in the stated aims of organizational bodies when oaths or codes of ethics are mentioned. Once autonomy has been won it is also this orientation which those in society use to explain the profession's independence, if it is questioned. (Freidson, 1970a:82)

The argument of a superior education can also be used to justify a group's monopoly over the provision of services. This is particularly true of consulting occupations (i.e. any occupation which laymen come to for advice). Differences in training were used by the

medical community from the beginning of the nineteenth century to eliminate competition. "Regular" physicians were those doctors with licenses who gradually gained a monopoly over medical care. Physicians with certain educational requirements acquired licenses because doctors before them with the same kind of education convinced those in power that their kind of education was needed for a competent physician. With the state of knowledge being as limited as it was in the nineteenth century, an observer can easily see that this claim was unfounded. However, the esoteric character of the profession's knowledge can be used to manipulate the extent of uncertainty in the doctor-patient relationship and thereby increase the probability of occupational autonomy. The phrase esoteric knowledge is used to differentiate this aspect of knowledge from the degree of complexity of knowledge and from the level of specialization in an occupational setting. (Johnson, 1972:42) Johnson does not clearly state what esoteric knowledge is but I would suggest that one take it as meaning a mystification of the knowledge at hand (whatever its level of scientific sophistication), into something which is pleasing to the consumer to attract them and to maintain them because they find it satisfactory.

It was not until the end of the nineteenth century that results from the "regulars" treatment had improved sufficiently to cause people to prefer their services to lay or "unlicensed" practitioners. Examples of advances in medical research and knowledge in the last third of the nineteenth century were used to demonstrate

the superior competence of the medical profession in areas of health care which in turn suppressed the status of other health care workers, such as nurses. As Johnson would see it, anything which enhanced the image of the physician as a holder of specialized knowledge would help him in his bid for an autonomous work structure.

Ehrenreich and English in Complaints and Disorders (1973b) would tend to agree. Thus the development from the opening of the nineteenth century of a special argot aided in the presentation of "expert" knowledge.

2). Methodology

The primary goal was to construct a history of the professionalization of medicine in Ontario and Quebec from the perspective of Terence Johnson in Professions and Power and Eliot Freidson in The Profession of Medicine. Discovering that I was limited in the number of English language sources for Quebec, I decided to concentrate on Ontario and make comparisons with Quebec's development where possible. It would have been negligent to ignore Quebec when she was the leader in Canadian medical journalism and she had the first and best medical school in Canada until the formation of the Medical Faculty of the University of Toronto in the 1880's.

(Abbott:1931)

Books on the histories of Colleges in Ontario were also useful sources because most schools tried to affiliate with a College. I then turned to an Abstract on the History of Medicine to direct me to journals which carried articles on the history of Canadian medicine.

Unfortunately the articles did not prove to be rich in data. As I saw it necessary to place medicine in a social-economic milieu, I turned to diaries of pioneers for primary sources and then read some histories of Canada for secondary sources.

My approach to this paper was both deductive and inductive. Deductively, I began with Johnson's hypotheses to see if they explained the developments in the field of medicine in Ontario. In other portions of my thesis I used an inductive approach because I started with my data and generated my own interpretations of the situation.

3) Organization Of Thesis

The organization of my thesis is as follows. In Chapter One I examine medicine from 1800 to 1840 to see if it supports Johnson's hypotheses concerning medicine under patronage control. I open with a description of the social-political milieu of Ontario to explain why I think that medicine in Ontario was under patronage control. While I provide a brief description of the economic development of Quebec I do not look at Quebec medicine as being under oligarchic control because the sources are in French. To make it easier for the reader, under each section of the chapter I discuss Ontario and Quebec separately.

The next section deals with how medical practitioners began to create an organizational structure. Whenever possible I traced the social networks between doctors and powerful individuals. This is followed by a section on the educational facilities open to potential

medical students which in turn is followed by a segment on the status of medical knowledge. I end the chapter with comments on Johnson's theory.

Chapters Two and Three follow the same general pattern: the Social, Political Situation of Ontario; The Institutionalization of Medicine in Ontario and Quebec; Medical Education in Ontario and Quebec and the General State of Medical Knowledge. Chapter Two deals with the period of time between 1840 and 1867 and Chapter Three looks at the post Confederation years until the beginning of the present century.

I have deliberately omitted a discussion on the Boards of Health and their relation to medicine because the Boards of Health in the nineteenth century were not primarily constituted with medical doctors. Thus to discuss Public Health is to introduce a tangent which is not necessary to the comprehension of the professionalization of medicine.

Keeping in mind that I intend to examine only Ontario medicine in depth, then the next section will only deal with Ontario. I have included a short description of the Social, Political milieu of Quebec under the section on the Institutionalization of Medicine in Quebec.

CHAPTER ONE

MEDICINE UNDER OLIGARCHIC CONTROL

I. The Social, Political and Economic Milieu of Upper Canada And the State of Medicine

Before we begin to look at the social, political and economic background against which medicine in the early nineteenth century is set, it would be advisable to outline some of Johnson's hypotheses regarding the oligarchic patronage control of medicine.

Johnson argues that in a consumer-producer relationship of high uncertainty and stress, such as a doctor-patient relationship, various means of institutionalized control will arise to reduce the stress. The social, political and economic milieu will decide whether it is reduced at the expense of the producer or consumer. (Johnson 1972:41) Looking at the situation in early nineteenth century Canada, I propose that the stress was reduced at the expense of the doctor, or, that the occupation was under oligarchic control until the Union of Canada (1841).

Patronage arises where the dominant effective demand for occupational services comes from a small, powerful unitary clientele. In this situation aristocratic consumers have the capacity to define their own needs and the manner in which those needs are catered to. (Johnson, 1972:65) Entrance into the occupation is based on sponsorship and prerequisites for sponsorship are that the recruit share the values and to some extent the status of the patron. Once inside the occupational community the practitioner is evaluated on the basis of social acceptability, not technical competence. (Johnson 1972:66) Physicians rise

in the occupational hierarchy through their association with more and more powerful patrons. (Johnson 1972:69) This leads to a fragmented, hierarchical, locally oriented occupational group. When the practitioner receives benefits from the elite he feels more allegiance to his patrons than to the occupational community. (Johnson 1972:69) In order to please his patrons the physician is likely to develop local knowledge and skills relevant to local demands. One may also find that there is more conformity with local customs and beliefs concerning non-professional matters than with conformity to professionally defined norms because the practitioner is trying to establish a good local reputation to improve his chances of advancement. (Johnson 1972:69) This can lead to a situation where a small servicing elite of practitioners share to some degree the social origins and characteristics of those who use their services. (Johnson 1972:66)

The hierarchical fragmentation to occupational practice and organization may even be systematically expressed and institutionalized as dual systems of practice within a single occupation. This means that the elite would monopolize the services of the highest status doctors while other social groups would be catered to by healers who are not officially and legally recognized as physicians and who may use divergent systems of knowledge. (Johnson 1972:69)

In attempting to apply these hypotheses to Canada, one discovers that the government in England tried to create a Canadian political-social structure which was to be in the image of British eighteenth century society and government. The intention of the Constitutional Act of 1791 was to create a social-political structure in Canada which

would offset the new tendency towards egalitarianism. (McNaught 1970: 61) This intention is significant in light of Johnson's comment that Oligarchic control was characteristic of eighteenth century England. On the basis of this comment I thought it worthwhile to consider whether in Canada medicine came under Oligarchic or Patron control.

Before we consider this question, I will briefly describe the loose structure of the occupation of medicine at this time.

In the early nineteenth century there was a vast array of people calling themselves physicians. The first categorical division could be made on the basis of charging as opposed to non-charging physicians. Within each of these categories there are differences in training. Non-charging physicians came from both the Upper and Lower classes. Generally they had been forced or drifted into this role because there was no doctor nearby. On the other hand, charging practitioners chose this role and either apprenticed with a licensed physician, enrolled in a session of private medical lectures or attended a medical school outside of Canada. There were also other healers who were able to practise without any formal education because the methods of regulation were ineffective. In Upper and Lower Canada there were regulatory laws but with most of the country in wilderness it was impossible to enforce them. To implement the regulations the power elite set up Boards of Examiners in the major cities of Toronto, Quebec and Montreal. All doctors who practised for a living were supposed to appear before the Board for examination and if successful were granted a license to practise.

The Medical or Examining Boards created a difference between licensed and unlicensed healers and thereby established a dual system of practise. (Johnson 1972:69). I use the word created because after the reader has finished the section on the state of medical knowledge she/he will see that there was little difference in technical skill between the two. Thus the distinction between the two had to be an arbitrary decision based more on political manoeuvrings than a justified reason. Therefore the Examining Board institutionalized the hierarchical, fragmented character of the occupation of medicine. By licensing only certain physicians the State supported Board was giving a higher status to one group and thereby officially recognizing the differences in training which existed within the group of healers. There was not only a difference in status and character between groups, there was also variability within groups. Firth mentioned that in the City of York, 1834, the fifteen practising physicians varied so greatly in education and competency that they usually did not co-operate readily. (Firth 1966:ixii) To differentiate between the licensed and unlicensed healers the former will be called regulars and the latter irregulars.

The category of "irregular" contained many different types of healers. In fact the only thing they held in common was a lack of license to practise. This category formed a continuum from illiterate healers who administered to the poor and received payment, to peddlers selling patent medicines, to well educated individuals who had acquired reputations for successfully applying their own medicines gratis.

Captain John Matthew, on the staff of the Governor-General, the Duke of Richmond, possessed a medicine chest. People from many miles around came to him for help in curing ague. (Seaborn 1944:45) "The possession of a medicine chest often turned its owner into a physician. William Imlach, of London, describes it this way:

My mother was the possessor of a large and valuable medicine chest, prepared and fitted up with common and ordinary drugs in use in that day, by a celebrated chemist in Old London who also published with it a most useful work describing uses and usual dosages, which, if well studied, would almost make a doctor of you at once...when it became known that such an apothecary's shop was in our settlement, how it was resorted to by our suffering humanity.

(Seaborn 1944:45)

Other individuals in a community would gain a reputation for mixing their own medicines from native Canadian plants. Catherin Traill (sister of Suzanne Moodie) stressed the food and medicinal possibilities of native Canadian plants in A Female Emigrants Guide 1854 (Innis 1973: 65).

The tradition of a community healer was brought to Upper Canada by the United Empire Loyalists. (Acton, Goldsmith and Shepard, 1974: 130) At least one knew the community healer and his/her knowledge of you made it easier to suggest more effective treatments.

The other kind of non-renumerated lay healer was the missionary. Presbyterian ministers in Scotland were given a course on medicine as part of their religious studies. It was assumed that if they were attached to distant and isolated outposts they had better be prepared for all emergencies. They received no extra remuneration for these services although they must have added considerable hours to their day,

particularly if they had to travel to the sick. (Bassett 1975:30)
With these sources of competition it was more economically feasible for the "regular" to remain in the more settled areas. There the number of patients per square mile made it worth his while and allowed competition to exist.

In regard to paid irregulars from my readings I discovered that some had trained under a doctor but had not bothered to appear before a board of examiners. The necessity for this was not crucial when the country was still in a state of wilderness. Others had trained under a physician but the Medical Board was uncertain as to the validity of his education and on those grounds refused to grant him license. (Seaborn 1944:78)

The category of regular was also hierarchical.

Within the regular community, status levels seemed to correspond to particular kinds of education. To begin with, his social class would decide to a large extent the type of schooling and his ascribed social status would introduce him into the elite which would ultimately affect his occupational status. In addition the friends he makes at school provide further influential contacts. When the level of skill could not be the only determinant of the physician's reputation because medical knowledge was sparse, then the physician's contacts took on that much more significance.

In Upper Canada at the turn of the century the better educated and usually higher status physicians came from positions as ships' surgeons and a little later military surgeons who had been attached to a garrison, served in the War of 1812 and who stayed after discharge. The

War of American Independence had also forced some United Empire Loyalist physicians to come up to Canada. (Cosbie 1968:5)

Only prestigious Canadians or individuals born in Europe could afford to attend European medical centres. They came from prominent families or held prestigious positions in the militia or navy.

Less important licensees received an education through apprenticeship; a medical school in the United States or a series of medical lectures given privately by a regular physician.

Regardless of the education chosen, a recruit needed a sponsor to gain entry into an educational facility. If the recruit chose apprenticeship, a sponsor could introduce him to a physician that he wanted to apprentice under or; if he decided to train in a European medical centre he needed to be recommended by someone who had contacts in Europe. Even the prestigious doctors who gave private medical lectures could be quite selective as to who they admitted into their courses. Since entrance into the medical community was based on sponsorship, the recruit usually shared the values and status of the sponsor. (Johnson 1972:67) As an example of this Peter Diehl, a member of the Board of Examiners for Upper Canada, apprenticed under a very prestigious physician because his father had been friends with this physician.

Sponsorship did not end with education. Once a physician had obtained his license his ascent up the occupational ladder depended on the help he received from influential people. The latter could be outside of the medical community. As an example, since the Medical Boards were maintained by the government members of the Board were appointed by

Government Officials. There were also government jobs on quarantine duty for privileged physicians. A doctor would also be hired to board boats further down the rivers than the quarantine stations to board boats and check for and treat sick immigrants. This will be dealt with at length when I describe the Family Compact.

It is extremely difficult to obtain statistics for the number of licensed doctors in Upper Canada before 1840 because the government had not established a system of keeping track of census data. Therefore I can only offer the numbers I came up with for the counties of Western Ontario (Lincoln, Norfolk, Suffolk, Essex and Kent) and Peel County. Seaborn found that in Robert Gourlay's Statistical Account of the Province of Upper Canada that there were six physicians in the London District (Kent County) in 1817. (Seaborn 1944:48) This covered the land north of the Thames River to Hudson's Bay. Seaborn also mentions that fifteen physicians from Western Ontario obtained degrees from Fairfield Medical College in Western New York State and nine physicians attended but did not complete the course between 1803 and 1840. (Seaborn 1944:40) It is difficult to determine whether all of them returned to Western Ontario to practise. I did however, count eighteen physicians practising in Western Ontario between 1820 and 1850. (Seaborn 1944:120-138) I also counted seventeen physicians attending patients during the Cholera Outbreak of 1832. (Seaborn 1944:61-111) Brantford had one physician from 1800 to 1811 (Seaborn 1944:119); London received its first doctor in 1828 (Seaborn 1944:128) and the doctor in Norwich found that his nearest competitors were in Tillsonburg, twenty miles to the south; Brantford, twenty miles to the east; and St. Thomas, fifty miles

to the west. (Seaborn 1944:156)

Turning to Peel County, it had to wait until 1821 for its first physician. In the next ten years the number grew from one to five.

(Bull 1934:46)

York had fifteen physicians by 1834 (Firth 1866:Ixii)

Other than the Examining Board, few facets of the occupation of medicine were institutionalized. There were no occupational associations or schools. What few hospitals there were, were established and maintained by private, not governmental, funds.

For each category of healer there generally corresponded a certain type of consumer. The majority of the demand for relatively expensive, licensed physicians came from the aristocratic elite. They were the only group of consumers who could afford to call on physicians on a regular basis rather than as a last resort. I will devote a greater amount of time to these people because they determined the amount of autonomy which the occupation of medicine had and therefore played an important role in the professionalization of medicine. I will demonstrate that the aristocracy in Upper Canada had a wide enough base of power that they were the stronger of the two in the doctor-patient relationship; that they controlled key positions in the occupation of medicine and that they determined just how independent medicine could be from outside control. The small interconnected cliques who viewed themselves as local aristocrats were nicknamed the Family Compact by later historians. Donald Creighton described the Family Compact as a fraternal union of judges, civil servants, bankers, merchants and Church of England clergymen. (Saunders 1957:166) He

further states that the clique was "a little oligarchy of appointed executive and legislative councillors at Toronto...and...a network of little local family compacts." Each district town had its own social-political oligarchy and ties between the villages and the city of York were very close. (Saunders 1957:173)

The Family Compact developed out of Great Britain's desire to establish an oligarchic social-political system in Canada. The first governor of Upper Canada accepted whole-heartedly this idea of establishing a backwoods version of eighteenth century English society in Canada. Having control over many government appointments, he endowed in every way that he could the "well-effected and respectable classes" of the province. (McNaught 1970:65) He chose people from his social circle who shared British values, beliefs and attitudes.

The Family Compact could be defined as two groups of people: "the elite of power" denoting the eight men who formed an inner circle of power and the "elite of office"; the larger circle of friends, associates and family connected to the "elite of power". The latter often received positions because of their close ties to the former. (Saunders 1957:169)

In addition to government appointments, the elite also pooled their financial resources, formed land companies and using any collective influence they had, bought land from the Crown at deflated prices. Then they turned around and sold the land to settlers at a good profit. (Langton 1964:x) With proceeds from the sale of lands the elite chartered the Bank of Upper Canada. Thus the only major source from which to borrow money was in the hands of the ruling class. (McNaught

1969:84)

Because they held the power in Upper and Lower Canada they had the resources to create and implement policies and institutions which they believed in. (McNaught 1970:83) This is particularly evident with the individuals who managed the tracts of land for the Land Companies. They had tremendous power over the activities of the community and even over medical facilities.

Colonel Talbot was a good example. In 1801 Talbot was given 5,000 acres on the shore of Lake Erie. He set about to establish an almost feudal domain with English immigrants. (McNaught 1970:78) Once inside Talbot's community an immigrant's goals were determined. Within three years he was expected to have cleared 10 acres, built a house of certain dimensions and opened half of the road in front of his farm. (Howison 1821:168)

In 1824 Talbot gave permission for Drs. Rolph and Duncombe to establish a dispensary-school in his settlement. Seaborn's interpretation of how Rolph persuaded Talbot is amusing.

Dr. Rolph in a brilliant moment had suggested that Colonel Talbot, the great 'I Am' of the district, should have his accomplishments recognized in an anniversary. The anniversary proved to be a gay and festive picnic and greatly pleased the good colonel. Rolph now suggested the formation of a dispensary where the poor might secure advice gratuitously and, to tickle the fancy of the colonel, suggested the name of 'Talbot Dispensary' with Colonel Burwell, the colonel's right-hand man, as its president, whose powers would be determined at some future date. It was suggested that lectures might be given to the public for a fee of 'a bushel of produce'.

The colonel by now had smelt a rat. The scheme had been to secure the political support of the colonel for the election of Dr. Duncombe to Parliament and in support of the Reformers.*

(Seaborn 1944:262)

Although the Family Compact itself did not include one physician (Earl 1967:14) there is evidence of physicians benefitting from their contacts with the aristocracy (Action, Goldsmith and Shepard 1974:133). To begin with, individuals who had graduated from British universities did not have a difficult time aligning themselves with the Family Compact. It is evident from the diary of Suzanne Moodie that a man's worth was measured by his education and not necessarily his occupation. Out of necessity prerequisites for entrance into the more prestigious social circles had to be relaxed because often in Canada a man would have to carry out tasks which in English society would be socially prohibited. A university education, political affiliation with the Tories and affiliation with the Church of England were attractive attributes to the Family Compact. Possession of any or all of the three increased a person's chances of being helped by this aristocracy. His chances were also improved by military service because the Family Compact looked favourably on people who had helped to defend Canada and if he held a relatively high status position he would have frequent contacts with the aristocracy as the militia and government officials worked in conjunction with one another.

*Seaborn's interpretation is also not found in a standard history of Canadian medicine and there is no way to judge its authenticity. Nevertheless I did feel that it was important to the reader to include this version.

There were several ways in which the Family Compact could help doctors. To begin with recruitment into the medical community was based on sponsorship. Either a man needed letters of introduction or he needed to be known by the physician to apprentice under him. If the recruit decided on a medical school outside of Canada then his chances were better if he had references who were known to the faculty of the school. Once he had been granted a license to practise his ascent up the occupational ladder depended on obtaining prestigious paying positions connected with medicine. Thus he was quite dependent on favours from the elite as they controlled all the remunerative positions. While the Family Compact controlled most aspects of society and the scientific basis of medicine was paltry, medical men had to depend on their social skills to win friends and influence people to advance their careers. Their public reputation however, may have been based on an image of technical competence. (Johnson 1972:68) Acton, Goldsmith and Shepard (1974:133) found that:

The leaders (in medicine) were men trained in medicine in British universities, many of whom were adopting a second career following military or legal positions; most of them were aligned through family ties, church activities and political sympathies to the Family Compact.

Let us look at the backgrounds of some members of the Medical Board of Upper Canada 1819 (also called Board of Examiners), the York Medical Board 1821 and two other prominent physicians to see how individuals were aided in their careers by their social status, political and religious affiliation and military duty. All of these attributes increased the individual's chances of being helped by the Family Compact.

There is some confusion as to who belongs to what Board because only one historian acknowledges the existence of two Boards. To reduce the confusion I decided to follow Heagerty's (1828) list of respective members as he was the one to distinguish between the two Boards.

Let us begin with the Board of Examiners of Upper Canada. English-born Christopher Widmer was a Fellow of the Royal College of Surgeons and for a time the Staff Surgeon to the 14th Light Dragoons. He opened a practise in York 1815 or 16 and Firth claims that for ten years he was the only qualified practitioner in town. (Firth 1966:126) This has to be incorrect because the York Medical Board was formed in 1821. (Heagerty 1928:243) Widmer became the personal physician of Sir John Colborne. (Firth 1966:126) Then in 1829 (Abbott 1931:46) he took on a partner; Dr. Diehl of Montreal. Both Widmer and Diehl were appointed by Colborne to the Upper Canada Medical Board sometime before 1834. (Firth 1966:236) It appears that both his political affiliation (Tory) and his social contacts helped his career because his appointments were numerous. In 1826 Widmer was appointed Medical Referee to the United Empire Life Association of York. Five years later he was made director of the Bank of Upper Canada and in 1832 was appointed as one of the trustees of the General Hospital of Upper Canada. This appointment was due to his leadership in founding and developing the hospital. (Firth 1966:83) His next appointment however, could be suspected to be a result of his pro-Tory sympathies. He was given the part-time appointment of magistrate by the Lieutenant Governor. (Firth 1966:273) Magistrates were the local government in town and country settings. They appointed a number of local officials and directed the activities of

those elected by town meetings. (Glazerbrook 1971:24) Therefore it was important for the Lieutenant Governor to appoint individuals who supported the Tories. Drs. Baldwin and King were also appointed by Colbourne. (Firth 1966:ixix)

Widmer was also commissioned as a member of the University of King's College in 1842 and became a member of the Legislative Council of Upper Canada in 1849. (Heagerty 1928:243) Scadding (1966:382) claims that he became a member in 1843. In 1853 Widmer was Chancellor of the University of Toronto for a short time. (Scadding 1966:382) In that year the Hincks' government reorganized the University. This is discussed in detail in the section on Education 1840-1867.

Peter Diehl, left fatherless at a young age, became the charge of Drs. Blake and Loedel Sr. (father of a member of the Montreal Medical Institute). Peter entered into apprenticeship with his guardians at the age of fourteen and remained seven years. His apprenticeship over, Peter travelled to Edinburgh in 1807 where he studied medicine at the University and Royal Infirmary for over one year. He returned to Canada and obtained his Provincial license to practise Surgery, Midwifery and Pharmacy in 1809. Two years later he sat on the Board of Examiners for the District of Montreal. (Abbott 1931:46) Since his uncle, Daniel Arnoldi, was a friend of two members of the Board of Examiners for the District of Montreal and his executor, Loedel, was the father of one of the members, one can only wonder how much his networks helped. It does seem odd though, that he should be chosen out of all the other candidates when he had so few years of practical experience. In 1818 his

uncle Daniel took him into partnership and in 1828 he was appointed to the staff of the Montreal General Hospital. Shortly after, he moved to Toronto where he went into partnership with Dr. Widmer and ended up on the Upper Canada Medical Board.

Information on other members of the Upper Canada Board was more difficult to find. Gwynne and King were born in Ireland and received education at Trinity College, Dublin, and Edinburgh University. (Firth 1966:258 and 288) Both came to York in the early 1830's and became prominent physicians.

Gwynne's brother was a lawyer, travelled in the better social circles of Toronto, as his membership in the Shakespear Club indicates, and in his later years became a judge of the Supreme Court of Canada. (Walker 1965:131) It appears that Widmer came from a prominent family. Gwynne married the granddaughter of Judge Powell while King married the daughter of Judge Sherwood. King decided to dabble in politics and was elected Alderman 1835-37 and 1839-43. (Firth 1966:238) King also served on the short-lived Board of Health in the 1830's.

Looking at some of the members of the Medical Board of York in 1821, Dr. Macaulay was a native of Scotland who not only possessed an M.D. but also was a M.R.C.S.E.. He married a relative of Admiral Hayter and was an intimate friend and staff physician of Colonel Simcoe. Macaulay served as a surgeon to the 33rd Regiment and later to the Queen's Rangers. After the Rangers were disbanded he received an appointment as Deputy Inspector-General of Hospitals. In addition, he expended a considerable amount of energy in helping to develop the town of York; for instance, serving on a Commission to oversee the construction of Yonge Street. (Heagerty 1928:242)

Another member of York's Medical Board, Dr. Grant Powell, was born in England. His father became Chief Justice of Upper Canada. It is not clear whether Powell accompanied his father to Canada, but we do know that Powell studied medicine at Guy's Hospital, England. He spent some time as a surgeon on a merchant ship and eventually came to Montreal in 1807. For three years he practised in Montreal but with the War of 1812 he became a surgeon with the Incorporated Militia at Chippewa. With the end of the War he moved to Toronto. While in Toronto Powell was an executive officer in the St. Georges Society, an organization to help the poor. (Thompson 1968:166) This placed him in close contact to the Hon. Col. Joseph Wells, a member of the Executive Council and Bursar of King's College (Walker 1965:138); and John Kent, headmaster of Upper Canada College. (Walker 1965:130) In 1817 he retired from practise and accepted an appointment as Clerk of the House of Assembly and Principal of the House of Assembly. (Heagerty 1928:244) Around 1820 Powell was made Magistrate because of his Tory sympathies. (Firth 1966:112) and later Clerk of the Legislative Council. (Heagerty 1928:244) He also was a member of the short-lived Board of Health. (Firth 1966:247)

William Lee was appointed secretary of the York Board. His past was quite distinguished. After serving as a surgeon for the militia in the War of 1812 he was placed on half-pay but was also designated surgeon for the Home District and appointed Gentleman Usher of the Black Rod in the Legislative Council. (Bull 1934:27)

The careers of two other prominent physicians show evidence of help from sponsors. Dr. James Rolls obtained his degree in medicine in

England. When he presented his credentials to the Medical Board at York, Rolls was immediately granted a license to practise, 1832. Within five days the Chairman of the Medical Board of the London District ordered that Dr. Rolls be added to the membership of the Medical Board. It appears that Dr. Rolls was a friend of Colonel Talbot and the Hon. Peter Robinson; Commissioner of Crown Lands and both were members of the Family Compact. (Seaborn 1944:90) The day after Dr. Rolls' appointment to the London Medical Board this advertisement appeared in the St. Thomas Liberal:

Dr. Rolls, member of the Royal College of Surgeons, and of the Company of Apothecaries, London, begs to inform the inhabitants of St. Thomas and its neighbourhood that he is, at all times; ready to attend to town and country practise. N.B. Advice given gratis at drug store.

July 2, 1832
(Seaborn 1944:91)

Six years later Dr. Rolls was found to be a surgeon of the First Regiment of the Middlesex Militia. (Seaborn 1944:91)

Dr. Crouse was one of the few United States' trained physicians to secure a position as surgeon for the militia during the Rebellion of 1837. (Seaborn 1944:64) I suspect that his various careers as Councillor of the Talbot District, member of the first Norfolk Council, Reeve of Woodhouse and Warden of Norfolk, as well as his military duty, had been secured with the help of influential friends. (Seaborn 1944:65)

From the above we can see that these prominent physicians held some or all of the following characteristics.

All of these physicians, with the possible exception of Lee, were born in Great Britain, were Tories and therefore were included in a social network of influential people. Some had served as surgeons on

ships and for reasons which will subsequently be presented it is noteworthy that Widmer, Lee and Powell were surgeons in the militia in the War of 1812. Their military record may have highly recommended them to the Family Compact. Every member of the power elite had commanded in a civil or military capacity during the War of 1812. The Compact was a group with a finely developed sense of loyalty and an awareness that they had worked to keep American institutions and ideas out of Canada. (Saunders 1957:176) The surgeons had worked for this too. A feeling of comraderie on the elite's part, fostered by the British, may explain why British surgeons in Canada became the domineering parent of Canadian medicine.

While the aristocracy helped out relatively high status physicians whom they had come into contact with through marriage, politics, religion, participation in civil affairs and social events and the doctor-patient relationship (Firth 1966:222-59) still they remained skeptical of physicians in general. Since medical men knew very little about anatomy and physiology, patients from the privileged class were well enough educated to offer as competent advice on treatment as most physicians. Lacking basic knowledge of anatomy and physiology, simple, singular (monist) reasons were given to cover the cause of all sorts of illnesses. As an example, many illnesses were thought to be caused by impurities of the blood.

The letters of Reverend John Strachan (later Bishop Strachan and a member of the Family Compact), published in the Kingston Gazette show a skepticism towards members of the medical community. Although he refers to the practitioners as quacks, he implies that they are

quacks because they use opium and mercury. (Bull 1934:39) These medicines however, were used by the "qualified" physicians. He also describes his interference with the doctors' prescriptions.

As the woman was evidently getting better I threw the calomel out of the window after his departure and sent her some bark and wine.

(Bull 1934:40)

On another occasion Strachan found that a "medical attendant" had left a large dose of calomel and had placed three blocks of wood, heated in boiling water, against a sick man's body.

The poor man was sweating himself to death. I commanded the blocks to be removed, ventilated the room, sprinkled it with vinegar, washed his face and hands with it and he began to breathe. Another hour would have killed him.

(Bull 1934:40)

There is a definite lack of social distance between physicians and well educated laymen when the latter has enough confidence in their own skills and not enough in the doctor's to reverse the doctor's treatment.

With the Family Compact's control over the economic and political scene in Upper Canada and their skepticism of medicine's worth, it was impossible for the occupation of medicine to gain autonomy at this time because the distancing and uncertainty between patient and doctor, which was necessary before the medical community could begin to manoeuvre a transfer of power from the elite to medicine, was not there. As long as the Compact perceived themselves to be in the controlling position because physicians depended on them for favours, and they remained skeptical of medicine's worth, then they would not be willing to give up the power they had over medicine.

Up to this point we have dealt only with the more prominent physicians of Upper Canada. It is time then to look at the general picture of medical practitioners in Upper Canada to put the elite of the medical community into perspective.

By 1818 "the number of doctors in Upper Canada...who were possessed of a degree did not exceed forty in number, but the number of the unlicensed was multitudinous." (Seaborn 1944:43)

Before the Union of Canada 1841, physicians with formal education could be found in either the towns or attached to defense garrisons or land companies.

Prominent physicians remained in Toronto. This city was particularly attractive because in addition to being a port and the most settled city in Upper Canada, it was also the seat of government. Thus the city contained potential patients in powerful and influential positions. Not only were these patients a guaranteed source of income, they also controlled or were linked to appointments with salaries. Looking at the Board of Medical Examiners for Upper Canada in 1819 (Heagerty 1928:320) we see that the same practitioners, minus two, were still practising in Toronto in 1850. (Heagerty 1928:244) The elite of the community were still probably having a difficult time making ends

In his discussion of the Family Compact, Glazenbrook points out that "of the original group in York a Heward married a Robinson, an Allan a Gamble and a Macaulay a Crookshank. In the next generation marriages took place between a Jarvis and a Powell, a Gamble and a Boulton, an Allen and a Robinson, a Macaulay and an Elmsley, a Cartwright and a Macaulay. (Glazenbrook 1971:70)

meet merely by their salary from medicine because most had a second job. The fact that they had the time to take on more occupations than just medicine says something about the lack of patients.

Dr. Baldwin, the first non-military physician at York and a graduate of Edinburgh, found so few patients that he became a lawyer as well. (Glazenbrook 1971:29) Dr. J. Glenner must have been having similar difficulties because in 1807 he placed an advertisement, noting his training in Europe and his readiness to accept patients. (Glazenbrook 1971:29)

Glazenbrook explains the pattern of physicians taking on more than one occupation in this way: first of all, the market was not broad enough and secondly, in a town where so many things needed to be started, enterprising individuals had a lot of opportunity to dabble. (Glazenbrook 1971:31) In addition when a doctor's pay was not necessarily in money, another job would allow him to meet his bills. As currency was very scarce, a physician was usually paid in barter or promissory notes. Passing notes from person to person was generally accepted in lieu of currency. "Often the fee for a visit or consultation was settled immediately by giving a note." (Seaborn 1944:81) Settlers in the Peel area, which is now Mississauga, usually paid for medical attention with labour, produce and sometimes cattle. If a healer came from a long distance away families sometimes had to sell parcels of their land to pay. (Bull 1934:46)

The Crown favoured incorporated bodies such as the Canada Land Company grants of land as a means of settling in Canada. In return for a huge tract of land grantees would bring settlers over, transport them

to the land and oversee the growth of the community. Usually a physician was sent over with the group. James Cattermole was an English born and trained physician who came to Canada, secured a license to practise in Upper Canada and in 1832 became a physician to the Canada Land Company. He resided in Guelph for three years and then returned to England. (Seaborn 1944:191)

II. The Organization And Institutionalization Of Medicine In Upper Canada From 1800 To 1840

i) Regulation

Until 1791, Upper Canada, as part of the Province of Quebec, came under the Quebec Ordinance 1788. As an independent province in 1796 the Parliament of Upper Canada passed an Act to enable the Governor of Upper Canada to appoint a Medical Board composed of the surgeon to his Majesty's hospital, and another physician from the surgeons of his Majesty's regiment or authorized surgeons and practitioners. (Anderson 1926:446) No one was permitted to vend, sell or practise physic, surgery, or midwifery within the province for profit, unless examined and approved of by a Board of Surgeons, and licensed by the Board. In the backwoods of Ontario it was unreasonable to demand that only a licensed surgeon could handle midwifery cases and the Act was repealed in 1806. After the repeal nothing took its place for nine years. On March 14th, 1815 an Act to license practitioners in physic and surgery was passed. It was repealed 1818 because the "provisions were found

to be impracticable." (Heagerty 1928:320) The new Act of 1818 included the licensing of practitioners in medicine. The subsumption of healers under the term practitioner marked a breakdown of the guild divisions which had been brought over from England.

(Bull 1934:44; Heagerty 1928:320) Canada was too unsettled to have a division between medicine and surgery and so all Canadian physicians were general practitioners in the sense that they practised both. (McWhinney 1972:231)

The qualifications for examination were far from exacting; applicants had to either have attended lectures in medical school or apprenticed to a well-known physician and surgeon. (Seaborn 1944:37) Since there were no medical schools in Canada it was unreasonable to demand a medical degree. The Act of 1818 exempted graduates of British universities and military and naval surgeons who could claim "honourable participation in the War of 1812," from having to appear before the Board. (Seaborn 1944:37) The exemptions, particularly the latter one, sound like policies which the Family Compact would support. It also sounds as though the founding fathers of medicine in Canada, who were retired army surgeons (McWhinney 1972:231) were imposing their values on the rest of the medical community.

The Act of 1818 specified that an Examining Board should meet twice a year. (Heagerty 1928:320) In order to implement the Act, the Lieutenant Governor, Sir John Colbourne, appointed Widmer, Gwynne, Hornby, Telfer, Nichol, King, Beaumont, Herrick and Clark to

constitute the Board. (Heagerty 1928:320)

The rapid increase in the number of qualified physicians in York from two in 1814 to at least seven in 1821; their high ranking in the social circles of the city and their excellent medical education were probably the factors responsible for the formation of the first city Medical Board. (Heagerty 1928:321) The members of the York Medical Board were Macaulay, Widmer, Lyons, Kerr, Baldwin, Powell and Lee. (Heagerty 1928:321) "Intimately associated with the ruling families of that day and connected by marriage with many of the prominent families in Upper Canada, Drs. Macaulay, Gamble and Baldwin exerted a wide and salutary influence, socially and professionally on the medical interests of York and the province in general." (Anderson 1926:448) Since they trained at Edinburgh I would assume that they used its standards to measure a doctor's qualifications.

It was very difficult to sort out the histories of the two separate Boards because most historians do not acknowledge that there were two. When Bull stated that in the first year only eight physicians were admitted to practice and in the second year four, it was impossible to discern whether he was talking about York or the whole of Upper Canada. (Bull 1934:45)

From Bull's account the Medical Board of York forcefully imposed its will upon the medical community.

Exulting in its prerogatives, the Medical Board dealt almost ruthlessly with applicants seeking the right to minister to suffering humanity. It set its own standards, and took no cognizance of beribboned parchments flourished by aspiring candidates. The Board was skeptical of diplomas, for many were spurious.

(Bull 1934:44)

While university graduates were exempted from examination, members of the London College of Surgeons and the Royal College of Edinburgh were not. (Bull 1934:45) The latter was offended by the two Boards discrediting of their credentials. Complaints concerning this discrimination must have been numerous because in 1827 London College licentiates were given the same recognition as university graduates. Following this, other independent medical colleges, including the Colleges of Surgeons of Edinburgh and Dublin and the Faculty of Physicians and Surgeons of Glasgow also claimed exemption from examination by the Medical Board. Finally in 1839 their Claims were responded to. In that year the College of Physicians and Surgeons of Upper Canada was incorporated. It admitted members and licentiates of every organized College and Faculty of Physicians and Surgeons in the United Kingdom. (Bull 1934:49)

Complaints concerning discrimination against London College licentiates formed only a portion of the discontent with both the York and Upper Canada Medical Boards. I would suspect that part of the dislike of the York Board stemmed from its connections with the Family Compact. Here was a small group of men with ties to the aristocracy, who were trying to impose their will on the medical community of the district.

Dissatisfaction grew to such an extent that the physicians of York met January 14th, 1836* to draw up some resolutions, to be presented to the Lieutenant-Governor, dealing with changes to the constitution of the Medical Board. (Heagerty 1928:242) During the meeting it was alleged that since members of the Board lived far away from the centre of activity, it was impossible for them to properly carry out their duties. A strongly worded resolution was passed declaring it "contrary to the practice in other countries, and manifestly inexpedient, that two or three medical practitioners, holding their inquisition in utter darkness, should have from year to year the power of pronouncing without appeal on the professional merit of their own pupils, or those of others with whom they may possibly be at variance." (Bull 1934:82)

When the occupation of Upper Canada institutionalized a procedure for differentiating between qualified and unqualified healers it introduced an instrument which certain members could seize in their bid for power and thereby impose their values on the specific community. Thus a dual system (regular vs. irregular) introduced the potential for conflict and competition which in turn retarded the move towards organizing the professions. (Johnson 1972:73)

In spite of these manifestations of hostility, the Board carried on. Its membership included Hornby, Gwynne, O'Brien, King, Baldwin, Horne, Sampson, Diehl, Ridley, Stratford, Durie, Hamilton

*By the mid 1830's the more populated districts, villages and towns of Upper Canada were fairly well supplied with physicians, but the sparsely settled districts were devoid of practitioners. (Heagerty 1928:242)

and Telfer. (Bull 1934:83) Taking a moment to see if and how these men are related to one another, Drs. King and Baldwin were both magistrates and therefore knew one another at least through meetings. (Firth 1966:lxix) Drs. King and Diehl were associates at the York Hospital. (Bull 1934:62) Dr. Baldwin, a graduate of Edinburgh, was the first civilian practitioner in York. Dr. Hornby belonged to the St. Georges Society of Toronto which put him in touch with influential members of the community, among them Dr. Powell, a former member of York's Medical Board. (Thompson 1968:83-94) Bull claims that all medical administration fell within its jurisdiction but in this era I am not sure if this amounted to much because the occupation was too unstructured. (Bull 1934:83) For instance in 1838 it drafted an informal schedule of professional fees. (Bull 1934:83) It had to be informal; who could enforce the schedule in the wilderness? In short, it seems irrelevant to the situation.

In 1836 the Medical Board of Upper Canada was reorganized and enlarged and the following were the members: Widmer, Baldwin, Ridley, Stratford, Grant, Powell, Horne, Sampson, Diehl, King, Rolph, Duncombe, Harnley, Lathan, O'Brien and Morrison. (Heagerty 1928:324) By comparing this list with York's we can see that of the seventeen physicians, eight were on the York Board.

ii) Societies

York was also the setting in 1833 of the formation of the first medical society in Upper Canada; the Medico-Chirurgical Society. Its primary object was "the interchange and advancement of professional

knowledge among the members of the profession." Dr. Widmer was elected president and Dr. Stephenson, secretary. Membership was limited to only the regular physician. (Heagerty 1928:285) For the next forty-five years it experienced short, intermittent periods of activity. (MacDermot 1967:152)

The medical students of York also started up their own Medical Society in 1832 to enable them to exchange information with others on the various branches of medical science. They were relatively selective as a recruit had to submit his name to the Secretary of the Society for approval of admittance. (Heagerty 1928:285) In the same year a Quebec Students Medical Society was instituted. (Heagerty 1928:285)

iii) Summary

Any history of Canadian medicine should mention that regardless of the regulatory laws for the practice of medicine they were only as useful as the situation in Canada would allow them to be. When there were so few regulars and most people could not afford them, the lay healer was usually their first choice. Even people in a position to direct policy could see the usefulness of irregulars. Bishop Strachan's alternative medication to the regular's was a well known lay remedy. Mrs. Jameson in Winter Studies and Summer Rambles (1972:29) mentions using Bayberry Bark as a remedy for ague. This was a favourite remedy of the Thompsonians Sect of healers. (Bull 1934:75). Some of the irregulars had such good reputations that some courts of law upheld their claims for payment of fees.

As a final point on the regulation of physicians, I was left with the impression that it was not the calibre of practice which caused the Government to interfere before 1840 with a doctor's livelihood, but rather his political sympathies. When Dr. Oliver Smith gave his reasons for refusing to join Family Compact forces to fight in the Rebellion of 1837, the government jailed him December 1837 for "seditious utterances" and acquitted him March 1838. Although he was never found guilty, they jailed him for a year, confiscated his two hundred acres of land and cancelled his license to practice. (Seaborn 1944:97)

As a final illustration of how easily people could fall out of grace with the establishment, Dr. Charles Duncombe was a member of the Medical Board, appointed surgeon to the second Middlesex Militia and became a member of the Legislature for Oxford in 1834; but after the Rebellion of 1837 the Government offered 500 pounds for his capture as a Reformist sympathizer. (Heagerty 1928:89)

From the evidence available it seems that physicians openly sympathetic to William Lyon Mackenzie were labelled as quacks, regardless of their qualifications, giving the Medical Board a legitimation for removing the physician's right to practise if they decided to pursue that course of action. (Bull 1934:83) The Toronto Patriot of October 12, 1838 provides an example of the propaganda which the Family Compact spread concerning "rebel" physicians:

All know how numerous have been the self-styled doctors implicated in the rebellion, but perhaps all may not know that they were almost one and all Yankee quacks. We are truly glad to see that the Medical Board are active in setting about means to annihilate the dirty birds.

(Bull 1934:84)

It is interesting to note that the Tories of Canada were consistent in their dislike of Americans; even American medicine was perceived to be inferior.

On the other hand, no tribute was too high for those doctors who actively served on the government's side. Dr. McCague who had been a surgeon with the militia was described in his eulogy as "particularly distinguished...for his bravery and exertion."

(Bull 1934:84)

Once again we are reminded of how important it was under oligarchic control to a physician's career to remain in the good graces of those in power. (Johnson 1972:67)

The Rebellion has a generally disruptive effect on all of medicine. In Lower Canada the Medical Faculty of McGill suspended lectures while in Upper Canada the formation of a permanent institutionalized medical school was delayed.

At this point I think it would be beneficial to make a few comments on Terence Johnson's Power and Professions in light of the data from Upper Canada. Johnson's book must be considered to be a prelude to an exciting perception of profession. Nonetheless, as merely a preface, it leaves the reader responsible for further enlargement of his preliminary paradigms. Theorists must take data from actual cases and using Johnson's theoretical structure as a

guideline, enlarge on points, generate substantive theory and possibly refine or revise Johnson's hypotheses. To illustrate this point, let us look at Johnson's presentation of the concepts of "dual system of practice" and "practitioner".

Johnson never qualifies his use of the term "practitioner". Therefore one is never certain as to whether he is referring to the practitioners with the highest status within the hierarchy of the occupation or all licensed practitioners. This differentiation is necessary to refine his hypotheses.

There is also a problem with his concept of dual system of practice. Johnson states:

The hierarchical fragmentation of the occupation may even be systematically expressed and institutionalized as dual systems of practice within a single occupation. The existence of an elite monopolizing occupational service in a traditional context does not, of course, eliminate the needs of other social groups, which tend to be catered for by subordinate occupations and even in terms of divergent systems of knowledge.

(Johnson 1972:69)

On what basis though is the dual system of practice determined? Would the first system merely encompass the elite of the occupation and the second system include the lower status members of the licensed occupational community? On the other hand the dual system may be formed on the basis of licensed and unlicensed practitioners.

Just from the above one can see that Johnson does not provide an inclusive enough formulation to be able to plug data into it. Further expansion and refinement is necessary before the latter can happen.

III. The Organization and Institutionalization of Medicine in Lower Canada 1800 to 1840

i) Regulation

The first attempt at organizing and regulating the occupation of medicine in Lower Canada was initiated by the surgeon of the garrison at Quebec. Around 1783 a Committee was appointed within the Legislative Council to encourage Agriculture and to consider means to increase the population of the Province of Quebec. Dr. Fisher, surgeon of the garrison at Quebec, took this opportunity to introduce a long Memorandum on the uncontrolled state of medicine in the country, suggesting that a decrease in the death rate would do more to increase the population than anything else. As a remedy he suggested the formation of Bureaus of Medical Examiners at the towns of Montreal and Quebec. As a result of his suggestions, a Bill was brought in at a meeting of the Quebec Legislative Council to regulate the practice of medicine. In 1788 the Medical Act became law. (Abbott 1931:47)

Thereafter no one could practice physic, surgery or midwifery in Quebec City, Montreal or their suburbs without a license from a Board appointed by the Governor. Physicians from the district of Quebec and Montreal were appointed as examiners. (Heagerty 1940:87) A license could be granted by presenting suitable degrees or diplomas or by submitting to examination. (Anderson 1926:446) At that time a degree from a British university recognized by the board or a diploma from a school in the States were satisfactory. Then in 1808 Lower

Canada began to require that persons legally qualified in the States had to be qualified again by the Board of Medical Examiners for the District of Montreal. (Abbott 1931:51)

Manoeuvres like these suggest that it is easier to persuade those in power to take certain steps when they know and trust the persuader. In addition, the persuader's task is made much easier when he knows the persuadee and can use the persuadee's philosophies to present a convincing argument. It is quite apparent that Dr. Fisher used one of the elite's goals (population growth) to persuade the elite to take steps which would further the occupation of medicine. Now the elite of the medical community began to have at least some legal control over medical workers.

By 1818 Lower Canada's Medical Act of 1788 was unsuitable to the growing needs of the country. While it was repealed that year it was difficult to propose legislation to replace it which would please both English and French Canadian parties. For fifty-eight years laws were established and then repealed. (Abbott 1931:71)

In Lower Canada the occupation of medicine not only had to contend with the tensions created by the dual system of practice but also with the conflict between English and French cultural identities. Thus not only were ill feelings created because physicians advanced more by their connections, than their skills; but in addition French physicians fought with the English to maintain as much power as their English counterparts.

One of the Repeals in 1831 stated that physicians, surgeons and man-midwives were not to practise without a license. The Examining Board was to charge for examinations and for issuing certifications of an individual's credentials. To obtain a license a student had to be at least twenty-one years old and have served a regular apprenticeship. The examination was not necessary for university graduates. Under the new law an apothecary had to be twenty-one years and have served a regular apprenticeship. (Heagerty 1928:323) Licensed Physicians and Surgeons and Midwives in the districts of Quebec and Three Rivers were eligible to serve as members of the Board of Examiners and to vote for members of the Board. (Heagerty 1928:284) Doctors could be appointed to the Board as they were in Upper Canada. Although these laws did provide regulations, the primitive state of the country made it difficult to enforce them so that anyone who wanted to practise the art of healing could do so.

ii) Societies

Shortcomings in transportation made it difficult for practitioners to meet and therefore in the early 1800's there was very little administrative structure to the occupation. Any organization was carried out on a local scale and initiated by a concern for the public's perception of medicine. In 1825 the regulars of Quebec City sent a petition to the Lieutenant General, Sir James Kempt (administrator of the government of Lower Canada) protesting that the laws of regulation were inefficient and that the consequential surplus of irregulars practising the art of healing was doing great

injury to the Public and increasing to an alarming degree the prejudice towards the profession. (Heagerty 1928:283) The next year the Quebec Medical Society was founded. (Gosselin 1907:11) Its stated aims were the dissemination and improvement of various branches of medical science: natural history, botany, chemistry, pharmacy, materia medica, physic, surgery, anatomy, physiology, medical jurisprudence, medical policy, and obstetrics. (Heagerty 1928:283) By stressing the science of medicine the society could improve medicine's image. The Society was also founded to organize and regulate medical practice so that only regulars could belong to the community. (MacDermot 1967: 152)

The President, J. Morrin: Vice-President, C. Perrault and Secretary, Tessier of the Society were respectively, members of the editorial committee and editor of the bilingual Journal de Medicine de Quebec.^{*} This was the first medical journal in Canada, 1826 to 1827. (Abbott 1931:67)

The overlapping of the members of the Quebec Medical Society with the Journal de Medecine de Quebec leads one to wonder if there were other instances of small groups of prestigious, energetic individuals attempting to organize the occupational structure of medicine in Lower Canada by any means at their disposal. The establishment of the Montreal General Hospital and the Montreal Medical Institution, its affiliation with McGill University and the reconstitu-

^{*}There appears to be some confusion as to who the members of the Executive were. According to Gosselin, Xavier Tessier was President, J.B. Blonchat was Vice President and Fremont was Secretary. (Gosselin 1907:11)

tion of the Board of Examiners from Montreal provides an illuminating example of how much easier it is to define an occupation, to build an occupational structure and begin to demarcate the boundaries of the occupation when you have friends in powerful positions helping. This point is covered in detail in the section on education in Lower Canada 1800 to 1840.

IV. Medical Education in Upper Canada from 1800 to 1840

Medical education can be divided into two categories: informal and formal. By the use of the term informal I am referring to the skill and knowledge one picks up through experience and an apprenticeship with a physician. On the other hand, formal refers to established medical schools. At times it was difficult to determine whether a school run by one physician and having several students should be placed under the category of informal or formal. I decided to place them under informal because with only one teacher it seemed too much like an apprenticeship to be included under the formal category.

a) Informal Education

Beginning with informal modes of education, the apprenticeship system was used by those individuals who could not afford to travel outside of Canada for an education. The system was at times very useful to both the apprentice and master. For some students apprenticeship was a means of establishing important contacts for future business. If the master was influential in a community, then living with him carried the extra advantage of making contacts with

other leaders of the community. (MacDermot 1967:111) The system was also very advantageous to the master not only in terms of the additional revenue he gained from tuition fees, but also after his apprentice had had some training he could send his younger "partner" out on routine calls and emergencies. This saving of time left him free to pursue other interests. Dr. Charles Duncombe acted as tutor for both of his brothers. Elijah acted as Charles' assistant in dispensing medicines and attending patients for seven years. (Seaborn 1944:78) During this time Charles was a military surgeon and a commissioner for the Welland Canal. (Seaborn 1944:73) Dr. Goodhe, who was known to have taken in at least one student, practised medicine and ran a store in St. Thomas. (Seaborn 1944:82)

Previous to the arrival of institutionalized medical schools we find private classes giving medical lecture series. In the 1830's Dr. Rolph established a private medical class and lectured to a small group of students. Although urged by the Lieutenant Governor to establish a permanent medical college his political views prevented him from complying. Rolph took part in the Rebellion of 1837 and was obliged to flee to the United States. (Anderson 1926:450)

Another physician seems to have conducted private medical classes in the 1830's. Dr. John Crouse, a graduate of Fairfield Medical School, western New York State, is rumoured to have conducted a medical school. Although his training was not equivalent to Rolph's it is conceivable that he had students coming to him for medical training because he was well regarded in the area. He held

many municipal and other offices. He was Councillor of the Talbot District, member of the first Norfolk Council, Reeve of Woodhouse and Warden of Norfolk; Commissioner for the erection of a jail, and a member of the building committee of the Congregational Church. (Seaborn 1944:65)

b) Formal Education

Turning to more formal types of education, schools in both provinces were influenced by three approaches to the study of medicine. Each approach will be given the name of the city in which it gained its strength.

Models

1. Edinburgh Medical school affiliated with a university
 Combined lectures and clinical observation
2. France Correlated clinical features with laboratory
 findings and autopsy.
3. London Combined hospital and out-patient clinics
 with the school. (MacDermot 1967:111)

When medical schools began to be established in Canada, each felt the distinctive touch of the philosophies of the school from which its founders had graduated.

Before 1840 there were no medical schools in Upper Canada. Therefore individuals in Upper Canada who wanted to attend a medical school had to leave the country or try to get into McGill. Canniff's History of the Medical Profession in Upper Canada 1783 to 1850 provides some insight into general trends of where physicians

went to obtain institutionalized schooling. Of the 260 doctors of Upper Canada between 1783 and 1850 whom he had investigated: 70 graduated from Scottish universities; 43 from English; 28 from Irish; and 40 from American universities. (Heagerty 1928:235)

There had been one attempt to establish a medical school in the Talbot settlement, St. Thomas, 1824, by Drs. Rolph and Duncombe. Colonel Talbot even put up the money but withdrew his support two years later when he discovered that its founders were supporters of William Lyon Mackenzie. (Heagerty 1928:72) There were no graduates.

In addition, the establishment of a medical faculty had been included almost from the start in plans for University College. At the second meeting of the College Council, 1828, considerations for a medical faculty were evident in discussions on suitable locations for the University buildings. It was argued that the buildings should be close to town so that students could have easy access to medical practice and lectures in the hospital. (The Librarian 1906: 168) According to the Chancellor of King's College one of the objects in opening a university in Upper Canada was to enable individuals to prepare for a professional life within Canada, rather than going outside of the country. Medical education was included under professions.

The Council of King's College did not entirely agree with the Chancellor. While they felt that a primary medical education was feasible, they did not feel that it was wise to invest a great deal

of the funds of King's College in setting up courses to qualify men for the medical profession. They believed that the profession of medicine in Ontario was not attractive enough to induce parents to send their sons to a university providing medical education. (The Librarian 1906:169)

In 1837 the new Chancellor, Sir Francis Bondhead, agreed to the plan submitted by the President of King's College for the division of the field of instruction. There were to be six departments, of which Medical Science was one. In regard to the department of Medical Science, one professor and three lecturers were to be appointed. They were not to reside within the university and their hours for teaching were to be arranged so as not to interfere too much with their practice in the city. (The Librarian 1906:169) The lecturers in Anatomy, Medicine, Surgery and Materia Medica were to receive a salary of 200 pounds each. Just as these preliminaries were about to be arranged the Rebellion of 1837 broke out (The Librarian 1906:169) and plans were suspended for a while.

In 1839 the Education Commission released a report which pointed out the serious consequences to Canadians by not having a university which could qualify the student in Divinity, Law or Medicine. In the same year the College of Physicians and Surgeons of Upper Canada applied to the Council of King's College for aid in establishing a medical school. The Council replied that it hardly felt justified in extending aid to any other corporation until they had first obtained the objects for which they had been incorporated;

instruction in all branches of a university education. (The Librarian 1906:169)

At this stage of its development Upper Canada did not seem ready for institutionalized medical education. After the medical school in the Talbot Settlement folded it took until the 1840's for others to appear. I suspect that this could partially be explained by the disruptions of the Rebellion of 1837 and also by the small degree of regulation over the occupational community. When legislation could not be enforced, when standards for obtaining licenses were low (i.e. one term at a medical school in the States) there was no urgency to establishing medical schools. An individual could simply train with the physician of his choice and then be examined by the Board to obtain a license.

V. Medical Education in Lower Canada 1800 to 1840

Lower Canada had the same kinds of informal education as Upper Canada but this province was much further ahead of Upper Canada in terms of formal, institutionalized education. This was probably due to Lower Canada's earlier start in economic development, and to the discipline and stimulation provided by the presence of the British army. (Abbott 1931:56) Montreal's high level of activity in all spheres was advantageous at this point as she was to face the most difficult crisis yet. Immediately after the War of 1812 a wave of peasant immigrants from England, Scotland and Ireland swept into the ports of Montreal and Quebec City. Arriving in poor health and with little or no money, they were unable to secure employment and had

to depend on charity to keep alive through the winter months. The year 1817 was particularly bad because the crops failed and the depression spread. The problem was so severe that the provincial Parliament was called on for help and the Governor announced the passage of a Bill to provide wheat and grain to the poor.

Care of the sick was an acute problem. A petition was presented in the House of Assembly 1819 by Mr. Molson "praying for the erecting and endowing of a Public Hospital in Montreal." At the same time the prominent physicians of Montreal were appalled at the state of the occupation of medicine and had concluded that conditions would change only if the regulatory legislation was accompanied by the establishment of medical schools. When Mr. Molson presented his petition, Dr. Charles Perrault, an eminent physician in Quebec (and a future editorial board member of the Journal de Medecine de Quebec) must have seen the opportunity to push for the advancement of medicine, judging from his speech in the House of Assembly.

Independent of the good which must result from the establishment of a well-regulated Hospital to humanity at large, another no less important object is obtained by establishing in such an institution a school for teaching the healing art in all its branches.

(Abbott 1931:58)

Evidently the medical community began to stress the service orientation of medicine right from the start. In other words, the primary objective of the medical community was to administer to the needs of Canadians, not to earn a profitable living.

Nevertheless, public funds were not used to establish a teaching hospital as opposition in the House caused the petition to be laid aside. Private charities tried to alleviate the crisis in medical care. The Female Benevolent Society established a small hospital to house the sick and arranged for physicians to volunteer their services. From the beginning the "House of Recovery" was too small so the Female Benevolent Society raised additional funds and leased and equipped in 1819 a somewhat larger house on Craig Street. Four professional gentlemen were appointed as medical staff. John Stephenson also acted as house surgeon. On May 1st., 1819, the building was opened and named the Montreal General Hospital. Once again facilities were found to be inadequate and a fund raising campaign was launched in 1820. Citizens of Montreal subscribed 2,167 pounds and the remaining 3,689 pounds formed a debt which was entirely paid in 1823 by the Honourable John Richardson who later became the Hospital's President. (Abbott 1931:57) Two wings were added to this building, one in 1831 and the other in 1848. (Abbott 1931:58)

Three months after the opening of the new Hospital building, August 9, 1822, Dr. Stephenson began to advertise in the Gazette that he would begin lectures there on anatomy and physiology in the fall, and surgery in the spring. (Abbott 1931:58) Drs. Holmes and Stephenson began in 1822 to give a systematic course of medical lectures. Chemistry was taught at Dr. Skakel's school and anatomy

and physiology at the Montreal General Hospital.

From its inception in 1819 the Medical Board, Drs. Holmes, Stephenson, Robertson, Caldwell and later on, Henry P. Loedel; had dreamt of the hospital as the headquarters of a medical school and as a teaching centre for students. As in Edinburgh's Medical School in Scotland, the students would be freely admitted to wards. (Abbott 1931:58) Practical training was to be as important as lectures.

Since one of the emphases of this paper is the social networks which were built as the occupation of medicine organized itself, let us take a look at the group of men who sat on the Board of the Montreal General Hospital. By doing this we might also be able to answer the questions: "Did the leaders of the community hold common characteristics?" and "Had the lives of the elite intersected more than once because of a common social network or schooling or a work assignment?"

Beginning with Dr. Holmes, he received a classical education at Dr. Skakel's School in Montreal. This could explain why he was able to teach chemistry here in 1822 as part of his series of medical lectures. Returning to 1811, he apprenticed with Dr. Arnoldi, received his license and then travelled to Edinburgh where he received his degree of M.D. from the University. During his time in Edinburgh he made friends with a Canadian, John Stephenson. (Abbott 1931:52)

Stephenson had apprenticed in Montreal under William

Robertson, and then left for Edinburgh, where he received his M.D. in 1820 and the Fellowship of the Royal College of Surgeons of London. (Abbott 1931:53) Both men decided to take on additional study in London, Paris and Dublin. From the foregoing it appears that both men were from wealthy families. In 1821 they returned from abroad and set up practices in Montreal. For his first five years of practice Dr. Holmes was in partnership with Dr. Arnoldi. (Abbott 1931:52) The latter was a common friend to Dr. Holmes and Henry Loedel Sr. (Abbott 1931:45)

I could find very little on Henry Loedel Jr. other than his time on the Montreal Medical Institution's Board was shortened by his death from typhus in 1825 while caring for stricken patients at the Montreal General Hospital. (Abbott 1931:61) One medical historian, Maude Abbott, found through deeds at the Montreal Archives that his father was a man of means and that he held a partnership of property with Dr. Blake.* From their accounts Abbott discovered that Henry Loedel Senior had had William England as a patient. He had owned the land on which the Montreal Hospital was built 1824. (Abbott 1931:45) Although Abbott gave no explanation for the seeming coincidence, it was not unusual for people to give blocks of land to

*Abbott's comments on financial statements concerning the partnership provide insight into the kinds of patients they saw. Their clientele ranged from the prominent classes to the tradespeople, but no lower. Their accounts seem to indicate that they perceived differences between the wealthy and tradesmen. While they recorded the accounts of their wealthier clients in a very formal style they called their middle class clients by their first name and noted their trade beside the name. (Abbott 1931:45)

physicians in lieu of cash payment. (Bull 1934:68) Realizing the financial plight of the Montreal Medical Institution and having a son on its Board, it would seem reasonable for Dr. Loedel to donate the land to the Institution.~ Unfortunately I cannot establish if his son was appointed to the Board of the Institution before or after the land was transferred to the Montreal Medical Institution.

William Robertson was also an Edinburgh graduate. He came to Canada in 1808 while serving in the 49th regiment and saw action in the battle of Queenston Heights in the War of 1812. In 1813 he retired on half-pay and settled in Montreal. From 1817 on Robertson sat on the Montreal Board of Examiners. Perhaps this was the way the Chateau Clique rewarded him for his gallant efforts during the War. It does seem unusual that he be allowed to examine others when he did not have a license himself. In 1828 he went through "the formality" of applying for a license to practise in Lower Canada. (Abbott 1931:54)

Dr. William Caldwell held the degree of M.D. from the University of Edinburgh and had been a surgeon in the 13th regiment of Dragoons. In 1819 he moved to Montreal where he obtained a staff position at the Montreal General Hospital. (Abbott 1931:53)

In summary, at least four of the five members of the Montreal Medical Institution had received training at Edinburgh; two members had fought in the War of 1812;* all but one had known one

*A doctor's participation in the War of 1812 could help his career in Lower Canada too because the Chateau Clique who were the power elite of Lower Canada were British and they held the same strong feelings concerning the War that the Family Compact held.

another either personally or through mutual friends and at least three had come from wealthy families.

In 1822 these individuals forwarded an outline of the reasons for needing the school and lectures to be given to Lord Dalhousie. Along with the request though, was a letter from Dr. W. Robertson suggesting "that in order to give the new Institution legal status, the Board of Medical Examiners for the District of Montreal should be reconstituted and made to consist of the Medical Officers of the Montreal General Hospital." (Abbott 1931:59) Dr. Robertson sent the letter because he was sitting on the Board of Examiners at that time and was therefore the only one from the Medical Institution in the position to make the request.

In a later letter he strengthened his suggestion by pointing out that the only active members of the Board were Drs. Daniel Arnoldi, Henry Loedel and himself. Since Arnoldi was the friend and past teacher of Holmes, and Loedel was the father of a member of the hospital staff, it seems likely that their cooperation had been secured before the letter was sent. (Abbott 1931:59)

After further correspondence the Governor-in-Chief, Lord Dalhousie, agreed to Robertson's suggestion of a reconstituted Board of Examiners. Dalhousie wrote Drs. Arnoldi and Loedel explaining that the omission of their names from the new Commission was due to a remodelling of the Board, not to disapproval of their services. Henceforth it would consist of persons holding diplomas or testimonials from Medical Institutions in Great Britain and those people who were

at present Medical Officers of the Montreal General Hospital, which was about to be incorporated.

In effect, the new prerequisites for the Board, gave the power to direct the course of medicine in Lower Canada only to persons trained in Great Britain. The radical "Free Press" reported that this policy was just another of the Chateau Clique's high handed measures aimed at keeping out anyone but the elite from positions of power. When you consider that Lord Dalhousie had reconstituted the Board and the President of the Hospital, John Richardson, who was part of the aristocracy and a Tory, had paid off the debt of the hospital (Jenkins 1955:255, 272, 276) then you can see that the opposition political party would perceive the Medical Faculty and the Medical Board as under the control of the Chateau Clique.

On February 22, 1823, Lord Dalhousie issued a Commission appointing any three or more of Drs. Robertson, Caldwell, Stephenson, Holmes and Loedel to be the sole medical examiners of the district. (Abbott 1931:59)

This was one of the first examples of the conflict which ensued when the elite of the medical community motivated by a desire to improve the situation of medicine in Canada, took steps which took away power from the lower status members of the medical community and ensured that they would remain in a powerless position. While the actions of Lord Dalhousie were motivated by a concern for the educational advancement of medicine in Lower Canada at a time when standards were low and competition keen (Abbott 1931:59), it was keenly resented by those members of the community who were ineligible for appointment to the Board.

The new Montreal Medical Institution began to hold lectures in 1824 on the following topics: Principles and Practice of Medicine; Surgery, Anatomy and Physiology; Midwifery and Diseases of Children and Chemistry, Pharmacy and Materia Medica. (Birkett 1939:323)

Lord Dalhousie then began to insist that a proposed charter be drawn up and submitted to the Solicitor General. This caused a delay of eighteen months in the progress of the Medical Institution for when it was submitted in 1826 objections were raised that the school was not associated with any "Seminary of Learning" and that it had no endowment or foundation. Even when the officers pointed out that the Colleges of Surgeons of London, Edinburgh and Paris had begun in the same fashion, the Solicitor General's mind could not be changed. Without a legal standing the school could not confer degrees.

Undaunted the Officers of the Montreal Medical Institution saw a way out of their dilemma. They approached Sir James Kempt, administrator of the Government of Canada, with the suggestion that they be appointed as Professors to the chartered McGill College. After some correspondence between the Montreal Medical Institution and McGill University the two bodies met to confer the necessary Charter and Foundation on the Institution on June 29, 1829. This step saved McGill College because it had to immediately begin active educational work to meet the time limit in the Founder's bequest. This was an extremely difficult task because the teaching staff was only on paper with a nominal appointment of five professors. With a new and active medical faculty teaching under the name of the College

began immediately. (Abbott 1931:60)

During the next twenty-five years, almost all of the activities of McGill University came from its medical faculty. It expended a great deal of energy in settling a lengthy litigation with the heirs of the McGill estate. It seemed that the heirs did not feel that the university deserved its bequest of ten thousand pounds. The Governors of McGill University gave the Medical Faculty authority to use any means to obtain a settlement and appointed Dr. John Stephenson University Registrar. (Abbott 1931:60)

The medical Faculty of McGill were also the ones to get legislation passed so that the Medical Faculty could begin to confer University degrees. The Royal Charter had given the Governors of McGill University the authority to confer degrees and diplomas but the University was not yet empowered to grant Degrees and Diplomas. (Abbott 1931:60) The Medical Faculty presented their problem to the Solicitor-General. They asked that he might consider putting into motion measures to empower the University to grant degrees to candidates who had completed the course of studies and been successfully examined by the Medical Faculty. At that time a Canadian who wished to receive a degree in medicine in 1831 had to travel to Europe or the United States. In response the Solicitor-General advised that, under its Charter, the University must first receive royal sanction of its statutes, before it could attain the power to confer degrees. Two days later, Dr. Stephenson presented a copy of the "Statutes, Rules and Ordinances of the Medical Faculty of McGill University" to the Solicitor-General in person. This was forwarded to London and

eight months later the Faculty received word that the Crown had approved the Statutes and the conferring of Professorships in the Faculty of Medicine on all four gentlemen recommended to him. (Abbott 1931:60) The Medical Faculty of McGill College were now empowered to confer degrees on graduates. The latter still had to appear before the Board of Examiners to obtain a license to practise. Thus from the inception of medical school education in Canada the licensing body was separated from the medical school. This characteristic which was distinctive from the United States (MacDermot 1967:102) becomes significant in the 1880's when the University of Toronto was trying to eliminate proprietary schools in Ontario.

While one may immediately conclude that a separation of medical school and licensing board would encourage high standards in medical schools, this may be a fallacy. To explain further, the Provincial Board of Examiners for Lower Canada was not an impartial body because it was composed of the Medical Faculty of McGill University. In light of the fact that they chose to recognize only certain colleges in Great Britain and therefore tended to impose their own values and beliefs regarding adequate education on others of the medical community, one wonders whether the Examining Board was merely a rubber stamp for McGill graduates.

Up until 1854 it appears that the Faculty of Medicine was the voice for McGill University. It also appears that they were given full rein by the University to take any action which might benefit them. For the first medical school in Canada, it was a

relatively powerful institution.

Although the Montreal Medical Institution was now part of McGill University it maintained its teaching facilities at the Montreal General Hospital on Dorchester St.. In every respect it operated as a private institution; neither the rent nor the salaries of professors were paid by McGill. When the Governors suggested that the Medical Faculty be given two rooms of the general university building the Medical Faculty suggested an alternative rent allowance because the campus was too far away from the hospital. The Board of Governors agreed. (Heagerty 1928:65) When the Rebellion of 1837 began the Medical Faculty of McGill suspended lectures for one year. (Heagerty 1928:65) This seems surprising since the rebellion was not widespread or very serious and lasted a very short time. One begins to wonder if there were ulterior motives for closing the school for a year. Whatever the motives the loss in student fees for the year must have been felt by the Medical Faculty. In 1839 the medical school found itself so handicapped by a lack of funds that it appealed to the Board of Governors of McGill for financial aid. The Board in turn applied to the Royal Institution for a grant but was refused. The Medical Faculty were thus forced to carry on without aid. (Heagerty 1928:65)

More informal modes of medical education were provided by Drs. Blanchet and Douglas. In 1823 Dr. F. Blanchet, von Iffland, Whitel and others established the Quebec Dispensary and lectured there on surgery, medicine, anatomy and physiology. After two years the

Dispensary was closed for lack of funds. (Abbott 1931:50)

In 1826 Dr. James Douglas began lectures and demonstrations on anatomy in the cellar of his house in Quebec City. A year later he moved his lectures into a small house which had been given to him by Dr. Painchaud in return for free admission to the lectures for him and his son. (Abbott 1931:55)

Douglas was a fellow student with Holmes and Stephenson at Edinburgh and his attempts at teaching in Quebec City were comparable to Holmes and Stephenson's program in Montreal. The latter though, were able to institutionalize their lectures and establish a power base.

Drs. Blanchet' and von Iffland's second attempt at establishing a medical school in Quebec City was more successful. The Marine and Emigrants Hospital in Quebec City was the source of the Medical Faculty of Laval University at Quebec. Founded in 1830 to handle the typhus and cholera epidemics, it was from the beginning a teaching centre due to the expert surgical work carried on by James Douglas, Anthony von Iffland, Joseph Morrin and Joseph Painchaud. (Abbott 1931:63) In addition, Dr. von Iffland taught medical courses (Abbott 1931:55) while Dr. Blanchet gave lectures on chemistry. Their students petitioned the legislature in 1835 for a medical school at the Marine and Emigrants Hospital. The Legislature referred the matter to Sir John Doratt, M.D., who had been appointed by the British Government as Inspector General of Hospitals for Canada. Doratt suggested that the medical school should be connected with the Hotel-

Dieu and Marine Hospitals. He also took the initiative in suggesting that the course of study should be five years long; the first three years to concentrate on lectures and the last two years to be spent at the hospital. (Abbott 1931:64)

As Sir John Doratt had been appointed by the British government to investigate, report upon and advise on the improvement of medical education in Canada, 1837, he included in his report a recommendation that a medical school be established in Quebec City in connection with the Hotel-Dieu and Marine Hospital. (Birkett 1939: 324) He also included his idea of a five year medical school course. It took twelve years though for the "School of Medicine of the City of Quebec" to be incorporated in 1847. (Abbott 1931:64)

VI. The General State of Medical Research and Its Effect on Canadian Medicine

Terence Johnson claims that under a Patronage system, knowledge tends to be local, and basic research associated with applied medical knowledge tends to be limited. (Johnson 1972:72) While Johnson does not elaborate on this point, Shryock in Medicine in America provides a supportive expansion of Johnson's claim.

Throughout North America and Western Europe developments in medical science; physiology, bacteriology and biochemistry was slow. Knowledge of physiology and biochemical processes was meagre or nonexistent. When Paris and other European centres began to delve into these areas, Canada and the U.S.A. did not follow suit because of their indifference to Basic Science. To some extent this reflected the colonial attitude that made people turn to London, Paris and

Germany for advances. Canada and the U.S.A. were too busy settling and building a nation and had little time or interest left for intellectual pursuits. (Shryock 1966:74) The English-Canadians' stress on capitalism, and the Protestant Work Ethic led to the belief or attitude that science was only useful if it yielded information to help develop the economy of Canada. (Shryock 1966:83) French-Canadians with their concern for intellectual pursuits were seen as backward.

Medical research requires a great deal of money from public or private funding. In regard to the former, the Canadian government showed a general lack of interest in health matters other than quarantine and immigration. (MacDermot 1967:80) Leaders of the medical community were more interested in legislating improper doctors out of practice, and in coping with the various epidemics and emergencies than in the pursuit of basic science or research.

The world-wide low priority for the development of basic sciences like chemistry and physiology meant that medical sciences took longer to appear. Chemistry at the beginning of the nineteenth century throughout the world was just starting to turn away from alchemy and to use statistics. By 1820 chemistry had undergone a revolution and been transformed into modern-day form. This was stimulating to medical science in the development of organic chemistry and biochemistry. (Shryock 1947:130)

Because the demand for research was not great there was no need to improve equipment. This further retarded the progress of some of the sciences. Bacteriology had to wait until the microscope,

which could pick out unicellular microorganisms, was discovered. By the 1840's the microscope was generally available. (Shryock 1947:122)

General disharmony within the medical communities of various countries interfered with the world-wide advance of medical knowledge. With practitioners vying for power, any innovative technique or theory is more likely to be met with skepticism, scorn or ridicule, particularly if it debunks an established school of thought.* The following example from the United States throws light on the lengths to which hostility can be taken and can seriously interfere with the development of medical knowledge. (Johnson 1972:73)

Around the turn of the nineteenth century William Cobbett considered how statistics might throw light upon the effectiveness of treatment and the natural history of disease. (Shryock 1947:138) When Benjamin Rush announced that the cure for yellow fever was bleeding and purging, Cobbett confronted Rush with a demand for proof of the treatment's effectiveness. Rush replied that doctors were too busy to keep complete figures on cases. Undaunted, Cobbett studied death certificates in the U.S. and eventually established a positive correlation between increases in bleeding and increases in mortality. (Shryock 1947:139) Despite the importance of his findings little attention was paid to Cobbett by either laymen or doctors. Eventually Rush lost his patience and sued Cobbett for slander. Cobbett was

*For further reading on this subject there is an essay "Resistances to Medical Change," in Bernhard J. Stern Historical Sociology (New York: The Citadel Press, 1959).

convicted, fined and practically driven out of town. (Shryock 1947:140).

A knowledge of the state of medical knowledge on a world wide basis is important to understanding the reasons for the condition of medical theories which in turn determined medical procedures in Canada. While Canada did not indulge in medical research to a significant extent in the nineteenth century, her medical community adopted any innovations and discoveries made in other countries. (Physicians Panel on Canadian Medical History, 1967) Let us now look at the popular theories of the cause of illness because they affected the treatments used and also the work structure of the occupation.

My findings support Johnson's claim that monist explanations were used in the situation where the consumer is more powerful than the consultant.

One model that doctors used until the 1850's held that disease was caused by systemic disorders of the blood or nerves. Impurities of blood, excessive laxity or pressure in vascular or nervous systems caused all illness. This was why regulars used purging and bleeding as treatments. Both the theory and the treatment lasted for a long time. One of the reasons for their popularity was their suitability to the situation. In order to keep patients, a physician would have to appear to the client to be doing something to help. Bleeding, purging and the use of opiates were simple yet strong measures which would at least markedly change the condition and symptoms of the patient. The explanations for the use of these measures were

simple enough for the layman to understand if the situation demanded this or could be couched in sophisticated enough terms to intimidate and impress the client. The following is an illustration of this. Howison in 1821 described a scene he witnessed between a doctor and a patient's husband.

Husband: "But, doctor, are you up the nature of her ailment?" inquired the husband. "Oh, perfectly," said the other, "nothing more simple; it arises entirely from obstruction and constitutional idiosyncrasy, and is seated under the muscular fascia. Some casual excitement has increased the action of the absorbent vessels so much, that they have drawn the blood from the different parts of the body, and occasioned the pain and debility that is now present." - "Well, now doctor," cried the husband, "I swear you talk like a lawyer, and I begin to have hopes that you'll be pretty considerably apt to raise my woman."

(Howison 1821:196)

The other reason for the longevity of this model was due to the inhibition of knowledge in physiology because of societal attitudes. It was difficult to procure corpses for autopsies because the lay public felt that autopsy was immoral and/or improper. (Shryock 1966: 78) The availability of cadavers was essential for learning anatomy as well as physiology. Only by learning what a normal internal system looked like could they begin to notice when areas looked abnormal. If, for example, they discovered local lesions while probing they might begin to see associations between the person's illness and the local pathology. Such knowledge would not only have cast doubt on the theory of a generalized cause; it would also help physicians to distinguish between symptom and cause. Doctors often took the symptoms of the disease for the disease itself. (Shryock

1966:213) Since bodies were not often donated they had to steal them from graves, resulting, of course, in further tarnishing of the image of medicine. (Cushing 1940:82)

Even when cadavers were available and dissection could be done and local lesions discovered, it was still necessary to make connective links between the symptoms of living patients and lesions in dead patients who had had similar symptoms. However, in the 1820's death certificates did not state the cause of death lest the family be stigmatized. (Heagerty 1928:102) Accordingly it was not possible to establish that lesions found in autopsy after exhumation were related to the cause of death.

Furthermore, doctors would have had to conduct much more thorough bedside examinations of patients and maintain adequate notes to begin to do comparisons between people who had had similar symptoms and their physiological state at death. Such thorough and systematic examinations were rare. Only if such connective links were made could doctors begin to describe and identify diseases by their symptoms and morbid structure and only then could they refute the model of systemic (system) causes of illness and start to sort out the causes of disease. (Rosen 1972:29)

This model of generalized cause not only affected medical knowledge, it also played a role in the work structure of the occupation of medicine. Since disease was perceived to be caused by systemic disorders there was no need to focus on limited areas of the body. This retarded the move towards physicians specializing

in their education and medical practice on a particular part of the body. Surgery was one specialty affected. Improvements in techniques were not considered necessary when all there was to treat was blood or a vague condition of the nervous system. (Shryock 1966:167-168)

VII. Conclusions of Chapter One

The intention of Chapter One was to describe the state of medicine in Upper Canada with references to Quebec and to present an argument for the claim that medicine came under Oligarchic control. I decided to investigate this possibility after learning from Johnson that Oligarchic control over occupations was common to societies which resembled eighteenth century England. (Johnson 1972:66) The intention of the Constitutional Act of 1791 was to create a social political structure in Canada in the image of eighteenth century England. (McNaught 1970:61) Seeing great variation in the degree of societal development between England and Canada I thought it would be interesting to see if Johnson's hypotheses held for Upper Canada too.

On the basis of data presented in Chapter One, one can conclude that medicine came under Oligarchic control. The social-economic context within which medicine was found was not ready for a profession of medicine. A profession needs a firmly established, clearly defined, nation-wide organizational structure if it is to appear to oversee and police all facets of the professional community. When the economic and social life of the geographical area which we

call Canada could only be sustained on a local level, then it was impossible to build an organizational structure beyond the district level. There were simply too many problems with transportation and communication to establish a network with effective interaction.

In addition, it was only within the upper class that there was a well defined division of labour. Therefore outside of this class there was little call for specialists. The lower class were usually settler-farmers who became used to self-sufficiency. With regard to medicine, the farms were so scattered that it was unlikely to find a doctor in the area. If a physician was nearby, the patients would usually only visit him as a last resort either because they did not have the currency^{*} to pay for services or they had become so used to treating health problems that they perceived the doctor as only the final option.

A review of medicine in the early nineteenth century shows the demand for services coming from the upper class. In both Ontario and Quebec highly paid, British government officials constituted this class. They were a tightly knit clique who had managed to manoeuvre themselves into a position where they controlled most of the political, social and for a while the economic life of the two provinces. The Family Compact or Chateau Clique was the group which medicine had to contend with, both as a consumer group and as the power elite. This last point was the stumbling block to medicine moving towards professionalization.

*I have included a chart on the number of Chartered Banks and Branches from 1820 to 1900 on Page . Assuming that the supply of banks was relatively responsive to demand then the growth in banks from 1 in 1820 to 50 in 1875 reflect the growth in currency.

In order to achieve professional autonomy the occupation had to persuade those in power that it needed autonomy to function properly. The task of persuasion however, requires one basic ingredient, social distance. The latter can be established when the persuaders are better versed in the specialty than the persuadees and can convince those in power that they are specialists. Another prerequisite for social distance is to have a homogeneous occupational community and a heterogeneous consumer group.

The occupation needs to be homogeneous in several different ways. First of all it must be centered in the upper and middle class to give it wider resources of power by virtue of membership in a dominant class. Secondly, recruits need to have undergone similar educational experiences to be able to present an image of equal competency to the public and to have undergone similar experiences of secondary socialization which could encourage the sharing of beliefs, values and attitudes. Only then would they tend to manoeuvre as a large and powerful group rather than being split by grossly divergent interests.

After reviewing the socio-political structure it is evident that medicine could not establish social distance between itself and the consumer. In light of the paltriness of medical knowledge at this time any university-educated individual could do as good a job at diagnosis and treatment as the majority of regular physicians in Canada. Judging from Strachan's opinion of doctors, the elite knew this. Nevertheless it was not only the actual condition of medical

knowledge which made it difficult for physicians to establish themselves as experts; it was also the occupation's inability to establish a social distance by other means to enable them to create a facade of the esoteric nature of medical knowledge. Without social distance it was impossible to create an aura of uncertainty to enable medicine to persuade the consumer to turn to it as the final authority in assessment of problem and treatment.

The more I discovered about this period of medicine the more I wondered why people continued to turn to doctors for help. In the case of wealthy patrons, many of them knew as much science as their physician and in many cases the treatments used were more harmful than helpful. Nevertheless, I think that Johnson provides the answer to this seemingly paradoxical situation. Serious illness brings on uncertainty and stress. As the patient becomes more ill, significant others become more concerned and step up efforts to help. Feeling themselves to be helpless, they refer the matter to individuals who have at least had more practical experience in healing.

Physicians took advantage of the layman's doubt to establish an occupation. In the early nineteenth century however, the consumers were sure enough of their healing capabilities to hold medicine's autonomy in check. Thus the Upper Class were not prepared to relinquish control over the occupation.

The other means for establishing social distance between practitioner and consumer was not to be had either. The consumer group belonged almost exclusively to the dominant class and thereby had

a wider range of resources to draw on for power than the doctor had. Both the Family Compact in Upper Canada and the Chateau Clique in Lower Canada were the dominant forces in the political, social and, for a while, the economic life of the two provinces. When all aspects of life were under their direction and practitioners were not found in this group (Earl 1967:14), then one is left with the impression that any power the physician had was granted to him by the power elite.

The first area where the power elite interfered in the concerns of medicine was at the point of entry into the medical community.

In Upper and Lower Canada entrance into medicine was based on sponsorship. If a recruit chose to enter by apprenticing under a licensed physician or attending a series of private medical lectures and sitting in at the Licensing Board examination, then he obviously had to have a sponsor to accept and train him. On the other hand, if he chose a more formal mode of training, a medical school outside of the country, it was necessary to have good recommendations from influential sponsors. The criteria for sponsorship was shared values and statuses. There were several examples in the body of Chapter One where physicians had apprenticed under family friends or family. Peter Diehl, a member of the Board of Examiners for Upper Canada, apprenticed under a very prestigious physician who had been a friend of the family. Colonel Tablot even sponsored a medical school until he discovered the pro-Reformist sympathies of the founders. (Seaborn 1944:262)

It was extremely difficult to determine whether the physician shared the status of the patron because the Family Compact did not include one physician. (Earl 1967:14) There is however, evidence of physicians benefitting from their contacts with the aristocracy, (Acton, Goldsmith and Shepard 1974:133) and with physicians sharing the same values. To begin with, the early leaders of the medical community were often military or naval surgeons with a university education. Political affiliation with the Tories and loyalty to the Church of England were correlated often enough with successful physicians for us to accept the notion of doctors sharing Family Compact values. Acton, Goldsmith and Shepard found that:

The leaders (in medicine) were men trained in medicine in British universities, many of whom were adopting a second career following military or legal positions; most of them aligned through family ties, church activities and political sympathies to the Family Compact.

Thus the elite of the regular medical community shared the values of their patrons and quite probably reached the pinnacle of the medical community by virtue of this. If one doubts the latter simply glance back at the biographies of the men on the Board of Examiners for Upper Canada. Sir John Colborne's physician was also director of the Bank of Upper Canada.

Sponsorship did not end with education. Once a physician had obtained his license his ascent up the occupational ladder depended on the help he received from influential people. From Section I we know that there were a great many jobs under government auspices which physicians were given. Johnson claimed that under Oligarchic

control, it was more social skills than technical competence which determined whether an individual was evaluated as worthy of promotion. (Johnson 1972:57) In reviewing the characteristics of the individuals who had been promoted, level of education appeared to be an important criteria for promotion in the occupational structure. However, we must take care not to impose our values and perceptions on the situation. Thus while we might tend to think that the physician had been deservedly promoted because he was more competent, it may have been that the physician's status was the primary determinant of promotion and level of education was only a criteria of status. Alternatively, we cannot dismiss education as an important factor simply because we perceive it to have been inadequate in medical science. The public in general probably held education in high regard. Thus, it is impossible to decide whether it was social skills or perceived technical competence which was the major determinant.

Upon observing that patrons maintained physicians on incomes which they socially or politically controlled, it seems quite justifiable to say that patrons "housed" or "kept" their physicians. (Johnson 1972:68)

Since the practitioners stood to gain by his associations with the power elite it is understandable that his first loyalty was to them and not to his fellow practitioners. This created a fragmented, locally oriented occupational group. (Johnson 1972:68) When each community was isolated from others and a small aristocracy ran the social, economic and political affairs of the district it is understandable that the regular medical doctors only thought about

the state of the occupation in their district. Not only were the district associations a manifestation of localism, they also encouraged this approach in administering medicine. It took until Confederation to establish a Canadian Medical Association and for years it was more like a grouping of local Societies than an assimilated national society. (Heagerty 1928:295) In Chapter Two I will discuss the question of whether successful practitioners truly desired solidarity and a community when they were doing quite well by keeping to a low-level form of organization.

Johnson also claims that when the occupation is patron-based practitioners tend to develop a locally oriented approach to solving local problems. (Johnson 1972:71) In Canada when the physician confronted an illness he went about solving the problem at hand without considering its broader implications and when he applied treatment he employed a rationale which he knew would be satisfactory to the people he was treating. This was where his social skills were useful.

When social skills (i.e. the art of persuasion) were held to be as useful to the doctor as medical knowledge and physicians, on the whole, concerned themselves with treating the problem at hand and staying alive or getting ahead, then as Johnson hypothesized, under Oligarchic control research would be neglected. (Johnson 1972: 72) Both Canada and the United States were too busy settling and building a nation for their power elites to decide to divert a great deal of time, energy and money on research that would not help develop their economies. (Shryock 1966:74) Medical research required

a great deal of money from public or private funding but both sources were tied up with more local and immediate concerns. The Government showed a lack of interest in health matters other than quarantine and immigration, (MacDermot 1967:80) and leaders of medicine were more concerned with legislating improper doctors out of practice, and in coping with the various epidemics and emergencies than pursuing basic science or research.

Theoretical knowledge is, then, less important than knowledge which is applicable to the current practical needs of the patron. Practitioners are more likely to stress monist explanations which can be simply and immediately applied in policy or therapy. (Johnson 1972: 72) Medicine in the period of oligarchic patronage in Canada only used monistic explanations for disease; either the person was suffering from impurities of the blood or excessive laxity or pressure in either the vascular or nervous systems. These explanations were quite versatile as they were simple enough for the uneducated layman to understand or they could be couched in sophisticated enough terms to intimidate and impress the more educated clients.

The emphasis on localism is also reflected in the hierarchical structure of the group. "Practice is not a continuous and terminal career shared by all." (Johnson 1972:69) From their entrance into the community, recruits held varying statuses because of their different educational attainments and as we have already mentioned, some rose in the hierarchy with the help of friends. Others found that they could not support themselves by practising medicine and thus

either practised part-time or gave it up altogether to pursue other careers. Thus the career of a physician was not necessarily life-long, nor did the practitioners share a common status.

Johnson claims that the ideology of patronage systems stresses superior rather than equal competence to justify the hierarchical organization of the occupation and that graded qualifications are institutionalized. (Johnson 1972:73) This was the case in Britain but it certainly did not apply in Canada. In England there was a large enough urban population to support a division of labour in the healing arts so that tasks were divided amongst healers according to their education which in turn was determined by their social class. (Poynter 1966:70) The initial divisions remained evident until the late nineteenth century with university educated physicians coming from the upper classes and barber-surgeons and apothecaries coming from the lower classes and obtaining their education through apprenticeship. (Poynter 1966:70) In order to protect their different interests each of these groups formed their own Medical Corporations and thereby institutionalized grades of qualification.

These grades disappeared in Canada because she did not have the population or extent of settlement to support this relatively sophisticated division of labour. The above should be a reminder that Johnson's hypotheses need to be tested in different time periods and settings to further refine them. In using only one country, one is never sure whether Johnson has generated a generalizable hypothesis or whether it is only applicable to the area examined.

"The hierarchical fragmentation of the occupation may even be systematically expressed and institutionalized as dual systems of practice within a single occupation." (Johnson 1972:69) Physicians from the higher social class, who had usually been military or naval surgeons, helped to create a dual system of practice. Military physicians convinced those in power that licensing laws needed to be passed and implemented through an Examining Board. The Lieutenant-Governor appointed members to the Upper Canada Board. (Heagerty 1928:320) It was impossible to discover how many Boards were in existence at this time but I would suspect that they were found only in largely populated centres. This narrows the number down to a possible nine as there were only nine cities at the time.

It is debatable whether the dual system itself was the instigation of conflict and competition or whether preceding conflict and competition led to the division within the system. Nevertheless, the early Licensing Boards did not promote harmony even within the regular section of the healing arts. The physicians of York were so enraged at the Medical Board's imposition of their values on the rest of the community that they presented a set of changes to the constitution of the Medical Board and presented it to the Lieutenant-Governor. (Heagerty 1928:242) In terms of irregular medicine, it was the Medical Board's intention to drive a wedge between qualified and unqualified practitioners.

Having established that medicine in Upper Canada fit Johnson's model of Patron Control, let us move on to the transitory

period of medicine's development. As you will see in Section One of Chapter Two the characteristics of this occupation reflected the character of the political and economic life of Canada West, (as Upper Canada was renamed in 1841).

CHAPTER TWO

THE TRANSITION FROM OLIGARCHIC TO COLLEGIATE CONTROL OF MEDICINE

I The Social, Political and Economic Milieu of Canada West from 1840 to 1867 and the State of Medicine

As mentioned in Chapter One, the economy of Canada underwent some drastic changes from 1840 to 1867 which undermined the power of the Family Compact in Canada West (formerly Upper Canada). This led to a slackening of the control which the Family Compact had over the occupation of medicine. The established tightly knit group was gradually being replaced by people with different values, beliefs and attitudes and therefore the power elite became more heterogeneous. No longer was a tightly knit homogeneous group controlling all facets of the economy and political positions. The Reformists, the opposition party to the Tories, were becoming more powerful and were able to offer their supporters some rewards in terms of positions. As an indication of their influence it was during these years that Dr. John Rolph, a leading Reformer, was able to offer his brother-in-law several jobs. Francis Hinck's (head of the Hinck's-Morin government) brother was given the Chair of Natural History at the University of Toronto, 1849. (Bissell 1953:6) As the power elite was changing in

composition, oligarchic control over medicine was slackening and the occupation was able to quicken the pace of professionalization. The latter was also helped by the appearance of a middle class.

Immigration was largely responsible for a population increase from three-quarters of a million in 1821 to 2,300,000 in 1850. (Lower 1958:189) While the Union of Canada remained primarily rural (Acton, Goldsmith and Shepard 1974:25) there were signs of growing settlement. The constant rise in rural population: the transformation of rough, stump-filled clearings into well cultivated fields, the transition in many districts from log shanties to buildings of sawn timber; the growth of hamlets around sawmills and gristmill sites were signs of settlement, economic development and the beginning of an inter-dependent community. (Careless 1967:35; Morton 1964:4-5) The more built up areas would begin to appear attractive to some of the regulars because potential clients were spaced relatively close together.

In the hamlets and market towns a middle class merchant group were beginning to provide services for the local hinterland. This group started to enlarge and diversify the consumer group who could afford regular physicians which enabled the occupation of medicine to begin its process of professionalization. With Johnson I would argue that when the power elite and the consumer group were one and the same and they held similar values, beliefs and attitudes, it was almost impossible for any occupational group who sought their business not to come under their control. This prevented the occupation from overseeing

and controlling recruitment, education and institutions.

The diversification of the consumer group and power elite was also aided by a shift in British-Canadian relations. In 1846 Britain repealed the Corn Laws and thereby deprived the Canadian colonies of a protected market. (Lower 1958:189) Canada then turned to her neighbour, the United States, to find markets for her products. The Governor-General, Lord Elgin, negotiated a reciprocal trade agreement in 1854 between Canada and the United States which lasted until 1866.

Increased economic and social interaction with the United States caused a change in the power structure of Canada West because the Family Compact's power was based on Canada's close and profitable ties with England; not commercial interests. This social aristocracy comfortably maintained themselves on their government incomes and their accumulated wealth was based on land, not vast commercial interests. Another group of people were slowly accumulating wealth by continuously reinvesting initially small profits in primary industries. (Morton 1964:5) In both Canada West and East the commercial aristocracy were becoming more powerful than the social aristocracy. (Family Compact and Chateau Clique)

The developing economy and the spread of wage earning affected the relative power of both the upper and middle class. "Old officialdom, backward egalitarianism in the West, French-Canadian agrarianism in the East, all gave ground before the growing power of middle-class

business interests." The mounting bourgeoisie influence was reflected in the politics of the Union of Canada, and in the Tory and Reform parties (Careless 1967:36) and in the consumer of medical services group.

The boom in the timber industry encouraged the development of transportation and railway building began in 1852. The Grand Trunk and feeder lines to the lake ports like the Northern Railway or the Canada Central and the Brockville and Ottawa were well underway by 1857. The Grand Trunk then extended from St. Mary's in Lower Canada to Brantford in Upper Canada. Montreal was connected to Portland in Maine to give her a winter port. The Great Western linked Niagara, Hamilton and Windsor. Feeder lines and logging railways were creating a network out from the main lines. (Morton 1964:7) With the completion of the Grand Trunk line in 1861, Quebec, Montreal, Toronto and Sarnia were linked up. As we shall see under Section II, iii, improvements to the transportation system speeded up the institutionalization of medicine because societies could be formed when physicians found it easier to travel to a central meeting place.

The completion of these lines helped the economy to develop and towns to grow which in turn caused the division of labour to shift from self-sufficiency to interdependence with skilled craftsmen handling specialized jobs. (Acton, Goldsmith & Shepard 1974:23; Careless 1967:29; Morton 1964:6). An interdependent economy was significant to medicine from two aspects. First of all, Canadians had to begin to think in terms of relying on a specific person to carry

out a task before they would become consumers of regular medical services. Canadians were so used to taking care of things themselves that they diagnosed and treated ailments themselves. It was only when their efforts failed that they called on the doctor. At the same time that interdependency developed, trade with the United States started to bring currency into the country. (Careless 1967:23) More people then could get money in the event that they had to call on the services of a physician. Both interdependency and an increase in currency helped bring about a change in the type of consumer of medical services.

II The Organization And Institutionalization Of Medicine In Canada West From 1840 To 1867

i) Introduction

Keeping in mind that Canada was a politically uncertain country, torn by sectional differences (Careless 1967:5; Morton 1964:11) and that the basis of power was shifting because of changes in the economy, let us look at the characteristics of the occupation of medicine within this milieu.

Any discussion of the occupation of medicine following Johnson's perspective is extremely difficult once medicine loses oligarchic control. The period of transition from patron control over to collegiate is not treated as a separate section in Johnson's Professions and Power. While he spends a section describing how the concepts of professionalization and professionalism are used by

different theorists he neglects to spend another section discussing the period of transition between oligarchic and collegiate control. A link was needed between these distinct states and so I chose points from both states which were supported by data.

As mentioned in the previous section, several factors had changed from the first time period and were causing differences in the ratio of power in the doctor-patient relationship. While the consumer was becoming more heterogeneous in characteristics, the medical community was becoming more homogeneous due to revisions in licensing acts and educational requirements. In other words the consumer group was not necessarily the same group controlling influential political positions. Divergencies in roles and social status meant that the consumer group was constituted of groups with unique beliefs, values and attitudes. Demands for medical services were coming from an aristocracy which was not only socially but also commercially based. In addition, demands for regular medical services were also coming from an emerging middle class. No longer was the consumer group tightly knit. Divergency weakened the power of the consumer group because they would not enforce a common policy because each component part of the consumer group would hold a different interest. Thus diversification excludes the possibility of consumers organizing to put pressure on the physician. This makes the consumer dependent on the physician and open to exploitation. (Johnson 1972: 41)

In contrast, the medical community was becoming more homogeneous in social class. Regulations regarding the practice of medicine were becoming more stringent. The Licensing Board, acting in its capacity as an agent of social control over entry into medicine, eased out apprenticeship. (Johnson 1972:54) Thenceforth, it would only examine men who had spent three years attending medical lectures in recognized schools and at least one year in the Medical Department of a University. (The Librarian 1906:172) Thus prerequisites to practise medicine became more difficult, institutionalized, longer and more expensive. Consequently the recruits became more homogenous; middle and upper class males. (Ehrenreich and English 1973a:23-27) This change in class composition shifted the balance of power between practitioner and consumer to the practitioner's favour. Since medicine only included members of the more powerful social classes it had wider resources of power to call upon if it needed them. It was also gaining the attributes which could be used in arguments to convince the State that for the good of the population and nation, medicine needed to be self-sufficient. (Johnson 1972:72)

The institutionalization and lengthening of medical education from 1840 to 1867 and new discoveries in medical science gave medicine a rationalization for demanding a professional status. (Johnson 1972: 58) New discoveries in medical science were fostering the development of a highly differentiated body of knowledge and the physician began to have a lever with which to establish distance between himself and the patient. Johnson sees this as easier to attain when the consumer group is divided into factions. (Johnson 1972:51)

In addition, the settlement and development of rural areas, the evolution of market towns with interconnecting roads made it possible for medicine to begin to build a network of communication. The most simple organization to allow physicians to gather and exchange ideas was the discussion group. This structure could also be used by segments to organize and ultimately counter segments within more powerful and established institutions, as for example when the physicians of Toronto organized and presented a grievance to Lieutenant Governor concerning the Medical Board. (Heagerty 1928:242) The more powerful institutions within the communication network were the journals and local societies. Both of these groups were dominated by a certain segment who would make certain policy decisions and see that they were implemented. Not only did they impose their values and beliefs on the general membership, they also became the spokesmen for the group so that particular institutions came to stand for particular groups. (Strauss and Bucher 1961:332)

Small-scale, local institutions added organization and stability to the occupation of medicine but they also played a role in retarding the advancement of institutionalization. Having established power, the local associations and societies discouraged the foundation of large-scale widely based bodies because they feared that the latter would usurp the power which they had worked a long time to establish. Following Strauss and Bucher's perspective (1961), the local societies were established by groups with their own definitions of what medicine should strive for, unique values and beliefs. (Strauss and Bucher 1961: 333) Thus the attainment of harmony was a goal; not a reality. (Heagerty 1928:289) In view of my data I cannot accept Johnson's hypothesis that where members had an equal status and a continuous

occupational career that they would share the same values and be equally loyal to all colleagues. (Johnson 1972:55) This assumption of homogeneity is too simplistic. As we shall see in Chapter Three, even when medicine became a profession it was not a totally homogeneous community, but rather a conglomeration of circles of collegueship. (Strauss and Bucher 1961:332)

By the mid-point of the century medicine had managed to make the prerequisites to practise medicine more difficult, institutionalized, longer and more expensive; and had started to build a network of communication and organization. Thus medicine was beginning to gain the resources necessary for imposing their own definitions on the producer-consumer relationship. (Johnson 1972:42)

ii) Regulation

In 1839 the occupation of medicine institutionalized the process of examining candidates and conferring diplomas within the structure of a College of Physicians and Surgeons of Upper Canada. Under the provisions of the Act most of the functions of the Medical Board were to be absorbed by the College. (Bull 1934:87) Midwives could practise as long as they were approved by the College of Physicians and Surgeons. Failing to seek approval left one vulnerable to legal action. (Acton, Goldsmith and Shepard 1974:163)

Within a year, word came from London that the Queen, on the advice of her ministers, had vetoed the enabling act. This introduces a fascinating aspect to the discussion of the transfer of supervision over the occupation from those in power to the elite of the occupational group in Canada. The occupation of medicine in Canada was caught in a peculiar situation in the early eighteenth hundreds because Canada was still considered to be a colony of Great

Britain. This created a situation where the degree of autonomy of medicine in England could affect the extent of control that the occupation of medicine in Canada had over its affairs. Theoretically, a ruling regarding the conferral of power upon the medical profession in England could curtail the autonomy of the Canadian profession. If the ruling was worded so that the power was to extend over England's Domain, then Canada was forced to submit to the power of England's medicine.

In the case of Upper Canada's College of Physicians and Surgeons, the government of England could not give it official recognition because the Queen's ministers felt that the powers and prerogatives of the College infringed upon the rights of the Royal College of Surgeons in England. The latter held the power "to practice freely and without restraint the art and science throughout all and every Her Majesty's Dominions, any law or custom to the contrary notwithstanding." (Bull 1934:88) Therefore the Queen maintained her veto despite Canadian protests and the College was disbanded in 1841. (Heagerty 1928:77)

In the same year Upper and Lower Canada were united under one government and called the Union of Canada and Canada West and East, respectively. In keeping with the philosophy of political unity between the two provinces, the occupation of medicine passed an Act to enable persons authorized to practise physic or surgery in Canada West or East to practise in the Province of Canada. (Heagerty 1928: 325) There were also exploratory attempts between King's College and the Medical Board of Montreal in 1847 to bring about uniformity in the system of examinations. (Heagerty 1928:81)

By 1865 the Parliament of Canada established the General Council of Medical Education and Registration of Upper Canada. (Bull 1934:133) This was the governing body for medicine in Canada West. (Heagerty 1928:327) The same act authorized the publication of a list of persons entitled to practise; the Medical Register for Ontario. (Heagerty 1928:327) By this time apprenticeship had been eased out because the Licensing Boards would only examine men who had spent three years attending medical lectures in recognized schools and at least one year in the Medical Department of a University. (The Librarian 1906:172)

Progress in the process of professionalization came to a standstill in the 1850's. Great competition raged between the regular medical schools and in the midst of the conflict irregular medicine had an opportunity to become more powerful. In fact, some groups of irregular practitioners became so powerful that they gained the right to be licensed. Thus we must use an alternative term to irregular. Herein certain groups will be called medical sects. Sects were groups of healers who were bound together by virtue of sharing distinctive paradigms on the cause and treatment of disease. During the 1850's sects were thriving in Canada West and managing to survive in Canada East.

Turning to one medical sect, Thompsonians condemned all mineral or metallic remedies. This placed them at juxtaposition

with members of the regular profession who used calomel because it was a solution of mild mercurous chloride. (Shryock 1966:170) Although the regular physician is traditionally associated with administering care to the better educated and more affluent Upper Canadians, some members of this group used Thompsonian remedies. For example, Mrs. Jameson, an aristocrat and authoress of Winter Studies and Summer Rambles, used Bayberry Bark to treat ague. (Bull 1934:75)

The acceptance of Thompsonian remedies by some of the more influential members of society explains why it was given permission by the Legislative Assembly in 1861 to set up its own Medical Board. (Bull 1934:133)

Other medical sects had followers in Canada. Dr. Lancaster felt that the sect of homeopathy was popular enough in 1850 for him to approach the Legislative Assembly for permission to set up a Homeopathic Medical Board. (Seaborn 1944:197) At this time there was at least one homeopathic physician in the towns of London, Ingersoll, Woodstock, Otterville, St. Thomas, Brantford, Guelph, Simcoe, Galt and Strathroy. (Seaborn 1944:199)

Nine years after Dr. Lancaster's request the first Homeopathic Medical Board was established by an Act of Parliament in 1859. This is a clear indication to me that at this point the State did not perceive the regular medical community to be more competent than the other sects in medical care. Therefore, the other sects deserved to be granted the same power as the regular community to organize and

institutionalize regulation, schooling and communication. At the same time, in the States, the public saw the regulars' attempts to drive the sectarians out of the medical field as stemming from selfish and mercenary motives rather than a desire to provide better health care. (Shyrock 1947:264)

The regulars fought on the only ground which could seem reasonable to the public. They constantly tried to level charges of malpractice or homicide on the sectarians. Regardless of whether the charges were found to be true or not, the sectarian would have been put through procedures which were expensive and emotionally draining and even if found innocent, doubt had still been cast on the accused's reputation. (Seaborn 1944:199-200)

If assaults from the regulars were not enough, the sectarian also had to contend with attacks from doctors of opposing sects. As an example, the Allopath's and Homeopath's schools of thought were in juxtaposition to one another and there was a great deal of hostility between the two groups. (Seaborn 1944:200)

Dr. Sam J _____, a fighting spirit and teacher of Homeopathy at A _____, had succeeded in having built a special theatre for his students. This enraged the Allopaths. On a Saturday night, after administering it a dose of croton oil, they pushed a widow's cow into the new amphitheatre, where it remained until Monday morning.

(Seaborn 1944:200)

Thus it was not a simple picture of sectarians opposing regulars and it was probably this situation which helped the regulars

in eliminating them. It appears that sectarians were motivated more by a philosophy of treatment than by political factors. If they had been motivated by the latter, the various sects could have formed an alliance to give them the strength with which to overpower the regulars.

iii) Societies

Seeing the need to counter the inroads of sectarians and to organize to effectively regulate practise, groups of practitioners formed local medical societies. (MacDermot 1967:152) While in one respect these small-scale groups were the beginnings of the organization of the occupation, once firmly established they began to counter efforts to organize the occupation on a larger scale. Local associations felt that if larger societies were formed it would lessen their power.

I have chosen to examine in depth one district Medical Society to show why its executive would object to assimilation into a larger body. Although this Society was formed in the early 1800's; still, it had the structure and characteristics which existed in the 1840's and which led to so much resistance to its subsumption into a higher level of organization.

In 1832, Drs. Crouse, Goodhae, Smith, Dowsley and Bowman were elected as officers to the London District Medical Society. Turning to their respective biographies, the Recreation Secretary, Dr. Bowman, was descended from United Empire Loyalist stock. After attending the 1825-1826 term at Fairfield Medical School in the United States, he opened a practise in St. Thomas. (Seaborn 1944:61) The President, Dr. Crouse, had also attended Fairfield and it is possible that his term overlapped with Dr. Bowman's. We also know that he received his license to practise in Upper Canada in 1828, and that he taught Dr. Gilbert, the Treasurer. (Seaborn 1944:64) Dr. Crouse's presence at

the initial meeting of this group might be explained by the fact that his student, Gilbert, arranged this meeting. (Seaborn 1944:81) Crouse's leadership abilities which were amply demonstrated in the public offices he held, could explain why he was chosen as President. Dr. E. Duncombe, Vice-President, also attended Fairfield for the 1829-30 term. His brother, David, held joint practise with Goodhue, Corresponding Secretary, in St. Thomas. (Seaborn 1944:78) Dr. J. Goodhue practised medicine and ran a store in St. Thomas. In 1831 he entered into partnership with Duncombe for two years. During these years they attended cholera patients together. (Seaborn 1944:81)

Out of this narration a social network appears. Drs. Bowman, Goodhue and Duncombe practised in St. Thomas; the latter two having a partnership. Dr. Crouse could have been the link between Bowman and Duncombe. In addition, the one characteristic that these men held in common was their low level of education. They both attended Fairfield Medical School, one of the least prestigious schools in the United States, (Seaborn 1944:61) and one did an apprenticeship. If they had to join a larger association and disband the local society, with their poor credentials they stood to lose the prestigious positions which they had had in the smaller societies and be dominated by higher status physicians in the larger institution. I suggest that this is part of the reason why the Canadian Medical Association remained as a conglomeration of locally oriented bodies until the turn of the century and why it took until the 1880's for the Ontario Medical Association to be formed.

Turning to Toronto, in 1861 Drs. Hodder (President) and Bull (Secretary) launched the Toronto Medical Society. Its objectives were

to unite members of the profession within Toronto to improve its image and to provide a united front against the inflow of sectarians and promote goodwill and friendly intercourse. "...Free interchange of opinion on all subjects brought before its members, is highly desirable, and would much add to our importance as well as much individual benefit." (Heagerty 1928:289) It sounds as though the Society is trying to pull the regular community together not only to improve the public image but also to provide a united front against the inflow of sectarians into the field. It also appears that the managers of the regular medical community were looking for ways to ingratiate themselves to the community. In his inaugural address the President discussed how the Society could be made of use to the community. (Heagerty 1928:290) Eligibility for membership was lax as one could be licensed, or hold a degree or Diploma in Medicine, Surgery, Midwifery or be engaged in the "pursuit of Collateral Sciences." This was probably the study of the circulatory and nervous systems.

In 1863, a medical section of the Canadian Institute was organized. (Heagerty 1928:291) The Canadian Institute was an extremely prestigious and potentially powerful organization founded by Sir Stanford Fleming to encourage and advance the physical sciences, the arts and the manufactures. (Burpee 1911:60) Either the medical community approached this body to possibly achieve a public image of increased technical competency which would give them a lead over sectarians, or, this body approached medicine, perceiving it as possessing enough expertise to merit association with this group.

Apparently the efforts of the societies of the regular community

began to show because the regulars pulled ahead of the sectarians in a bid for power. In 1865 the Parliament of Canada established the General Council of Medical Education and Registration of Upper Canada. (Bull 1934:133) Initially, Homeopaths and Eclectics were given a representation of five physicians each on the Council. (Bull 1934:134) It did not take long however, for this special representation to come to an end. Within a few years Eclectics and Homeopaths were obliged to conform to the general standard of qualification to practise medicine. (Bull 1934:132)

iv) Summary

This era saw changes in the characteristics of the occupation of medicine. Oligarchic control over the work structure dwindled and was eventually lost. This could be traced to opposing trends occurring in the consumer and practitioner groups. While the consumer group started to include more diverse groups, the regular practitioners were narrowing the scope of eligible recruits by making the prerequisites to practise more difficult, longer and more expensive. Consequently, recruits became more homogeneous. (Ehrenreich & English 1973a:23-27; The Librarian 1906:172) To sustain the mores and subculture of medicine once the student had graduated, a network of communication was being established with journals, discussion groups, and local societies. One could say that this era experienced the greatest amount of institutionalization in Canadian medicine than any time before or since.

Local societies provided organization and institutionalization on a small-scale, local level. Nevertheless, by 1866, the occupation had managed to move towards a more complex form of organization with the

incorporation of the medical occupation of Canada West; nineteen years after incorporation in Quebec. (Heagerty 1928:327) The next year the Canadian Medical Association was formed.

The vested interests of societies was one example of the great competition between various organizations within the community of licensed or regular physicians. While exploratory attempts were made between small organizations in each province to cooperate (Heagerty 1928:81); still, the lack of cooperation between regulars allowed groups of healers who held different beliefs from regulars on the causes and cures of disease to become powerful enough to gain the right to be licensed. As we know, the regulars were able to amass their strength and pull ahead of the sectarians in 1865 so that the sectarians had to conform to the regulars' standard of qualification. (Bull 1934:134)

III. The Organization of Medicine in Canada East 1840-1867

i) Regulation

On August 10, 1847, a Bill for the Incorporation of the College of Physicians and Surgeons of Lower Canada, passed the Legislature. This Act contained many of the provisions of former Acts. (Heagerty 1928:325) The provincial Medical Board was to make up the Board of Governors to examine candidates. No person was to be licensed without a certificate from the Board, and licenses were to be granted by the Governor. Persons who had obtained a medical degree in the British Commonwealth could obtain a certificate without examination. Persons

licensed to practise in Upper Canada could also practise in Lower Canada. Therefore, the Bill for the incorporation of the College of Physicians and Surgeons of Lower Canada, 1847, did not create a "uniportal system" of entry to the medical community. This situation would not deter members from holding divergent values, beliefs and attitudes. (Johnson 1972:55) In addition, they allowed competition into the area of health care. Females could practise midwifery if they could prove competency before any two members of the College. (Heagerty 1928:326) This was a definite stumbling block to the monopolization of medical care. Instead of ignoring their existence and allowing midwives to work in an unofficial capacity, the medical community gave them official recognition by this proviso.

On May 30, 1849, the previous Act was amended so that "all persons resident in Lower Canada, and licensed to practise and actually practising Physic, Surgery or Midwifery therein at the time of the passing of this Act shall be and are hereby declared to be members of the corporation of the College of Physicians and Surgeons of Lower Canada." (Heagerty 1928:326) By this Act, the Board of Governors was to consist of three members from the District of Three Rivers, three from the District of St. Francis, eight from the City of Quebec and eight from the City of Montreal. Licenses were to be given by the Board and not by the Governor. I interpret this as official recognition by the government that the medical elite was considered competent enough to independently control entrance to the

occupation.

Graduates of the United States were to be licensed without examination providing that they proved to the satisfaction of the Board that they were of good moral character, and applied for such license and produced the necessary testimonials and proof within one year from the passing of the Act. (Heagerty 1928:327)

This Act lasted for eighteen years until the Quebec Medical Society appointed a committee of Drs. Sewell, Marsden, Russell, Tessier, Simond, Yarve and Blanchet in 1867. It was to consider the legality and ethics of altering regulations so that holders of degrees or diplomas would have to appear before the Provincial Medical Board for Examination for a License to practise. The committee met in a week and passed a resolution advocating the adoption of a uniform system of granting licenses to practise medicine, surgery and midwifery and the creation of a Central Board of Examiners to examine all holders of medical degrees as a prerequisite to practising and the establishment of a committee to confer with universities, colleges and medical schools regarding the creation of a Central Board.

On the 18th of June, 1867, thirteen days after the meeting of the Committee, the Quebec Medical Society met and drew up a report which was sent to every medical practitioner in Canada. This report contained the resolutions passed by the Committee and recommended calling a Convention of Medical Delegates from Universities, Colleges, Schools and Medical Societies to meet in Quebec City in October to

adopt uniform medical legislation and to form a Canadian Medical Association. (Heagerty 1928:292)

ii) Societies

The first attempt in Canada East, after 1840, to facilitate the sense of community on a local basis was made by Dr. Badgley. In 1843 he founded the Medico-Chirurgical Society of Montreal with the hope of exchanging information with local members and also establishing ties with the comparable Society in Toronto. The link with a distance city was one more block in building an inter-provincial structure of communication. A highly developed network of interaction would result in a relatively homogeneous community. Interaction would tend to reaffirm the beliefs, attitudes and goals which the elite of the occupation felt were important. The Executive of the Medico-Chirurgical Society of Montreal were a tightly knit group. The President, Dr. A. Holmes was one founder of McGill University. (Abbott 1931:52) One Vice-President, F. Badgley, was a faculty member of McGill up until 1843 when he left to become the President of l'Ecole de Medecine et Chirurgie de Montreal. (Abbott 1931:64) Two members of the Committee of Management of the Society also belonged to l'Ecole. Dr. F. Arnold was the Founder of the School and Sutherland was the Secretary. (Abbott 1931:64) A year later, 1844, MacDonnell from McGill (Secretary of the Society), Badgley and Sutherland, formed the Montreal Medical Gazette. (Abbott 1931:56) MacDonnell broke with Badgley and Sutherland

to form with Hall, from McGill (who also was on the Committee of Management for the M-C Society), another Medical Journal; the British American Journal of Medical and Physical Science. As I will explain at a later point, it appears that Badgley and Sutherland, in cooperation with MacDonnell, ceased to publish their journal. (Abbott 1931:68) The only piece of information which I could gain on the Treasurer of the Society was that Dr. W. Fraser had received his M.R.C.S. of London. (Abbott 1931:53)

The Medico-Churgical Society of Montreal never seemed to gain popularity with the general medical community as it experienced discontinuous bouts of activity for twenty-seven years. (MacDermot 1967:152) Perhaps this can be explained by the fact that a relatively closely knit clique of the medical elite of Canada East managed it. (The names of the Executive were obtained from Heagerty 1928:286)

As soon as the Society was founded, Dr. Badgley drew up resolutions to recommend the Montreal and Toronto Medico-Chirurgical and Quebec Medical Societies act as centres for the organization of a General Medical Association of Canada. Members of all existing societies would be included and as new societies were formed they would be added to the Association. Toronto and Bytown reacted to the proposal positively but we learn from the British American Journal of Medical and Physical Science that Badgley's recommendations were blocked by a "radical and French-Canadian faction." This helped to delay the formation of a Canadian Medical Association for more than twenty years.

(Abbott 1931:69)

During the debate over Dr. Badgley's proposal the doctors in the Eastern Townships were deliberately left out. They were not invited to a General Meeting called by Dr. Daniel Arnoldi to discuss the formation of a General Association structured on the basis of Districts rather than Societies. Maude Abbott, a medical historian, felt that the meeting was in fact intended to defeat the proposal of a General Association. Let us not forget that French Canadian physicians would probably fight a Canadian Medical Association on the grounds that their interests would be engulfed by a dominant English-speaking group. The interests of the French-Canadian physician would be kept only if the power remained at the provincial level. It stands to reason that the French-Canadian physicians would be as scared of domination by the English medical community as other French-Canadians were fearful of societal domination by the English. During this time an educated, professionally based elite of the French Canadian community were fighting for protection from English domination.* (Careless 1967:25)

*Although the English versions of Canadian medical history never explicitly mention French and English friction and the French-Canadians' fear of English domination, in glancing at a French version of life in Lower Canada one finds that Dr. Blanchet's office was not only a refined school of medical science but also a centre of patriotism. Along with Bidand and Taschereau he founded The Canadien in 1806 as a reaction to The Mercury, a Tory-based, anti-French publication. One can see a reason for fear of English domination by the following lines from the paper:

(continued on next page)

The British American Journal attributed the omission of physicians from the Eastern Townships to the large proportion of English speaking physicians in that area. (Abbott 1931:69) On the basis of Abbott's review of the minutes of the Frontier Medical Society of Clarenceville, Quebec (Abbott 1931:69) English speaking physicians would have gone against the wishes of the French Canadians and supported a proposal for a Canadian Medical Association. English physicians in the Eastern Townships were concerned that the College of Physicians of Quebec was not giving just representation to the physicians of the frontier and townships. In contrast, a Canadian Medical Association based on representation by districts rather than society, would better suit their needs. Unlike the French they had no fear of a large-scale organization overwhelming their culture.

This province, said he, is already too French for a British Colony. Whether we be at peace or at war, it is essential that we make all possible efforts to oppose any growth of French influence. We have now been in possession of Canada for forty seven years - it is only just that this Province becomes English. (Gosselin 1907:87)

For their criticisms of the Tories, Blanchet, Bidard and Taschereau went to prison. (Gosselin 1907:87) In this atmosphere of fear and mistrust the French Canadians established their own medical community. (Gosselin 1907:11)

When the meeting which Dr. Arnoldi called was adjourned, the sponsors held their own informal convention. With Dr. Morrin in the chair, Drs. Painchaud, Fremont, Sewell, Kimber, Valois and Arnoldi considered Dr. Wolfred Nelson's proposal for incorporating the Profession of Canada East in a College of Physicians and Surgeons. (Abbott 1931:71) The proposal was adopted and letters were sent out to local physicians asking for their support at a general meeting at Trois Rivieres, October 14, to ratify the proposal.* Support for this plan was small as the proposal contained a clause which disqualified all persons from membership in the College with licenses less than twenty years old. Only thirty-five members of the occupation showed up at Trois Rivieres.

Still, the idea of a Quebec based medical association was a generally popular idea. As Dr. Leprohon presented the issue in his French Canadian medical journal:

*Another historian claims that in Quebec City, Dr. Joseph Painchaud was proposing, around the same time as Dr. Badgley, the formation of a Medical Association of Canada which would include the medical societies of Montreal and Toronto and the district societies of Upper and Lower Canada. (MacDermot 1967:53) Although MacDermot did not offer an explanation as to why the proposal did not proceed further, I suspect it was probably due to the strong negative reaction which the French Canadian practitioners had towards a Medical Association of Canada.

We are truly concerned to note that there exists not one possible link capable of enclosing in a vast reservoir all the physicians scattered in the different localities of Lower Canada and to thus confine in the most concentrated union, the noble confraternity that ought to exist between all men having the same mission next to (or with regards to) the human race. [English translation]. (MacDermot 1967:157)

What the proposal needed was some modification. (Abbott 1931:71)

After improvements were made the proposal was presented as a Bill to the Legislature and on August 10, 1847, a Bill for the Incorporation of the College of Physicians and Surgeons of Lower Canada passed the Legislature. This Bill had the almost unanimous approval of both French and English regulars in Montreal, Quebec and Trois-Rivieres and districts. (Abbott 1931:72)

Under this law certain persons were incorporated as The College of Physicians and Surgeons of Lower Canada,"with the power to frame its own Statutes for the regulation of the study of medicine in all its departments and by-laws for its own government." Under this law,

The College of Physicians and Surgeons of Lower Canada shall by that name have perpetual succession and a common seal, with power to change, alter, break or make new the same; and they and their successors by the name aforesaid may sue and be sued, implead and be impleaded, answer and be answered unto in all courts and places whatsoever, and by the name aforesaid shall be able and capable in law to have, hold, receive, enjoy, possess and retain for the ends and purposes of this Act and for the benefit of the said College, all such sums of money as have been or shall at any time hereafter be paid, given or bequeathed to and for the use of the said College; and by the name aforesaid shall and may any time hereafter, without any letters of Mortmain, purchase, take, receive, have, hold, possess and enjoy any lands, tenements or hereditaments for the

purposes of the said College and for no other purposes whatever, and may sell, grant, lease, demise, alien or dispose of the same, and do or execute all and singular the matters and things that to them shall or may appertain thereto; provided always, that the real estate held by the said Corporation shall at no time exceed in value the sum of one thousand pounds. (Heagerty 1928:326)

I have included the above excerpt because I feel that we must not brush lightly over the act of incorporation. The government gave a legally recognized body of the occupation of medicine the power to handle its own business affairs. For the first time there was an official body to handle the affairs of the occupation for the whole of the province. This was an organization which could co-ordinate the workings of the local societies and present a united front to society. The image of unity was important to many groups asking for independence.

In the same year as the incorporation of the College of Physicians and Surgeons of Lower Canada, a typhus epidemic broke out and past medical boards were resurrected and new ones created so that Canada East had a total of 75 Boards to try to deal with this epidemic. Most were only temporary arrangements and once the crisis had seemed to pass, so did the Boards. (Heagerty 1928:343) Boards of Health then, were not a permanent enough structure to help medicine gain power.

By the 1860's there were approximately eighty physicians practising in the City of Montreal and about half of them belonged to the Medico-Chirurgical Society. (Heagerty 1928:291) During this decade an effort was made to financially protect the beneficiaries of

these physicians. Dr. Smallwood and Von Iffland tried to establish a Medical Benevolent Society to provide funds for the widows and orphans of physicians but the plan did not gain popular support. Even the medical students had their own association. Judging from the location of the University Medical Students' Association's meetings in the Faculty Building, Cote Street, I presume that it was closely tied to McGill. (Heagerty 1928:289)

Montreal was the scene of another proposal for a Canadian Medical Association. At the semi-annual meeting of the College of Physicians and Surgeons of Lower Canada held in May 1867, Dr. Marsden made the following speech:

In consequence of the important changes that are about to take place in this great and growing country under Confederation, and in view of the beneficial influence which the American Medical Association exercises on the medical ethics of the United States of America, your delegate would respectfully offer a suggestion that the formation of a Canadian Medical Association, to consist of all members of the profession in good standing in the Dominion of Canada, is worthy of serious consideration and action of this College. (Heagerty 1928:291)

Note the ideological argument to this speech. There is an implication that the ethical standards will be helped by a National association. In addition, this speech illustrates the modelling role which the United States played once the two countries entered into closer economic and social relations.

To give some perspective to Dr. Marsden's comment on the beneficial influence which the American Medical Association exercised

on the medical ethics of the United States, one must keep in mind that some of the members of the Association blocked measures which would have eliminated the commercial colleges. They acted not to improve the calibre of education, but to preserve vastly inferior schools which provided them with a supposedly good income. (Shryock 1966:154) Although medical schools were not profitable in Canada this may have been due more to the fact that she was not as wealthy or as populous a country as the United States, than to any characteristic of the school.

By October 1867 a meeting to form a Canadian Medical Association was held at Laval University, Quebec City, and representatives from Quebec, Ontario, New Brunswick and Nova Scotia, were present. The motion for a Canadian Medical Association was passed and the Executive of the Association was set up so that there was one President; four Vice-Presidents, (one for each of the provinces); one General Secretary; four Corresponding Secretaries, (one per province); and a Treasurer. (Heagerty 1928:293) Committees were set up to oversee the areas of by-laws, preliminary examination, hygiene, medical registration, medical ethics, publications, arrangements and auditing. (Heagerty 1928:294)

Each of the committees had some significance to the process of professionalization. The areas of by-laws, examination, education, licenses and registration all were concerned with establishing a monopoly over the practise of medicine. Thus, the calibre of a

doctor entering the medical community would be controlled; ensuring equal competency and at the same time making it easier to justify a claim for self-regulation or autonomy. Having a clear code of ethics which was perceived to be strictly imposed on all, would encourage society to trust the occupation's members. Vital statistics and hygiene were stressed because the occupation had to appear to be doing a better job of health care than its competitors.

The formation of the Canadian Medical Association was the beginning of a new stage in the professionalization of Canadian medicine. It was the manifestation of a definite change in the power relationship of client and consultant. With a change in the social structure of Canada, new needs were created; the need for a regular physician amongst them. The content of knowledge and skills were beginning to change and medicine was using this to their benefit. These changes helped the institutionalization of controls, rules and conventions about who can do what and to whom and when. (Johnson 1972:45)

IV Medical Education In The Union Of Canada 1840-1867

This time period can be characterized by the growth of a relatively large number of proprietary medical schools, in keen competition with one another. In this section we will see the manipulations and manoeuvres used by schools to eliminate competition and establish themselves in a more dominant and secure position. The

scene in Canada West (Upper Canada) provides a fascinating story because each school represented either a religious denomination or a political faction and the school's growth or disintegration depended a great deal on how powerful the religious body or political group was.

A precise definition for proprietary school was needed for this period of time because, according to Maude Abbott, their numbers grew tremendously during these years. As I began to check my Canadian sources however, I realized that this was going to be a difficult task. None of the Canadian sources I used gave a definition. Nevertheless, when I delved into Spragge's history of Trinity Medical College I realized that Spragge was saying that all the schools in Canada West were proprietary. Since Spragge maintained that until 1887 all of the medical schools were proprietary I noted their characteristics in order to formulate my own definition.

From what I could gather from the data, a proprietary school was any school which received the majority of their funding from private as opposed to public sources, such as government grants. Regular private sources were comprised of students' fees and staff contributions. Funding from a governmental agency was rare and irregular. My definition is substantiated in Spragge's article when the President of the University of Toronto described Toronto schools as self-supporting. (Spragge 1966:89)

MacDermot also made an observation which was in line with my suggestion that all medical schools from 1800 to 1867 were proprietary because they were financially independent. According to MacDermot the University affiliation really meant very little because the medical schools existed entirely independently of the University; either they were housed in buildings off campus or even in other towns. They did not make use of the University's research facilities (if it had any) and financial help was either non-existent or insignificant and irregular. (MacDermot 1967:95-103) While I noticed that the Medical Faculties of Trinity and King's College received small annual grants from their universities (Spragge 1966:70; The Librarian 1906:174) I was not sure if they in return had to turn over a certain percentage of their fees to their respective universities.

Thus, while it has been assumed that the widely recognised, prestigious schools which usually had a university affiliation were not proprietary, we can now include them. Therefore, proprietary schools formed a hierarchy, from the locally known, non-institutionalized, unprestigious school up to the widely recognized one.

The above definition is in striking contrast to the term as used by the regular medical community. Reading books on the history of medicine for the United States, one is left with an impression of a school with inferior facilities and teachers, running on a thin budget to maximize profits because their first priority was the making of money, not the teaching of students.

Implicitly, there were two kinds of schools: the vastly inferior proprietary school and the superior institute approved by the regular community. (Fishbein 1969:21; Shryock 1966:152-154)

If we accept Spragge's contention that the schools in Toronto were proprietary then these negative connotations are unfounded for many, but not all of the proprietary schools of Canada West. The high status schools may have run on a tight budget but they had prestigious men on their faculties who had received training in the leading centres of Europe. Also, in all due fairness to the medical men of this era, the claim that the owners of these medical schools were motivated by pecuniary interests seems to be unfounded. All the schools seemed to experience financial difficulties and had it not been in many cases for the generosity of the medical staff of the schools, they would not have continued.

In short, for years we have accepted without question the negative connotations of the term proprietary. It is time to realize that the medical community probably found it useful in the nineteenth century to encourage these negative implications in order that the favoured schools be set off from the less favoured. By questioning the established interpretation in light of the data from Canada West and East, I was able to formulate a more relevant and less emotionally charged and distorted definition.

In light of this new perspective on medical schools in Canada, let us take a look at the medical schools in Canada West.

i) Canada West

a) Reputable schools.

A Reformist, John Rolph, established the first school in Canada West in 1843. Exiled after the Rebellion of 1837, he returned to Canada with the General Amnesty of 1843 to start the Toronto School of Medicine. Although Rolph's School could be taken as an indication that his political party was gaining power, there were still intense feelings regarding the rebellion and to some, one's political affiliation reflected one's level of competency in medicine. While many members of the medical community considered attendance at Rolph's lectures as equivalent to attendance at a medical college, (Heagerty 1928:80) there were still individuals, particularly the public, who saw his lectures as inferior because Rolph was a Reformist. (Bull 1934:88) Unfortunately for his students, while they shared his stigma, they were not protected, as Rolph was, by a community recognition of extraordinary talents and they did not even attain a degree upon graduation. Students were treated with contempt by those who did not differentiate between Rolph's professional attainments and his political activities as a Reformist. (Bull 1934:88) Their status may have improved somewhat when the school was incorporated as the Toronto School of Medicine in 1853. (Bull 1934:88) With incorporation the school had the appearance of being a more permanent institution of higher learning rather than a "fly-by-night" arrangement.

At the same time that plans were made for Rolph's School, plans were also being implemented for a medical faculty for King's College, (Glazebrook 1971:87) a Church of England University with Family Compact ties. (Bissell 1953:3) After years of debate over whether to have a medical faculty, King's College suddenly resolved the conflict. Perhaps the Tories decided that if they could not eliminate Rolph's School, then at least they could provide a counter-force.*

King's College began in 1842 to give their medical faculty financial support in the form of an annual bursary to maintain a number of beds in the Toronto General Hospital for students to supervise. Money was also set aside for medical preparations, models and books with the apportionment of funds to be left to the Faculty. By the time it opened its doors to students in 1844 (Glazebrook 1971: 87) it was on par with the Faculty of Arts and Law, receiving several thousand dollars annually from the College endowment. Thus King's College appeared to be the only non-proprietary medical school in Ontario. (The Librarian 1906:174)

*To lend support to my interpretation, when the Baldwin Act of 1849 replaced King's College with a secularized University of Toronto, Bishop Strachan went to England to collect funds to establish a Church of England University in Upper Canada. Trinity College was the outcome of his efforts. In 1850 a medical faculty was added because Bishop Strachan saw the need for physicians and he wanted them to receive a Christian education. (Spragge 1966:63)

Through the efforts of one member of the power elite, who was also the Chancellor of King's College, the faculty was immediately given representation on the College Council. (The Librarian 1906:170) Thus we have a medical school loosely tied to a University by financial and political means.

It was important to the Medical Faculty that no status differentiations be made amongst its members and so the four members were made professors and given equal remuneration. (The Librarian 1906: 170)

The first building used for teaching was a frame structure containing two small, sparsely furnished rooms; one for anatomical, the other for chemical classes. Since classes contained only twenty students in 1849 it was possible for them to stand around the dissecting table during lecture. (The Librarian 1906:175)

By the Baldwin Act of 1849, King's College was legislated out of existence and a secular, government controlled University of Toronto, took over the endowment. (Bissell 1953:3; Glazenbrook 1971:93) At some point the medical faculty became attached to the University of Toronto because in 1852 the University had a building erected to house the sixty students in the faculty of medicine. (The Librarian 1906: 175)

In the summer of 1850, Drs. Hodder and Bovell organized a third school of medicine and called it the Upper Canada School of Medicine. Looking at the Faculty's educational backgrounds, one is

impressed with the fact that all but one studied at more than one institution on the Continent. Edinburgh was common to all and London, France, Germany and Dublin, were the other locations. (Spragge 1966: 97) Reed summed up the group in these words:

It had a distinctly brilliant group of men on its teaching staff who had the support of social Toronto and later became the controlling influence in the Toronto General Hospital...(Reed 1952:57)

Although Spragge did not advance this idea, I would think that Bovell conspired with Strachan to establish a University affiliated medical school before the Bishop travelled to England in the Spring of 1850 to collect funds to establish a Church of England University in Canada West. To begin with, Bovell was a very devout Christian in the Anglican Church, and took a prominent part in the meetings of the Toronto Diocesan synods. (Spragge 1966:98) He also was connected with King's College, having received the degree of M.D. ad eundem in 1848. Therefore Bovell, was associated with Strachan before he established the Upper Canada School of Medicine.

The timing of events seem to be a little too well co-ordinated to be coincidental. Bishop Strachan travelled to England in the spring of 1850 to collect funds. At the same time money was being collected in Canada. In the summer, Bovell, a friend of Strachan's, organized a school of medicine with Dr. Hodder. Both Strachan and Bovell urged Melville to move from Niagara to Toronto to help launch the Upper Canada School. (Spragge 1966:98) On the Bishop's return

to Toronto in the autumn of 1850, a deputation from the proposed medical school offered their services for free as the medical faculty of the proposed university. (Reed 1952:38) The Bishop accepted at once. (Spragge 1966:65)

Would it not seem more likely that Bishop Strachan included the medical faculty in his strategy plans when he sought funds in England? I would think that Strachan had a better chance of raising money if he could say that he had a Medical School prepared to affiliate and begin sessions.

In December 1850, rooms for the Medical Faculty were secured in a building which had been used as a gaol and ten students were enrolled for the first session. Until the governing body for the proposed university was organized the Faculty was under the direction of the Bishop. Cases for clinical instruction were selected from the Toronto General Dispensary and obstetrical practise was acquired at the Lying-in Hospital. (Spragge 1966:66-67) Some time during 1851 the Medical Department moved from the old goal building to a large house which was nearer to the University but was less convenient to the Dispensary. (Spragge 1966:68)* By 1853 the student body numbered 52 but in 1854-85 it dropped to 38. (Spragge 1966:69)

*Location on university grounds seemed to create a problem of access to the dispensary for most university affiliated medical schools.

For the M.B. degree the candidate had to pass the matriculation examination on Divinity, Classics and Mathematics; take the oath of allegiance and supremacy; and "willingly and heartily" declare that he was "truly and sincerely" a member of the United Church of England and Ireland. For the first year he had to pass the examinations prescribed for the students in Arts and attend Medical Department lectures in Chemistry and Materia Medica. For the next three years he had to attend lectures in medicine and pass examinations in his third and fourth year. Upon successful completion of the exams and providing that he was twenty-one years of age, he would be granted a license to practise which, after two years, would be exchanged for the M.B. degree without further examination or expense. (Spragge 1966:69)

To qualify for the M.D. degree the candidate had to have his M.B. or an equivalent, have been engaged in actual practise or have attended the practise of a hospital, for at least two years after having graduated with his M.B., be of moral character, have passed an examination, and furnished a commentary on cases in Medicine, Surgery, and Midwifery. (Spragge 1966:69)

From the beginning of Trinity's Medical Faculty's life, its religious affiliation was problematic. There were many young men who wished to study medicine but because they could not make the religious declaration, were debarred from becoming regular students in the Trinity Medical Department. Since a good part of the Faculty's livelihood depended on the number of students, they were motivated to find

a way of side-stepping the regulations. As a solution, they offered to instruct occasional students for the same fee as regular students. The occasional medical student at Trinity was in the same position as students at the Toronto School of Medicine: he could attend the lectures at a recognized Medical School and be examined by and receive his degree from the University of Toronto. (Spragge 1966:70)

When the Medical Faculty began to openly advertise that occasional students could take the full medical course without declarations or tests, it brought them into conflict with the Corporation of Trinity. The inability to resolve this dilemma led to the eventual resignation of the Faculty members in 1856. (Spragge 1966:71)

In light of the construction of a building in 1852 to house the University of Toronto's (previously King's College) growing student body (The Librarian 1906:175) it must have come as quite a shock when the Hinck's government a year later made the University of Toronto a purely examining and degree conferring body. (MacDermot 1967:96) It seems strange that the faculty of medicine did not continue under the newly formed University College because the latter was instituted to take care of the instructional section of the University of Toronto. (Bissell 1953:3) Some physicians felt that the Hinck's Bill could be blamed on Dr. John Rolph who was a member of Parliament at this time. There were far too many medical schools for one city to maintain and the Medical Faculty of Trinity College and the Medical Faculty of the University of Toronto were in vigorous competition with

Rolph's academy. What is not mentioned however, is the fact that the occasional students of Trinity and students at the Toronto School of Medicine had to obtain a degree through the University of Toronto. If the University of Toronto's Medical Faculty was in competition with the two, then how difficult did the Medical Faculty make it for the students from the competing schools to apply for examination and receive a degree? In certain respects the Hincks Bill gave legal recognition to a role which the University of Toronto had been playing. On the basis of several comments made by Claude Bissell, it seems that it was relatively common for the government to interfere with the affairs of the University of Toronto.* Therefore it was quite possible that the government on the advice of John Rolph, withdrew the University of Toronto's teaching facilities and medical faculty to ease the congestion of medical schools in Toronto. Although the government gave a different rationalization for the Bill, several historians commented on

*When the University of Toronto succeeded King's College it accepted almost all the staff of King's College but it also added some new professors. Francis Hinck's (head of the Hincks-Morin government) brother William was given the chair of Natural History. "That the appointment of the last named was an example of the nepotism of the so-called 'Reformers' can hardly be doubted; for it is on record that a rival applicant for the post was Thomas Henry Huxley." "This was the first, but not the last, time when the effects of the new principle of 'government control' became evident in the affairs of the College." (Bissell 1953:6)

how unsatisfactory the reason was to them. (Heagerty 1928:84; The Librarian 1906:175)

Despite attempts to reinstate the Medical Faculty of the University of Toronto, it took thirty-four years for the University to regain its school. Apparently the government did not accept the argument that medical students could only obtain a sound training in sciences by access to university labs and lecture rooms. (Heagerty 1928:85)

While the Hinck's Act may have improved the supply of students to Trinity's Medical Faculty and Rolph's School, both of these institutions experienced trying circumstances in the following years.

Rolph's School affiliated with Victoria College in 1854 and was renamed the Medical Department of Victoria. Aside from its name, few conditions changed at the School. Classes continued to be held in Toronto and Victoria oversaw the curriculum and business affairs only slightly. In return for affiliation a portion of the fee for degree was retained by Victoria. (Sissons 1952:98) Unfortunately, it seems that while Rolph excelled as a teacher, he was not as successful in handling staff or financial affairs. (Sissons 1952:124) In 1856, four of Rolph's colleagues took the charter and name of the school and set up a new Toronto School of Medicine. (Bull 1934:115; Spragge 1966:78)

Trinity did not appear to have better luck in managing its affairs. Towards the end of 1854 conflicts once again flared up between

the Corporation of Trinity and its medical Faculty over the latter initiating discussions with members of the government without going through the Corporation. (Spragge 1966:73) For three months relations between the Corporation and the Medical Faculty were unfriendly. Nonetheless, after April, relations improved for approximately one year. Then the Medical Faculty once again inserted an advertisement which the Corporation found objectionable; the Corporation reminded the Faculty that all advertisements had to be submitted to the Bursar for approval and demanded that the ad be withdrawn. In response the Medical Faculty resigned July 1856. (Reed 1952:58; Spragge 1966:74-75)

Queen's University, Kingston, was the only university affiliated school outside of Toronto. It was housed in a \$10,000 building while the rest of the University was housed in \$6,000 facilities which the University was struggling to pay for. (Calvin 1941:67) Although the University appeared to give a great deal of financial support to faculty of medicine, the latter maintained itself as late as 1907 solely on the basis of fees and thus came under the definition of proprietary. (Flexner 1960:322) Seven years after the Medical Faculty had been given its building it was disbanded for a while and a Royal College of Physicians and Surgeons affiliated with Queen's took its place. (Calvin 1941:74)

b) Low Status Schools

As I mentioned in the introduction, the range of standards for proprietary schools was wide. Let us examine a few which fell at the lower end of the continuum; the locally known, unprestigious schools.

A well-established physician might take in several articulated students and then been credited with conducting a medical school. Yet, the difference between this and an apprenticeship seems to lie with the number of students articling at the same time. An advertisement appeared in the London (Canada) Times, April 1, 1847

WANTED. Student for the medical profession, suitable young man will meet with peculiar advantages, and liberal terms. Apply to Dr. Turquand, Woodstock.

(Seaborn 1944:38)

Another example of the same kind of school was Thomas Phillips. Described as "a very elegant young man" he also was an ambitious one for we learn that before he moved to London and began his school he dealt in Real Estate in Brockville. (E. Seaborn 1944:87) In 1843 he began to advertise in the London Inquirer for students.

FOR MEDICAL STUDENTS

Dr. Phillips will devote two evenings in the week, Mondays and Thursdays, to giving private instructions, and examinations, to medical students, in the following branches. Anatomy, Physiology and Pathology, also Theory and Practise of Medicine and Surgery, Chemistry, Obstetrics and diseases of women and children. Dr. Phillips has letters from Professors in the Universities of London, Dublin and Edinburgh, as to character and qualifications.

January 9, 1843

(Seaborn 1944:88)

Although the schools were considered to be unprestigious we have no way of determining the calibre of education which was given.

This is due to the little attention paid to informal schools by medical historians. On the basis of descriptions of more prestigious schools, the smaller schools may have offered as thorough courses. Certainly the latter could provide the same kinds of equipment and facilities for dissection and perhaps as well-qualified instructors. In addition, the smaller schools could offer individual attention to their students. The one thing that they could not give their students, however, was a reputable name to back up their educational qualifications (attainments).

c) Summary

To sum up medical education in Canada West from 1840 to 1867, I would have to say that most of the schools were founded within too short a period of time within one city. It was evident that they were established more for emotional and political reasons than on the basis of long term planning or in terms of supply and demand. To expand on the last point the Tories could not allow the Reformists to look after medical education in Toronto. They had to have a Tory based medical school. Thus the Faculty of Medicine of King's College was the outcome of emotionally charged political motivations rather than long-term rational planning. The destruction of the University of Toronto's medical school could also be attributed to these motivations. One thing the latter does show is that the government was still interfering in the affairs of medicine.

ii) Canada East

a) Réputable Schools

L'Ecole de Medecine et de Chirurgie de Montreal was incorporated in 1845 by English physicians because they resented the way that McGill was dominating the "profession" of medicine in Lower Canada. (Abbott 1931:66) Complaints were lodged against McGill on two counts. First of all, physicians resented the monopoly of teaching privileges and of appointments by the elite of McGill to the Montreal General Hospital. (Abbott 1931:66) It was almost impossible for aspiring young doctors to gain a position on Faculty and therefore his ascent up the occupational ladder was blocked. This must have been particularly frustrating to French Canadian physicians because in spite of the fact that this was a French province, the English seemed to initiate programs and institutions in Canada East. I am not inferring that the French were less aggressive but would suggest that they took a more passive role because the English had established and occupied the upper echelon of the occupational structure. This may explain why a school which catered to French students would be staffed by English professors; Drs. Francis Arnoldi, Francis Badgley, William Sutherland, Pierre Munro, and William Macnider. At a later date the school was taken over by French Canadians. (MacDermot 1967:98)

In trying to discern any previous connections between these men, I discovered that Drs. Badgley and Sutherland, along with Dr. Robert MacDonnell from the faculty of McGill, had begun to edit the

first medical journal in Montreal, the Montreal Medical Gazette, 1844.

(Abbott 1931:56) A year later Badgley and Sutherland stopped publication to give place to the British American Journal of Medical and Physical Science, edited by Drs. A. Hall and R. MacDonnell.

(Abbott 1931:68) This move appears to me to be more out of friendship than competition. Although this journal is accused by Maude Abbott of holding pro-McGill sympathies, evidence points to a disillusionment with McGill on MacDonnell's part. He was the initiator of the St.

Lawrence School, 1850. (Abbott 1931:67) Dr. Badgley had another connection with McGill's Medical Faculty. Around 1824 he apprenticed under Dr. Robertson for three years. (Abbott 1931:56) Francis Arnoldi was the son of Daniel Arnoldi. The latter had sat on the Board of Examiners before it was reconstituted by members of McGill's Medical Faculty and he had been Andrew Holmes' preceptor. Therefore, his son Francis would be familiar with at least two members of McGill's Faculty. Their associations formed through past working relationships

with members of McGill's Medical Faculty may have enabled Arnoldi, Badgley and Sutherland to leave l'Ecole en masse and join McGill in 1849. (Abbott 1931:65) Two years later Arnoldi and MacDonnell left McGill to form the St. Lawrence School. (Abbott 1931:67) Dr. William Macnider has been left until the last because his medical career and his contribution to l'Ecole was cut short by his death in 1846 from tuberculosis. (Abbott 1931:64) During his short career he established the

Montreal Lying-in Hospital in 1842, which supplied clinical teaching material for the Ecole de Medecine. (Abbott 1931:83) While he taught at l'Ecole he was also a member of the Montreal General Hospital staff, which tells us that while the McGill Faculty dominated positions at the General Hospital, there were some outsiders on staff. There is an indication that Macnider was viewed as an outsider for although his Lying-in Hospital was situated in Montreal, McGill professors turned around three years later and established the University Lying-in Hospital and staffed it entirely with McGill professors. (Abbott 1931:68)

l'Ecole de Medecine's Act of Incorporation passed the Provincial Legislature on March 29, 1845. Under this Act lectures at the School were to be delivered both in French and English, and authority was given for certificates to be awarded to its graduates, entitling them to a license to practise medicine. The latter was automatically cancelled when the College of Physicians and Surgeons of Quebec was incorporated in 1847. The College only granted licenses to those holding a University degree. (Abbott 1931:64) Thus, l'Ecole reached an agreement with the Medical Faculty of McGill whereby all lectures at l'Ecole de Medecine were to be delivered in French only, and students who had completed their course there were to be admitted to the final year at McGill, so that they could graduate with a degree from the latter. At this time Drs. Coderre, Peltier and Boyer were l'Ecole's teaching staff. (Abbott 1931:65)

This arrangement lasted until internal disputes within l'Ecole disrupted it in 1849. A majority of the staff at l'Ecole wished to appeal to the Legislature for authority to issue certificates which qualified its owner to receive a license to practise from the Board of Examiners. Arnoldi, Sutherland and Badgley disapproved of this measure and transferred en masse to the Medical Faculty of McGill. Thus in 1849 the school became purely French. (MacDermot 1967:99) They were replaced at the Ecole by Pierre Beaubien, Eugene Trudel, K. Leprohon and J. Bte. Trestler. Coming from a distinguished family, Dr. Beaubien was a graduate of the University of Paris and a member of parliament from 1841 to 1851. (Abbott 1931:65) Dr. Leprohon produced a purely French medical journal, the Lancette Canadienne. It was discontinued however, within six months. (Abbott 1931:70) Dr. Trestler obtained his M.D. at Edinburgh and also studied in London and Paris. (Abbott 1931:54) He was replaced, however, a few weeks later by T.E. d'Orsonnens, son of an officer in the Swiss-Meuron regiment. (Abbott 1931:65) Dr. Peltier also obtained his M.D. at Edinburgh. Although I cannot discover the kind of training Dr. Coderre received, I did uncover that he was a "patriot" during the Rebellion of 1837 and suffered punishment for his views. (Abbott 1931:65) At this point all the Faculty of l'Ecole were French-Canadian.

It took a year for the petition of l'Ecole to reach the Legislature in 1850 and it was withdrawn after second reading. Its

withdrawal may have been due to a counter petition signed by Holmes and twenty-six other practitioners of Montreal. They opposed the idea of a school having the power to grant diplomas in medicine because it was an infringement on the authority of Universities. They also argued that the standard of medicine would be lowered because schools with incomplete qualifications would be able to issue diplomas which gave them as much credit as a university diploma.

These maneuvers were an attempt to impose a "uni-portal system of entry" to the occupation. Consequently all students who travelled through this system would emerge with a constant status instead of a hierarchy of statutes based on dissimilar training. Thus all who called themselves physicians would be assumed to share a common level of competency. Graduates would also have shared similar entry and socialization experiences which would assist somewhat in the development of a shared identity. Nevertheless one would still find groups with their unique interests, attitudes and goals. (Strauss and Bucher 1961:332)

Limited by an inability to confer a diploma and lacking a university affiliation, l'Ecole applied for affiliation to Laval University, Quebec, in 1862 and again in 1864. Not meeting with success, it appealed to the University of Ottawa in 1866 and met with the same rejection. Nonetheless, in this year a graduate of the school, Mr. Thomas Bulmer, bargained for an invitation for l'Ecole to

affiliate with Victoria University, Cobourg, Ontario. In return for affiliation Victoria was to receive two-thirds of the examination fee. This offer was promptly accepted and the l'Ecole de Medecine et Chirurgie de Montreal became in 1866 the Medical Faculty of Victoria University in Montreal. (Abbott 1931:65; Sissons 1952:125)

Another French-Canadian school of medicine was incorporated in the Province of Quebec in 1847 two years after the incorporation of l'Ecole de Medecine et Chirurgie de Montreal. It was called the Incorporated School of Medicine of the City of Quebec. This school had the same problem as l'Ecole de Montreal because it could not confer diplomas because it was not attached to a university. In 1851 their problem was solved when its teaching faculty was invited to become the Medical Faculty of Laval University. (Abbott 1931:64)

The Medical Faculty of the School of Medicine of Quebec, had six members; Charles Fremont, Jean Blanchet, James Sewell, E.Z. Nault, Landry and Alfred Jackson. (Abbott 1931:71) I discovered that Dr. Fremont, along with a Dr. Morrin, had helped Dr. James Douglas establish Beauport Assylum for the Insane. This working relationship would have given Fremont many important occupational connections and may explain why Laval chose the Incorporated School of Medicine over l'Ecole de Medecine et Chirurgie. James Douglas was a classmate of Drs. Holmes and Stephenson at Edinburgh. Dr. Painchaud gave Douglas a house in Quebec City in 1827 to conduct lectures and demonstrations in Anatomy in return for free admittance to lectures for him and his son. (Abbott

1931:55) Nineteen years later Fremont, Sewell and Painchaud would sit on a committee to consider the incorporation of the Profession of Canada East into the College of Physicians and Surgeons. (Abbott 1931:71) Thus Dr. Sewell knew Fremont before the school was incorporated. Fremont and Sewell's participation on this prestigious committee made them known to the College of Physicians and Surgeons and might have helped the reputation of their school. Dr. Douglas was also appointed to supervise surgery and medicine at the Marine Hospital (the forerunner of the School of Medicine of Quebec) in 1831 and continued there until 1845. His presence was one of the elements that made this hospital a school of practical surgery unequalled on this continent. (Abbott 1931:55) A superb reputation in surgical competency would help the incorporated School of Medicine gain affiliation with Laval. Dr. Alfred Jackson, a Canadian graduate of Edinburgh, was added to the Medical Faculty. (Abbott 1931:64) At the inauguration of the University in 1854 the teachers of the "Incorporated School of Medicine in the City of Quebec" became professors and Jean Blanchet became Dean.

Over the years the new Faculty of Medicine of Laval at Quebec expanded and in 1863 added a maternity service and two years later began the teaching of pathological anatomy. (Abbott 1931:64)

The rapid growth of an English speaking medical community in Canada East and the growing number of well-qualified younger physicians who could not get positions on the teaching staff of McGill, led to the establishment in 1850 of a significant but short-lived school;

the St. Lawrence School of Medicine. Two eminent physicians, Robert MacDonnell, a graduate of Dublin University, and George Gibb (later to be knighted) founded the school. Staff consisted of Drs. Thomas Jones, Francis Arnoldi, R. Howard, G. Fenwick and Henry Howard. (Abbott 1931:67)

Very little could be uncovered on the teaching staff of the St. Lawrence School. We know that MacDonnell and Arnoldi came from McGill and that they were probably introduced to one another by either Badgley or Sutherland.

The St. Lawrence School was incorporated in 1851 with a charter which allowed graduates to be examined without the need of another diploma by the College of Physicians and Surgeons of Quebec. Upon successful completion of the examination they were awarded a license to practise medicine. (Abbott 1931:67)

The newly established school had two factors in its favour; it was near the Montreal General Hospital which, I assume, meant that its students could improve their clinical experience by access to hospital wards; and it was the only alternative school to McGill with lectures in English. (Abbott 1931:67)

McGill's Medical Faculty seems to have felt threatened by the intrusion of this medical school into its territory because it purchased a building on Cote St., close to the hospital and moved its lectures and dissecting room from the University to Cote Street in 1851. (Abbott 1931:67) This move takes on more significance when one discovers that only seven years before the Medical Faculty had requested

and received anatomy and dissecting rooms on the University campus. Although the medical faculty of McGill cited distance from the hospital and the growing number of students as reasons for the move (Heagerty 1928:66) these do not seem legitimate. To begin with, the distance from the hospital must have been taken into account when the Medical Faculty moved to the University campus and, in addition, sixty-five students does not seem to be an extraordinarily high number to necessitate a move. In short, the transfer by the Medical Faculty of McGill appears to be a move to re-establish its territory and pre-eminent position in the City of Montreal.

b) Low status schools

Although Abbott makes no mention of the development of sectarian medicine in Lower Canada, I discovered in Bull's book that a College of Homeopathy was set up in Montreal. The College granted the degree of M.C.H.P.S., Montreal College of Homeopaths, Physicians and Surgeons. Faculty of the College established a Homeopathic Institute to provide free medical care to the poor. I wonder if, as in the United States' dispensaries, the poor had to be recommended by a respectable citizen before becoming eligible for care (Rosenberg 1974:42) because Seaborn talks of 303 patients applying for treatment. (Seaborn 1944:197) To have an irregular form of medicine setting up a College and providing free medical care at a dispensary must have been a severe blow to McGill.

c) Summary

In reviewing medical education in Canada East one can say that the medical faculty of McGill University dominated the province. This situation was intolerable to some and in response a few ambitious members of the medical community established rival schools; l'Ecole de Medecine et Chirurgie and the St. Lawrence School. If the teaching positions on the Faculty of McGill were sewn up, then they would create additional positions in other institutions.

It was during this time period that the French Canadian physicians organized and emerged as a group and created a school to cater to French-speaking physicians. l'Ecole de Medecine et Chirurgie started out with a bias towards the French Canadian and eventually became entirely French.

As the years 1840 to 1867 were a period of transition from oligarchic to collegiate control, it is at times difficult to clarify certain situations. Events occur which appear to be inconsistent with each other. While at one point the elite of the occupational community appeared to be introducing policies which could force medical schools to affiliate with a university, at other times the elite seemed to tolerate rules which would interfere with this. To be more explicit, l'Ecole de Medecine was not allowed to grant diplomas and was thereby forced to join a University so that its students could graduate with a degree which, in turn, was a prerequisite for obtaining a license from the Medical Board. At the same time, the St. Lawrence School was

incorporated with a charter which allowed its graduates to be examined by the Board without a University degree. Perhaps the inconsistencies can be dismissed by the suggestion that the policy of l'Ecole was established by the medical elite and the other by the government. In such times of transition conflicts between the two are likely.

V. The State of Medical Knowledge

Within this section lies one reason why regular medicine was having a difficult time convincing the State that it should have a monopoly over the area of health care; it was lacking a scientific foundation. During this period the science of medicine was just being established. In the process long held beliefs and practices came under scrutiny and were either accepted or abandoned. More satisfactory explanations took their place and sometimes they too were found to be incompatible with new discoveries and were therefore left behind. These years were a transitional phase for medical science. Etiology of illness and consequently treatment came under question as a consequence of a world-wide realization that methodology in medical research was poor and thus findings unsubstantiated. A Belgian authority on probabilities summed up the condition of medical data quite nicely "...incomplete, incomparable, suspected heaped up pell-mell...and nearly always it neglected to inquire whether the number of observations is sufficient to inspire confidence." (Shryock 1947:141) Students trained in Paris became particularly aware of the need for critical examination of confused and radical remedies inherited from the old schools. (Shryock 1947:158)

Canadians adopted the French method of exact clinical descriptions. This event was probably hastened because Canadian medical schools had

established from their inception, access to hospital wards and patients. The doctor was expected to find exactly where the symptoms were, in what form, to what degree. (Shryock 1966:221) To help him in his task the stethoscope was generally available by the 1850's. (Bull 1934:101) As Bull presented the situation in Ontario, "The students at the Toronto School of Medicine and at the Colleges profited by the clinical teaching introduced at the Toronto General Hospital, and the profession as a whole showed increasing understanding of the enemies with which it had to deal." (Bull 1934:101)

Physicians took an additional step and started to compare clinical observations. Slowly the classification of disease was taking place and consequently diagnosis was becoming less confused. (Bull 1934:102)

In addition, the use of statistics was being encouraged to improve observation. (Shryock 1966:16) In Paris and elsewhere there was great interest in applying the calculus of probabilities to social and medical data. For the first time numerical studies were carried out on the causes and remedies of various diseases. On the basis of statistical evidence Oliver Wendall Holmes could prove in 1843 that puerperal fever was conveyed from one woman to another by the doctors or nurses who had attended them at the birth of their babies. (Shryock 1947:167) The mortality rate from his was high.

Along with improvements in methodology came new information in anatomy and physiology. Through the study of organs which led to tissues and after 1860, observation of the microscopic constituent cells, Paris was providing increasingly reliable knowledge of structural pathology. (Shryock 1966:27) A Frenchman, Claude Bernard,

released to the world information on the functions of the liver and pancreas, and had established a basis for the modern theory of digestion. (Bull 1934:102) Nevertheless, sects, were a manifestation of the uncertainty of medical knowledge. There was no well-established paradigm to guide explanations; only narrowly defined schools of thought in juxtaposition to one another.

To give the reader some idea of the paradigms which the various sects held, I will quickly review the popular sects. Homeopathy was brought to the United States by some regular physicians who had trained in France. (Shryock 1947:163) When this sect began to speak out against bleeding and purging which the majority of regulars used, this sect was forced out of regular medicine. Homeopaths and Eclectics believed strongly in the efficacy of drugs with vegetable sources. (Physicians Panel on Canadian Medical History 1967) Homeopaths maintained that the colour and shape of the plant yielding the drug indicated the part of the body it should be used for. (Abse 1967:180-181)

Shryock felt that in the United States the Thomsonian sect took advantage of the rising protest against excessive purging with calomel to enhance their position. Calomel was a mercury based drug which was often used frequently and in excessive quantities. At times patients were poisoned with mercury and the consequential symptoms were attributed to the original disease. Thompsonians maintained that vegetable based remedies were superior to chemical. (Shryock 1947:252)

Sects were proof of the non-scientific basis to medicine. Each sect and regular medicine held a variety of unsubstantiated theories of etiology and treatment which were supplemented by widely

variable clinical skills and judgements. (Freidson 1972a:15) When the average regular doctor could not offer any more reliability and predictability than any sect in controlling illness or offer any better chance of recovery, then why would it be given a monopoly over the healing arts?

Nevertheless advances were occurring in the area of medical science. Out of this chaos came one of the most important breakthroughs in clinical techniques. Physicians finally came to realize that ether and chloroform could be used to give the patient relief during an operation. Although Chloroform was independently discovered in 1831 by both a French chemist and a New York physician, its relevance to surgical procedures was not recognized for another sixteen years. Shryock claims that doctors turned first to ether as a sedative. (Shryock 1947:175) I discovered in the diary of Sophia MacNab that ether had been used by their family doctor for a sedative. (Carter & Bailey 1968:28)

The first public operation under ether was performed in the Massachusetts General Hospital in 1847. (Fishbein 1969:48) In the same year Horace Nelson of Montreal publicly demonstrated the effect of ether on dogs and weeks later he used it in an operation to remove a tumor from a female patient. Dr. Worthington of Sherbrooke used ether when performing an amputation. (Abbott 1931:73) Canadian dentists were quick to realize its significance to dentistry. The same year that ether was introduced to the public a dentist from Montreal purchased the formula and apparatus for ether. (Heagerty 1928:304)

Doctors soon discovered a drawback to ether; it was highly explosive. In those days operations were usually performed on a kitchen table and next to the open hearth to provide extra light. We can only guess at the unfortunate consequences of some operations. (Physicians Panel on Canadian Medical History 1967)

Physicians turned to chloroform as an alternative. Andrew Holmes used chloroform in a difficult midwifery case in 1847. In 1848 E.D. Worthington used chloroform in three cases at Sherbrooke and J.E. Mortin used it in an amputation at Marine Hospital, Quebec. (Abbott 1931:74) Nevertheless, this does not tell us anything about its general use. The only information which I could gain about its general use was that it became fashionable after Queen Victoria used it at the birth of her eighth child. (Wyndham 1968:200-201) It was not without its drawbacks either; in large doses it was lethal.

The introduction of ether and chloroform into use as an anaesthetic enhanced the value of surgery. Where doctors were hesitant before to surgically intervene because the pain for the patient was too great, now with the problem of pain out of the way, the doctor could try to help by taking this route. Before anaesthetics "one minute for an amputation was considered ample and the skill of the surgeon was judged largely by his speed and the amount of blood on his frock coat." (Heagerty 1928:273) Now surgeons could take their time and improve their technique.

Although anaesthetics widened the scope of surgical action, the death-rate was too high to use it as a standard procedure. In hospitals, doctors lost as many as thirty out of one hundred patients. This was entirely due to the lack of aseptic conditions during the

operation. "Surgeons were not particular about the cleanliness of their hands, instruments or bandages, to say nothing of their patients; nor did they see any necessity for precautions in these respects. Wooden tables, rarely, if ever, cleaned, were used for operating. Surgeons wore old, frowsy, blood-stained, frock coats, and ligatures often were used a second time. Conditions at the Toronto General Hospital were very bad." (Bull 1934:138)

...The floors, walls and ward appurtenances are extremely filthy, the patients swarming with vermin; no ablutions, no baths...

(Bull 1934:138; The Medical Chronicle Vol. 1854-5)

Although this is a description of a hospital in New Brunswick, there is no reason to believe that conditions were better in Ontario and Quebec.

Surgery was done without benefit of washing up and other preliminaries--often on kitchen tables and with very few instruments. Sterilizing instruments was unknown, so germs had their heyday. Some old surgical instruments folded into a little case like an ordinary pocket knife: some had beautifully engraved frames, sometimes an animal's head or a lady's figure formed the handle but all were far from being aseptic as one can well imagine.

The surgeon used to hand a leash of waxed thread through the buttonhole of his coat, so he wouldn't have to hunt for sutures during an operation. There were no face masks, no nurses done up in caps and gowns. And the patients kept most of their clothes on--sometimes even to their boots...patients often used a stiff hooker of Jamaica rum to bolster up their intestinal fortitude...calomel, oil and bleeding were used as healing agents.

(Acton, Goldsmith and Shepard 1974:131)

Under the circumstances, a patient's chance of survival were lessened. It took a while for doctors to realize that there was a causal link between their patient's death and the unsanitary conditions. Before this, physicians assumed that patients died of the pathology they had entered the hospital with.

There was a tremendous gap between the practices of leaders in medicine and the average practitioner.

One possible reason for this situation was the general reluctance of any medical community to accept a new idea. The latter meets with opposition from a group either because it runs counter to prevailing paradigms; the idea is so new that some individuals are not comfortable with it; or it threatens the existing power position of an occupation with society or of a group within an occupation. (Johnson 1972:56)

Alternatively, perhaps it was the state of transportation (refer to Section I) and communication in the Union of Canada that slowed down conveyance of new breakthroughs and advances to the average practitioner. While it was difficult for the latter to attend meetings; still the situation could have been helped if physicians had subscribed to a medical journal. Nonetheless, for some reason doctors would not. The common dilemma of medical journals was that they could not keep going because there were not enough physicians who would subscribe. (MacDermot 1967:158)

Although progress was taking place in the area of medical knowledge, there were several situational factors that were impeding it. To begin with, the government did not consider medical research to be one of its responsibilities. Even if it had, the construction of the railways was taking all of its revenue at this time. Therefore, there were no publicly supported facilities. Hospitals were built to care for the sick, not to do medical research in. Thus if a physician wanted to carry out exploratory work he had to secure facilities privately. Some doctors built facilities in their homes and some used the space

provided in the medical schools. In Shryock's words, Canadians and Americans inherited from the British a voluntary rather than obligatory tradition in professional and educational matters. With issues left to individual initiative and without financial sponsors, prompt, systematic research was difficult. (Shryock 1966:33)

Canadian medicine did not begin to emphasize science in medicine until the last years of the nineteenth century and even then the full force of these pressures were not felt until the twentieth century.

VI. Summary of Chapter Two

Using Johnson's theoretical structure, the data on Canadian medicine show it to be going through a transitory period between Oligarchic and Collegiate control of medicine. The social economic structure was changing so that the demand for occupational services was spreading from a small, unitary clientele to a group of more diverse elements and interests. I would suggest, however, that the consumer group was still not heterogeneous enough to provide the conditions for medicine to become a profession. (Acton, Goldsmith & Shepard 1974:23) The medical schools founded during this time provide evidence that the Tories and the Church of England were losing control over the occupation of medicine. Medical schools did not necessarily have affiliations with the Church of England. The Toronto School of Medicine was founded by a Reformist.

Entrance into the medical community was beginning to change. While recruitment might still have been based on sponsorship, when the College of Physicians and Surgeons of Lower Canada was incorporated in 1847 the College decided to grant licenses only to those holding a

university degree. (Abbott 1931:64) Upper Canada was a little less ambitious; the Licensing Board would only examine men who had spent three years attending medical lectures in recognized schools and at least one year in the Medical Department of a University. (The Librarian 1906:172) The lengthening and institutionalization of medical education began to effect the characteristics of medical recruits. For one thing, it channelled out the poorer classes because they did not have the means to support themselves while attending school. (Ehrenreich and English 1973a:23-27) It also prevented women from obtaining a license because they were not admitted into Universities. (Ehrenreich & English 1973a:23-27) Secondly, the necessity of attending university initiated the idea of large groups of medical students sharing the same teachers and experiences. Thus recruits began to undergo similar conditions which affected their values, beliefs, attitudes and goals. Nevertheless, they were not at the stage under Collegiate control where the educational institutions were similar enough that students began to share the same values, beliefs, attitudes, and goals.

When the educational requirements narrowed the range of perspective candidates down to the upper middle and upper classes, the occupational group started to gain strength. The occupational group could rely on wider resources of power by virtue of their members belonging to a dominant class. (Johnson 1972:43) In support of this hypothesis, the faculty of the Upper Canada School of Medicine was composed of Upper and Upper Middle Class men who, being perceived as

distinctly brilliant and having the support of social Toronto, became the controlling influence in the Toronto General Hospital. (Reed 1952:57) Medicine was also able to impose educational standards on recruits because this community was able to convince politicians to pass regulatory legislation. As the class range of members became smaller, the collective lobbying power of the community became larger. It was evident though, that the community did not have the amount of lobbying power needed by a profession when Parliament passed an Act in 1859 to establish a Homeopathic Medical Board.

A complete turnabout in the characteristics of the consumer and practitioner group released medicine from Oligarchic control, enabling it to move towards Collegiate control. The increasing homogeneity of the occupational group and the growing heterogeneity of the consumer group was shifting the balance of power in medicine's favour; enabling it to establish social distance between itself and its patrons.

In order to maneuver a more autonomous position, the practitioner group had to create a social distance. The medical community's growing resources of power helped but it also needed public trust in the efficacy of treatment. Regular medicine was unable to command a monopoly over the healing arts at this time because internationally medicine was undergoing a re-examination of paradigms and consequently, treatments. The emergence of sects in Canada and the United States was a manifestation of the uncertainty to medical knowledge. With so many competing schools of thought, it is little

wonder that regular medicine could not establish itself as the exclusive repository of skills and expertise. Without the public believing medicine to be wiser than the layman in medical matters, medicine could not establish a social distance between themselves and the public and gain professional autonomy. (Freidson 1970a:137)

The image of all practitioners being equally competent would also generate public trust and faith in medicine's ability to provide the best solutions to health problems. (Johnson 1972:54) This is one reason why the gradual narrowing of educational requirements which occurred during this period, was important. It could also have had an effect on the institutionalization of the occupation. As you will recall, medicine experienced problems organizing on a large scale because the executive of the local associations felt threatened by the more powerful physicians who would form the larger scale organization. I suggest that part of the reason for the intimidation was the large gap between the local administrators and the elite in education. If this reason is valid, then a standardization of education would make it easier to amalgamate local associations.

The other problem which delayed the formation of a national association was the friction between English and French practitioners; as the English pushed for regulatory measures to be handled by more centralized agencies, the French fought to maintain control at a more local level. This was observed in matters of regulation and administration. The French faculty at l'Ecole de Medecine et de

Chirurgie de Montreal wanted to appeal to the Legislature in 1850 for authority to issue certificates which would qualify the owner to receive a license to practise from the Board of Examiners. On the other hand, the English speaking faculty held such strong objections to this measure that they transferred en masse to McGill. Consequently, the two factions aligned themselves with particular schools. L'Ecole and the French Canadians were no match for the power of the predominately English University and Government. Holmes and twenty-six other practitioners of Montreal (I presume that most of the others were McGill Faculty) submitted a counter petition to defeat L'Ecole's petition. In matters of administration, the nationalistic French Canadians could not stem the move towards a national association.

In 1867 the Canadian Medical Association was formed. The formation of the Canadian Medical Association was the beginning of a new stage in the professionalization of Canadian medicine. Finally, various groups were brought together under one body so that administrative concerns could be handled by a large organization. Medicine needed a national body to show the public that it was capable of managing its own concerns. When a national body began to oversee by-laws, examination, education, licensing, registration, ethics and publications, then decisions could carry more weight because they were made by a larger and more powerful body. At last the occupation had an elaborate and formalized system of norms to regulate behavior. (Johnson 1972:56) The Association could work

towards imposing conditions which insured that all members would have equal status in the eyes of the public and a continuous occupational career. The image of equal competence would generate public trust in medicine. (Johnson 1972:54) Trust would also grow when the Canadian Medical Association could show that it was capable of undertaking proper action when a practitioner did not perform his work competently or ethically. As Freidson points out, the occupation can not attain professional autonomy until the public believes that it will take action on cases of deviancy. (Freidson 1970a:137) Judging from the report of the Committee on Ethics of the Ontario Medical Association (Ferguson 1930:19), by 1891 the public probably perceived the profession to be handling its delinquent cases capably.*

From the foregoing then, it is evident that patron control over medicine had eased up considerably and the occupation had been able to further organize and institutionalize facets of its administrative structure. Nevertheless, even with the formation of the Canadian Medical Association, for the reasons outlined above, it could not be called a profession. Therefore, we shall continue into the last third of the nineteenth century to demonstrate to the reader how during this time, medicine gained professional autonomy.

*The Report is discussed in Chapter Three under the Section on Societies.

Population Of Canada, Quebec and Ontario, Census Dates, 1851 to 1901

| <u>Year</u> | <u>Canada</u> | <u>Quebec</u> | <u>Ontario</u> |
|-------------|---------------|---------------|----------------|
| 1851 | 2,436,297 | 890,261 | 952,004 |
| 1861 | 3,229,633 | 1,111,566 | 1,396,091 |
| 1871 | 3,689,257 | 1,191,516 | 1,620,851 |
| 1881 | 4,324,810 | 1,359,027 | 1,926,922 |
| 1891 | 4,833,239 | 1,488,535 | 2,114,321 |
| 1901 | 5,371,315 | 1,648,898 | 2,182,947 |

(Urquhart 1965:14)

CHAPTER THREE

MEDICINE BECOMES A PROFESSION

I. The Political and Economic Milieu of Ontario and Quebec 1867 to 1900

By the end of the nineteenth century medicine had attained professional autonomy in Canada. This Chapter will look at how medicine proceeded through the process of professionalization from Confederation to the final decade. Employing Johnson's theoretical structure, I will focus on the conditions which were amenable to the advance of professionalism.

Johnson considered the socio-economic milieu to be the deciding factor in medicine's progress in professionalization. I would argue that the rise of a middle class which designated a more extensive division of labour along with an increased flow of currency* helped to change people's use of medical services. I will also show that the middle class not only enlarged the consumer group, they also joined the ranks of recruits for medicine. (Johnson 1972:52) We will see that the requirements for entry into medicine closed off this option to the lower classes. In addition, Johnson would see that the selection of the medical community from the dominant class

*See Appendices A and B, pp. 248-9.

gave it a wider base of power from which to increase its autonomy.

(Johnson 1972:52) I would not agree however, that recruitment from similar social backgrounds necessarily led to homogeneity of outlook and interest. In this Chapter we will see that medicine developed into circles of collegueship holding unique notions of their mission in life and common attitudes and approaches to problems surrounding their work. (Strauss and Bucher 1961:332)

At the same time that the medical community was becoming more homogeneous in social class, something was happening within the social structure which Johnson would see as the cause of diversification within the consumer group.. As a result of the economic policies and growth during the last third of the century, the middle class grew to a significantly large number and joined the group which made use of medical services. Johnson saw the increasing diversification of the consumer group as advantageous to medicine's usurpation of power.

(Johnson 1972:52) Following Johnson's lead, I would suggest that the more heterogeneous the consumer group, the less confident they would collectively feel because their education varies and thus each group would bring to the collectivity their beliefs regarding the cause and cure of illness. Not only would uncertainty be high, but the wide range in social class would prevent consumers from collectively responding to medicine's claims of expertise. Sheer numbers alone makes it impossible for consumers to organize to share ideas and promote desired policies. Their isolation makes them less sure of the accuracy of their evaluations and more open to exploitation. Placing this phenomenon within a socio-economic

milieu, the relatively sophisticated division of labour found in Canada at this time would increase the likelihood of people to refer problems to individuals who specialize in handling a particular problem.*

When the government held a Royal Commission Inquiry into the working conditions of Bell Telephone operators in 1896 the commissioners called on physicians' advice and medical studies to include in their report and also called for a further inquiry based on medical expertise. (Acton, Goldsmith and Shepard 1974:248-249)

When the Power Elite alone had constituted the consumer group it was more difficult for physicians to convince the consumer that they were the experts because the consumer group were first of all, powerful, well-educated and self assured. They were quite aware that they controlled all aspects of economic and political life, including the occupation of medicine. The Elite were tightly knit, could share information on certain physicians and could take disciplinary action on any delinquent physician. Under the circumstances it was impossible for physicians to distance themselves from their beneficiaries and without the social distance it was impossible to manipulate a more autonomous position. In addition, in the early nineteenth century the division of labour was too simple to support experts. As we noted in

*William Goode in "Community Within a Community: The Professions" American Sociological Review 22 (April 1957), 195 provides support for the claim that if a society becomes industrialized, it depends increasingly upon professional skills. Goode found in Comparative Occupation Statistics for the United States, 1870-1940 that there was a higher number of professionals per 100,000 population (859 in 1870 to 3,310 in 1950) and a growing number of occupations that aspired to professional status.

Chapter One although there was more of a division of tasks in the Upper Class, still members of the Power Elite could hold several different jobs at one time and thus did not specialize in one area. As an indication of the lack of acknowledgement of specialties, even doctors held several jobs and usually they were unrelated to medicine.

Johnson claims that through rigid entry and educational requirements medicine could control consumer skepticism. (Johnson 1972:58) This claim is impossible to validate but we will see that in the last two decades of the century the public began to use physicians as experts to resolve debates over matters of health.

Johnson also contends that Associations impose a monopoly on practice in the field and regulate entry to it, in an attempt to sustain uniform interests among members and promote uniform policies. (Johnson 1972:54) I would tend to accept Strauss' and Bucher's argument that Associations are established by a powerful circle of colleagues and this elite works to promote their policies and impose their values on the rest of the community. (Strauss and Bucher 1961:333)

Having touched on the conditions which Johnson hypothesized would help medicine during professionalization and the characteristics which would demonstrate that medicine had achieved professional autonomy, let us turn to the task of elaborating the points which I have just briefly presented.

As previously mentioned the socio-economic milieu created the precipitating factors for the professionalization of medicine. Beginning with the economic scene, Canada was undergoing industrialization* accompanied by a more extensive division of labour. With the advent of Confederation, a national economic policy was implemented to aid the transition from primary to secondary manufacturing. (Naylor 1975:5) Macdonald's National Policy created a protected market for Canadian goods and attracted a large amount of foreign capital to Canada. Between 1879 and 1883 Canada experienced an economic boom. (Naylor 1975:9)

The spread of mass production carried ramifications for medicine. Under industrialization high cost skilled labour was replaced by low cost unskilled labour. Complex skills were broken down into simple repetitive tasks and gradations in level of skill and pay occurred.

*Both sugar refining and cotton clearly showed the role of the tariff in the transition to industrialization. (Naylor 1975:44) In 1879 there were two refineries in Canada, a defunct one in Halifax and the Redpath Refinery in Montreal, run by George Drummond. Within three years of the introduction of the National Policy five new refineries opened; in Montreal, Walkerville, Ontario, Halifax, Moncton and Dartmouth. (Naylor 1975:46) By the end of 1883 however, overexpansion of the industry led to its collapse. In Ontario and Quebec the number of cotton mills rose from four to seventeen between 1878 and 1884. In 1870, Canadian cotton production satisfied about one-quarter of domestic demand; by 1882 it supplied more than the demand. (Naylor 1975:50) Although the industry collapsed in 1883, the cotton industry had established the factory system as a pattern in Canada.

This transition in the division of labour caused people to move beyond a self-sufficiency mentality towards a reliance on interdependency. Even the farmer was experiencing this change. High grain prices during the Crimean (1853-55) and the Civil War made it possible for them to begin to mechanize. After 1870 fewer goods in larger volumes were produced. (Lawr 1972:241) This meant that more necessities had to be purchased and the farmer was now more dependent on the merchant in the nearest town for goods which he had previously produced.

The pattern of specialization and interdependency was becoming stronger. (Acton, Goldsmith and Shepard 1974:23) This would help the occupation of medicine because people would begin to seek out a physician because they saw him as holding specialized knowledge.* Instead of waiting until the patient had failed to respond to home made remedies, more people would visit the doctor at the start of the illness.

Other factors were further lessening people's hesitancy to visit a doctor. During the Civil War, Americans brought more goods from Canada and thus currency poured into the country. With more people working at paying occupations and an increase in the amount of currency circulating in the economy, people had the means to eventually pay a physician. Now a doctor had paying patients from more than merely the Upper Class. In other words, the consumer group was

*This perception was enhanced by a definite improvement in the results of treatments. The use of antiseptic procedures, anaesthetics, and a general growth in physiological and anatomical knowledge were producing better probabilities for improvement and cure.

becoming more heterogeneous.

When the consumer group enlarged its ranks to include not merely the landed aristocracy but also members of a rising middle class bourgeoisie, then it was no longer a homogeneous group merged by common interests, values, beliefs and attitudes. Large metropolitan centres like Toronto had developed by the 1880's a largely differentiated population with distinct social classes. At the top were high ranking government officials and the judiciary, followed by the professionals (the Toronto Directory for 1868-9 listed 72 physicians and surgeons [Glazenbrook 1971:87]) which included clergy, lawyers, doctors, teachers and musicians; and then the business community. (Lower 1958:306)

As the demand came from an increasingly larger and more heterogeneous group of consumers then it became easier for medicine to establish and maintain itself. (Johnson 1972:52) By the last third of the century it was able to establish itself as a profession but it did not have the power that it has today. This can be explained in terms of Johnson's perspective. Medicine had to wait until Canada became more industrialized; the middle class grew as a consumer group and the division of labour became even more specialized and people became very dependent on others for services.

Along with advances in industrialization came improvements in communication and transportation. Railway and telegraph lines were increased and electricity was introduced to towns. St. Catharines had the first electric street railway in Canada in 1887. At Brantford, Alexander Graham Bell worked on perfecting the first primitive telephone in 1876. The first telephone exchange in the British

Empire was installed at Hamilton in 1878. (Encyclopedia Canadiana 1975:51) All of these innovations were making it easier for local medical societies to establish themselves. As you will discover in the section on organization, the number of local societies flourished during the last two decades of the century because of improvements in transportation and communication. Advances in medical science could also be relayed to the average practitioner at a much faster pace. Although the leaders in the field were, under the circumstances, remarkably quick to adopt new ideas the average practitioner could have been as much as twenty years behind current trends. Improvements in communication were also making it more difficult for irregulars to continue to practise undetected by the regular community. The more built up the area the higher the concentration of people and the more attractive a regular would find the location to practise in. The appearance of a regular marked the end of an irregular's practice because the regular did not have to tolerate economic competition from an irregular. He could have his professional community press charges against the latter for practising illegally.

While the National Policy encouraged the establishment of new businesses, it also created an inflationary situation which led to the economic slump around 1883. This brought problems to both Ontario and Quebec's metropolitan areas. Large numbers of immigrants and any rural immigrants who had come to the city looking for work could not be absorbed by an expanding industrial sector. Plants were

closing down and people were being laid off, not hired. Crowding in the industrial centres, growing slums with high disease and mortality rates, vagrant youth and increasing numbers of unemployed, destitute, old and sick individuals were social problems which the middle and upper classes in the cities had to contend with. (Acton, Shepard and Goldsmith 1974:133)

In an attempt to deal with these social problems, a reform community emerged. The same individuals or close associates promoted a great variety of movements for change: temperance, urban renewal, social welfare and female suffrage. (Bliss 1974:viii)

The one area in which the medical community could dominate was the problem of high disease and mortality rates. It is quite likely that ambitious members of the medical community saw an opportunity in which they could gain a stronger position for the profession by working on an area which would be perceived as for the public good. Medical schools began to teach sanitary science, and both Ontario and Quebec established Provincial Boards of Health in 1882 and 1887 respectively. (Heagerty 1928:344, 359) The first Board in Ontario was composed entirely of doctors (Heagerty 1928:35), while in Quebec only 50% of Board members were physicians. (Heagerty 1928:344)

Having established the economic and political setting of the last third of the century let us take a look at how medicine established itself as a profession during these years.

II. The Organization of the Occupation of Medicine in Ontario
1867 to 1900

In addition to the formation of the Canadian Medical Association the decade of the sixties was important to the medical profession of Ontario because finally in 1869 the medical community of this province was given control over the education and licensing of its doctors through the College of Physicians and Surgeons of Ontario. (Acton, Goldsmith and Shepard 1974:145)* In addition the Ontario Medical Register was created in 1871. At last the occupation had an organization to bestow status and identity on incoming members. By being able to impose a monopoly on practice and regulating entry to the field the College could promote uniform policies. (Johnson 1972: 54) Johnson is quick to point out however, that the mere existence of an association is not in itself an indication of professionalism. This type of group may exist without the occupation having enough power to attain full professionalism. At the time of Confederation medicine could not be viewed as a profession. It needed another ten years (1877) at least for the Canadian milieu to become favourable to professionalism in medicine.

*When the College had been dissolved in 1841, control over licensing and examination had reverted to the Medical Board of Upper Canada which had meant that once again an external agent, the government, had been managing the prerequisites for entry into the profession. (Anderson 1926:447)

The indicators which pointed to medicine's lack of professional autonomy all relate to the question of how much actual control the occupation had over who could practise medicine. Control over who can practise is ultimately determined by consumer choice. Without the support of the public, any rules regarding regulation are useless. Johnson maintains that "Only where there exists an effective demand for the occupational skills from a large and relatively heterogeneous consumer group can the institution of professionalism fully emerge." (Johnson 1972:51) In Ontario the occupation needed another ten years for the composition of the consumer group to become more variable. An economic boom occurred during these years which increased the ranks of the middle class. This class expanded the market for medical services and made the consumer group much more heterogeneous in social class and therefore lacking wider bases of power.

The conditions of medical schools in Ontario, 1867, did not seem to point to professionalism. The standards of the various schools needed to be more uniform and the competing schools within one city needed to be amalgamated. Both of these moves would decrease the extreme and overt conflict within the area of medical education. In addition the public would perceive all physicians as holding the same identity and status.

*For a concise view of the situation turn to Appendix D, Medical Schools, p. 252.

A standardization of education would encourage public confidence in the competency of regular physicians. This was evident when the public turned to medicine for advice on working conditions in the late 1880's. (Acton, Goldsmith and Shepard 1975:248)

The conclusive reason for hesitating to call medicine a profession in 1867 lay in the records of the Ontario Medical Register for 1871. In that year there were 1777 licensed physicians in Ontario but there were also approximately 500 practitioners practising illegally. (MacDermot 1967:19) That large a number indicates that medicine did not control the field of health care adequately.

While a heterogeneous consumer group; uniform medical schools; medical associations and few irregulars are all indicators of a profession of medicine, it is impossible to put a date on when medicine became a profession. I believe that attempts to attach a date would only lead to futile controversy. One can only safely say that by the end of the century medicine had been granted the status of profession by the State. This meant that only the occupational community would determine who could enter this group; the standards of the schools would be set by certain members of the community; the community would oversee the behaviours and ethical standards of members and misdemeanors would be handled by the group rather than by society. Having a mandate over all the managerial, financial and educational concerns of the community kept outsiders from viewing the power struggles and quibblings which took place within the community. This made it much easier to present doctors as rather God-like creatures

who were dedicated to the service of others. Freidson touched on this concept when he stated that it was time to secularize the profession of medicine. Having stated that it is impossible to affix a date to the professionalization of Canadian medicine, let us look at the characteristics which made it one by the 1890's.

ii) Societies and Associations

Improvements to the transportation system in Ontario made it much easier to maintain local societies and made it possible to establish a Province-wide one. MacDermot noted the increase in local societies during the 1870's and also mentioned the formation of the Toronto Medical Society in 1878. The latter had been organized from the remnants of the Medico-Chirurgical Society of Upper Canada. (MacDermot 1967:152) During the present century it gave up its identity to merge into the Academy of Medicine, Toronto.

The intention of these numerous societies was stated by Osler in his presidential address to the Canadian Medical Association in 1884:

By no means the smallest advantage of our meetings is the promotion of harmony and good fellowship. Medical men, particularly in smaller places, live too much apart and do not see enough of each other....In many towns, the friction being on a small surface hurts, and mutual misunderstandings arise to the destruction of all harmony.

As a result of this may come professional isolationAs a preventative of such a malady, attendance upon our annual gatherings is absolute.

(MacDermot 1967:154)

This objective is also stated in the minutes of the Ontario Medical Association. It was founded in 1881 because Canada was too large a country for all the members of the medical community to attend the national associations meeting. It appears that they assumed that in some years the Canadian Medical Association would hold meetings in a province which was distant from Ontario.

The objects of the Ontario Medical Society stood as follows:

1. The cultivation of the science of medicine and surgery.
2. The advancement of character and honour of the profession.
3. The elevation of the standard of medical education.
4. Promotion of public health.
5. A furtherance of unity and harmony among members.
6. The forming of a link between county and city societies and the Canadian Medical Association.

(Ferguson 1930:6)

A review of these objectives provides a great deal of insight into the problems which the Ontario medical community were having. The one point which is missing is the elimination of "quacks" from the medical field. It could be an indication that at last the medical community was strong enough to unite and also had enough power to keep the irregulars outside of medicine. The means to keep them out of competition are found in the objectives of the Society.

The creation of an image of the science of medicine and surgery was a tool which the regulars could use to advance their position. Stress on expertise could be used to persuade the public that medicine offered the best care. This explains the call for elevation of the standard of medical education. If the public believed that a high level of education existed, then if serious blunders were made

medicine had a better chance of brushing over them or making it appear as though this was the natural course of events.

A furtherance of unity and harmony amongst physicians was in keeping with the image of men of science. In the public's eye the latter would be above petty disputes. Conflicts could be used by irregulars to point out the immaturity of the group and the self-motivated interests of some members of the community. Only by the elimination of conflict could the character and honour of the medical profession be advanced. The occupation had to maintain an image of being trustworthy and putting the patients' interests first to keep its autonomy over education and licensing.

The minutes of the Ontario Medical Society tell their own story of medicine's progress at this time and therefore for the next page or so I will discuss pertinent points from their meetings.

In keeping with the new emphasis on the science of medicine Dr. Geikie made a motion at the Ontario Medical Association's 1888 meeting to ask the Ontario Legislature to amend the Anatomy Act to furnish a more abundant supply of anatomical material for the use of medical colleges. This Bill passed the Legislature the same year. (Ferguson 1930:15)

From the President's message at the 1884 meeting, leaders in the medical field were not warm towards the idea of specialization within the community. He called the tendency to engage in specialties regrettable because outside of the city the physician must be equipped

for all sorts of cases.*

Another Association member had previously claimed that practitioners turned to specialties after failing as general practitioners. (Lewis 1962:143)

The adverse reaction to specialism was to be expected. Here was another segment with different goals, attitudes, values and beliefs, (Strauss and Bucher 1961:325) posing a threat to medicine's goal of the appearance of unity. (Rosen 1972:63)

Rosen also perceived that when the general practitioner had to compete with specialists the former felt his public image had been devalued and his clientele diminished. Johnson would say that the emergence of specialists would bring the presentation of equal competency for all physicians into question. I feel that when the economic situation of the medical profession was poor and the average practitioner had a hard time making a living, it is quite conceivable that the general practitioner would be hostile to the specialist. (Rosen 1972:64)

While it is difficult to understand the medical community's strong reaction to advertising (they referred to it as "methods of the quack") Johnson provides a satisfactory explanation. Advertising gave the wealthy and influential members of the community an unnecessary advantage, setting them apart from other practitioners and thereby threatening the homogeneity of the community. Since the wealthy were

*The profession's concerns were a bit premature because there were very few specialists in Ontario until the twentieth century. (Heagerty 1940:103) For a discussion of specialisms in Canadian medicine turn to the section on the state of medical knowledge.

comfortably maintaining themselves it seemed unfair that they should use their funds to advertise and thereby improve their situation.

Returning to the minutes of the OMA, the report of the Committee on Ethics for 1891 dealt with the following three points:

1. No physician or surgeon shall perform a post mortem on the patient of any other physician or surgeon, without making a reasonable effort to have the attending physician or surgeon, or the one whose reputation is likely to be influenced, present.
2. Complaints have been made to the Committee about certain advertisements that have appeared. The committee recommended that the secretary write to those who have so advertised informing them of their violation of the Code of Ethics.
3. In the case of a certain member who had issued an objectionable circular the secretary was instructed to write him demanding an apology, and, if he refuse, it was decided that his name be erased from the roll of membership.

(Ferguson 1930:19)

Collectively the points illustrate two trends; maintenance of a closely knit body and the upholding of a professional reputation.

Roles are clearly outlined to preclude conflicts due to misunderstandings.

The second and third items outline the disciplinary steps to be taken when doctors behave in an unethical manner. Emphasis on a Code of Ethics accompanied by the discouragement of advertising would help establish the image of a service orientation where the physician is perceived to be motivated more by a desire to serve the public than by pecuniary interests. (Freidson 1970a:82)

It would be interesting to discover if this Association had anything to do with the amalgamation of the medical schools of Toronto

(discussed in the section on education). The President stated at the 1886 meeting that it was the duty of the Association to watch the course of medical education and while medical education was at a satisfactory state in Ontario there was still room for improvement. (Ferguson 1930:11) There appears to be a great deal of cooperation with this Association and the Minister of Education, G. Ross, as he had offered the Association use of the educational buildings and attended the meeting. Ross was also the individual who invited both the new Toronto School of Medicine and Trinity College to amalgamate and become the Medical Faculty of the University of Toronto.

The Hon. Charles Drury, Minister of Agriculture, was present at this meeting and in his address he said that he was glad that the Ontario Government was sympathetic towards the subject of medical education. (Ferguson 1930:15)

If the Association did not personally persuade the government that amalgamation would allow the educational institutes to provide the facilities which a scientifically oriented discipline needed; then, at least the Association was anxious to encourage the science of medicine. The President of the Association in 1886 mentioned in his opening remarks that "in the great centres of medical learning the scalpel and the microscope had opened up new fields, and those who expect to accomplish much must work along scientific lines." (Ferguson 1930:11) He then went on to say that the Government should undertake the collection of statistics on preventable diseases.

The profession wanted as much control over its various aspects of work as possible. This is why the OMA strongly protested the Ontario Government's act of annulling in 1898 the right of local districts to agree upon a scale of fees and to make them effective with the approval of the Medical Council. (Ferguson 1930:30) The OMA sought to reinstate this right; there is no mention as to whether or not they were successful. The desire to control its work as much as possible led the OMA to condemn lodge practice. Assuming it to be the same as contract medicine, the consumer rather than the practitioner controlled the patient-doctor relationship. Having contracted to provide medical care for a certain amount of time, the doctor is not in a position to end the relationship any time he feels like it. Johnson perceives that in this situation the consumer is in a less exploitable position (although he does not explain why). Assuming this, then the State is not as likely to give the occupation professional status because the consumer can set out the conditions which the doctor must follow under contract (Johnson 1972:53) thus; it would be unnecessary to give the occupation the power to police its doctors.

In 1888 the Committee on Credentials introduced a new ruling whereby candidates for membership had to be voted upon by the Association. Previously they had just paid the fee and signed the register. (Ferguson 1930:15) From Strauss and Bucher's perspective, the segment dominating the Association now had the means to control the type of physician admitted into the Association. Theoretically,

they could vote in favour of only those people who held their values, beliefs and goals; or at least, admit a larger proportion of this segment. Voting on membership could also be used as a sanction on established members. If a member was voted in he could also be voted out. Therefore the dominant segment of the Association could use this threat to gain the cooperation of the general membership on policies which the elite wanted to implement. (Strauss and Bucher 1961:333)

The Ontario Medical Association also hoped to be a focal point for the County Societies of Ontario and to have amiable relations with the Canadian Medical Association. (Ferguson 1930:16) The growth of an interlocking communication system would promote common rather than competing interests.

The 1880 meeting of the OMA saw the beginning of a movement for a Dominion-wide license. (Ferguson 1930:19) The difficulties of getting Federal legislation to establish central qualification were great. Under the B.N.A. Act the area of education had been placed under the jurisdiction of the Provinces and any attempt by the medical profession to secure uniformity of education could be construed as an infringement on Provincial jurisdiction. It took ten years for Dr. Thomas Roddick, doctor and politician, to come up with the solution. He pointed out that the Dominion Parliament had power under the B.N.A. Act to create a corporation to regulate medical education and practice if it was of general Dominion interest and beyond provincial powers. Such a body could be instituted by the Federal Government and called

the Dominion Medical Council. It was to be constituted of medical practitioners from each province and its function would be to grant Dominion registration to all persons who complied with certain requirements for medical and surgical practice. Once registered the holder could practise anywhere in Canada. Roddick pointed out that the profession would also need interprovincial registration. For the latter, all of the Medical Boards of the country would have to consent to the passage of a short Act in their legislature, giving any person registered under the Dominion Act the right to practise in any province (subject to the Province's fee). He suggested that the Dominion Council should consist of three members in each province; one appointed by the Provincial Medical Board, one by the Governor General and the last should be the Past President of the Provincial Medical Board. (Abbott 1931:73) It took another ten years though for Roddick's Bill to become law.

A coverage of the highlights of the OMA's minutes until the turn of the century points out that while the occupation of medicine attained professional autonomy around 1880 (it is impossible to set an exact date), this control was tenuous and needed time to gain a stronger position. When the Government annulled the right of local districts to set a scale of fees, we were reminded that the Government could step in at any time and take away any powers which it felt the profession should not have. In addition, the profession's pronouncements against lodge practices and specialization demonstrated how easily the balance of power could tip away from them and cause their fall from power.

iii) Licensing

The Ontario Medical Act was passed in 1874 and revised in 1897. With the revision the College of Physicians and Surgeons of Ontario was to be continued as an incorporated body with the power to acquire, hold and dispose of real and personal property for the purposes of the Act but there was also to be a Council, composed of one member from each of the following Universities: The University of Toronto, Queens, Victoria, Trinity, the Royal College of Physicians and Surgeons (Kingston), The Toronto School of Medicine, The Trinity School of Medicine, Ottawa University, Regiopolis College, Western and other universities and colleges granting medical degrees satisfactory to the College of Physicians and Surgeons of Ontario. Keeping in mind the amalgamation of the Medical Schools in Toronto this list seems rather strange. Either Heagerty has made a mistake or the schools kept their separate identities and guarded some of their independence. (Heagerty 1928:329) Apparently the Council appropriated some of the powers of the College as it was given the authority to appoint examiners and to make by-laws and regulations and to keep a Register. It also prescribed the rights of the practitioners along with a schedule of annual fees and certificates and offences and penalties. (Heagerty 1928:329)

III. The Organization of Medicine in Quebec, 1867 to 1900

i) Introduction

By separating the topic of the organization and institutionalization of medicine into Ontario and Quebec one is struck with how much more precocious Quebec is than Ontario. Consider that in 1847 the College of Physicians and Surgeons of Quebec was incorporated with the power to examine and confer licenses to practise medicine. It took Ontario twenty-two more years to reach this stage. At this time the College decided to only examine those holding university degrees. (Abbott 1931:64) This attempt at establishing uniform training for recruits was weakened when the St. Lawrence School was incorporated in 1851 with a charter which allowed graduates of the school to be examined by the College without a university diploma. (Abbott 1931:67) This could be interpreted as a move by the Government to reduce the powers of the College. It could also have been a move by the College to allow a rival institution to McGill's Medical Faculty to compete effectively. This is a possibility when one realizes that the first President of the College, Dr. F. Arnoldi, was also on the faculty of the St. Lawrence School. (Abbott 1931:65) I suspect that he objected to McGill's domination of the medical field because he left the Faculty of McGill to join a school which had been established to provide teaching positions for qualified people who had been unable to secure positions on McGill's teaching Faculty. (Abbott 1931:66)

Although the appearance of the St. Lawrence School with its ruling concerning applications to the College of Physicians and Surgeons may have appeared to weaken the strength of the College, the School did not last very long and the College retained its licensing powers.(Abbott 1931:72)

Nevertheless, the conferral of control over licensing to the College of Physicians and Surgeons did not give Quebec medicine professional autonomy. In the 1850's and 1860's and even 1870's the competition between medical schools indicated that the elite of the occupation did not have control over the affairs of the occupation; and even as late as 1875 doctors in Montreal were having such a difficult time making ends meet that 165 doctors acted as insurance agents, and conducted apothecary shops. (MacDermot 1967:40)

Although Ontario may have been behind Quebec in establishing a permanent College of Physicians and Surgeons; still, Quebec was behind Ontario in resolving conflicts between competing medical schools in the same city. As you will discover in the section on education, the Medical Faculty of Laval of Quebec City established a branch in Montreal in 1878. From its conception Laval of Montreal experienced serious problems with L'Ecole de Medecine, yet they did not settle their disputes until the 1890's when they amalgamated. (Abbott 1931:66) During this time Bishop's College Medical School was also running in Montreal. This meant that there were four medical schools in the same city until the 1890's. Bishop's did not immediately follow the idea of amalgamation but rather prolonged its existence

until 1905 when it finally joined the Faculty of Medicine of McGill University. (Abbott 1931:67) These amalgamations needed to take place to reduce a source of competition and conflict within the occupation. Only with the easing of tension and the banding together of members within the community could medicine hope to maintain a relatively more homogeneous group than the consumers and thereby maintain a stronger and more autonomous position.

During the process of professionalization medicine was also aided by physicians who had turned to politics. In Quebec Dr. William Hingston, in his role of mayor, created the first voluntary Health organization in Canada; the citizen's Public Health Association. This manoeuvre not only improved the sanitary conditions of Montreal City, it also gave sanitary science a role under the profession of medicine. (Abbott 1931:89)

ii) Societies and Associations

It is difficult to ascertain whether Quebec experienced a growth spurt in local medical societies during the last third of the century when transportation improved because there was a dearth of information on this area. We do know that the Montreal Medico-Chirurgical Society was able to reorganize itself in 1870 on a stronger foothold and continued at least until the end of the century. (MacDermot 1967:152) Nevertheless, from the comments made by Dr. Michael Ahearn at the revival meeting of the Quebec Medical Society in 1897, other Societies had not been as fortunate and had died out because of a lack of support.

Je crois qu'il est temps a la fin du dix-neuvieme siecle que l'on songe a fonder une societe medicale a Quebec. Il est vrai qu'on a deja organize ici quelque-unes de ces associations, mais l'apathie... etc., ont fait qu'elles se sont bientot dissoutes.

(MacDermot 1967:153)

In contrast to Ontario, Quebec had separate societies to represent French and English physicians. The 'Societe Medical de Montreal' represented part of the six hundred French Canadian doctors who practised in the province (MacDermot 1967:158) and used the French language medical journal, the Union Medicale du Canada (begun in 1872) as its written media. (Abbott 1931:70) In addition there was also the Medical Society of Quebec City who began to publish the French language Bulletin Medical de Quebec in 1889. (Abbott 1931:70)

IV The Canadian Medical Associations

Although formed in 1867, the first regular meeting of the Canadian Medical Association was held in Montreal, 1868.

The report of the committee on education recommended that all persons intending to study medicine should sit for a matriculation examination which included English, French, Grammar, Composition, Arithmetic, Algebra, Geometry, Latin, Natural Philosophy, and logic. Anyone holding a degree in Arts from any British or Canadian university would be exempted. (Heagerty 1928:294) This ensured a common base level of education for all medical students and created a situation where students would be more likely to hold similar attitudes, values and beliefs. (Heagerty 1928:294)

The Committee of Medical Education then presented their report on professional education, recommending that professional education extend over four years with yearly sessions of nine months. From the curriculum it was evident that Canadian medicine was influenced by Parisien schools of thought and that the science of medicine was permeating through medical thought. Descriptive and practical anatomy, chemistry, materia medica, physiology, general pathology, theory and practice of medicine, principles and practice of surgery, midwifery and diseases of women and children, clinical medicine and surgery, practical chemistry and practical pharmacy were listed as the required courses. (Heagerty 1928:294)

At the 1868 meeting a Code of Medical Ethics was drawn up, outlining the kind of behavior befitting a professional. (Heagerty 1928:295) In its early days the association was precarious because it was more like a grouping of local societies than an assimilated national society. (Heagerty 1928:295)

Lewis felt that part of the reason for this was the fact that under the British North America Act health and education were placed under provincial jurisdiction which gave medical bodies at the provincial level more power than a federal body. Up until the federal incorporation of the Canadian Medical Association in 1909, it experienced slow and irregular growth. There was no continuous membership; it lapsed unless the practitioner attended the Annual meeting every year. (Lewis 1962:7) When the CMA was incorporated federally the provincial associations entered into closer affiliation with this central body.

V. Medical Education in Ontario from 1867 to 1900

i) Introduction

As I discuss the progress of medical schools it is important for the reader to keep in mind Strauss and Bucher's concept of segment. Schools can be perceived as products of groups of powerful individuals. Even though many sociologists see controlled entry through the schools as bringing cohesiveness to the profession, in fact, the schools were manifestations of circles of collegueship. Each of the circles held notions concerning their mission and various attitudes towards aspects of medicine. (Strauss and Bucher 1961:332) Thus what tied one man closely to one group within his profession alienated him from another. (Strauss and Bucher 1961:332) Consider the Toronto School of Medicine at its inception (1842). This School had been founded by the rebel Dr. Rolph and he and his colleagues were highly resentful of the privileged position which Trinity College held. In contrast to the Toronto School, Trinity's colleagues were Tories, belonged to the Church of England and therefore had useful connections with men holding high positions in government. Even as the strength of the Family Compact ebbed, resentments towards aligned associations did not. As late as 1854 Dr. Aikins was spying for Dr. Rolph on activities of Trinity's School. Aikins claimed that all cadavers from Herrick Hospital were quietly going only to Trinity; that all her expenses were paid by the Bishop and that she was receiving help from the most wealthy, learned and numerous sect in Canada (the Family Compact). In

addition Trinity was supposedly graduating students "on easy terms". (Spragge 1966:72)

I think that Trinity's medical faculty would have been amused at Aikin's perception of their favoured position. In reality, they were at loggerheads with Trinity College's administration over the requirements of religious tests for students. (Spragge 1966:75) An inability to resolve the differences of opinion led to the dissolution of the Medical Faculty in 1856. Fifteen years later the school was reorganized and was back competing with the Toronto School, but on different grounds. The political and religious differences which had caused so much friction were gone. Rolph, the spearhead of the Reform movement had resigned, the old Toronto School of Medicine (affiliated with Victoria College) had folded in 1870 and its students had gone to the new Toronto School of Medicine. (Spragge 1966:84) As one Medical Faculty folded students and sometimes staff transferred to another school; this and the appearance of a threat (the establishment of a government supported medical faculty at the University of Toronto) reduced the intensity of animosity between the two schools.

In addition, the schools no longer represented one unique segment. Judging from the frictions within each of the schools there were several circles of collegueship within each school and some of these circles overlapped between schools. Take Drs. Girkie and Rolph; while Girkie had belonged to Trinity Medical School, when it folded he went to teach with Dr. Rolph at the School which stood for ideals counter to the ideals of Trinity. Here is an example where the

attraction of personalities overruled loyalty to schools. When Dr. Rolph resigned from his school in 1870 Dr. Geikie resigned with him. (Spragge 1966:84)

In 1887 the new Toronto School of Medicine amalgamated with the University of Toronto and in 1903 Trinity's Medical Faculty decided to put away its differences and join the University of Toronto.

Thus, having set the perspective from which to look at medical schools, let us enter this area at the point at which the Medical Faculty of Trinity College in Toronto was reactivated in 1871.

When Bishop Strachan died in 1866 the main obstacle to the removal of the statute requiring religious tests was removed. (Spragge 1966:80) The College still held reservations however, about entirely eliminating the statute. As a first step to re-establishing a Medical School, Drs. Bowell, Hodder, Bethune, Hallowell and Hall were appointed provisionally in 1870 as "a Board of Medical Examiners in Trinity College."* At the same time a committee was appointed to consider the revival of a medical school. The committee provided a resolution to the problem of the religious tests. The original statute regarding this matter was amended "so as to allow of the exercise of a dispensing power as to the exaction of tests from students in Arts, Law, and Medicine prior to graduation." (Spragge 1966:81) In March

*Another historian claims that in 1870 all physicians who had signed the letter of resignation (which had dissolved the first Medical Faculty of Trinity College) and Dr. Hall were appointed to the provincial board of examiners. (Reed 1952:76)

1871 the first Professors in the revived Faculty were appointed: Hodder, Beaumont, Hallowell, Geikie and Fulton. Trinity also benefited from the internal disputes which Victoria was having. She picked three of Victoria's men; Bethune, Fulton and Geikie. Having no building available to serve as a medical school, the Trinity Corporation appointed a committee to arrange for the erection of a building on the lots owned by the Corporation, near the General Hospital. (Spragge 1966:82) By the beginning of October 1871 the Medical Faculty of Trinity University was operating.

The school soon gained the reputation of keeping abreast of new developments in medicine. In 1872 Dr. Fulton lectured on Sanitary Science; in the same year Dr. Johnson held talks on Microscopic Anatomy; in 1878-9 Dr. Alt Adolf lectured in Ophthalmology and Otolology. The Announcement for 1872-3 states:

in view of the growing importance of Chemistry, great care has been taken in the fitting up of the laboratory, and the practical course will include experiments of various kinds, qualitative and quantitative analysis, Toxicological investigations etc.

(Spragge 1966:83)

When the Victoria Medical School closed in 1874, there were only two schools left to battle for domination. In 1877 The Toronto School of Medicine tried to prevent Trinity students from competing for University of Toronto honours and prizes, by trying to attain exclusive right for their students to examination by the University of Toronto. (Spragge 1966:84) In 1877 the Government of Ontario changed the terms of affiliation with the Provincial University for all medical

teaching bodies. No medical body which formed part of any other University empowered to grant degrees in Medicine could continue to try examinations at the Provincial University (University of Toronto). The government had been pressured for a long time by the Faculty of the Toronto School of Medicine.

As soon as this change of policy was announced the Trinity Medical Faculty arranged to have a Bill introduced which if passed would make it an independent institution associated with Trinity but able to affiliate with other Canadian universities. (Anderson 1926: 452) Although the Trinity Corporation was taken aback they agreed not to oppose the Bill. (Bull 1934:237; Spragge 1966:85)

In spite of its newly found independent status, Trinity Medical School was regarded by the Trinity Corporation as its medical faculty. Nine out of ten medical students chose to be examined by Trinity although they were also free to choose the Provincial University. In addition, meetings of the Trinity University Board of Medical Studies continued to be held on a regular basis with the Provost of Trinity in the chair and Dean Geikie and other medical professors present. (Spragge 1966:86) The Medical School also saw fit to call upon the University for financial assistance.

By 1878 larger quarters for the Medical School were required and with the "help of favourable financial arrangement with Trinity" a new wing was built. This gave the school a new Chemistry Laboratory and a large Dissecting Room, among other things. From the Ontario Sessional Papers, No. 51, 1894, we learn: "The members of Trinity

Medical School alone have spent out of their own pockets ten thousand dollars within a short time in increasing the efficiency of their school." (Spragge 1966:86) Both staff and student contributed to the improvement of the school.

Regardless of the success of the School its years were numbered. Increasingly the University of Toronto Senate's thoughts regarding medical education were gaining more widespread approval. Spragge implies that this body considered both The Toronto School of Medicine and the Trinity Medical School to be proprietary schools. To some members of the Senate these schools failed to meet the standards of a satisfactory medical education as medicine became more scientific. Competition might be stimulating to medical thought but it was wasteful to install the complicated and costly instruments now needed and to provide the facilities to house them in several different schools rather than just one. (Spragge 1966:87; The Librarian 1906:176)

When the Minister of Education, George Ross, discussed with the Dean of Trinity's Medical School the possibility of introducing an Act to reinstate the University of Toronto Medical Faculty as a teaching body, Geikie was visibly upset. He sent letters to the Premier, Sir Oliver Mowat, Ross, the Legislature and to the public. Trinity Medical School was invited to join with the Toronto School of Medicine in forming a teaching faculty at the University of Toronto but loyalty to their school blocked this amalgamation. (Spragge 1966: 87) It also appears that Dean Geikie had been led to believe that the University of Toronto's teaching faculty would be no more than an

additional "self-supporting" rival.

It is also evident that Dean Geikie expected to share in any grants made towards medical education. In a letter to the Minister of Education in 1888 he wrote, "Delighted to hear that the Government is prepared to aid in the direction of higher medical education now in demand. Physiological and chemical apparatus is very expensive and when you are devising liberal things don't forget Trinity Medical College." (Spragge 1966:88) Therefore in 1887 the Toronto School of Medicine alone amalgamated with the University of Toronto Medical Faculty. (MacDermot 1967:97)

When Geikie assumed that his College would be entitled to the same amount of financial help from the government it must have been distressing when no help came. Trinity was having a difficult time trying to keep its facilities up-to-date. At the end of 1887 Trinity Medical School had to approach its College for financial assistance to maintain a competitive position with the University of Toronto's Medical Faculty (nee: Toronto School of Medicine). The University of Toronto was paying for four chairs which although under the Faculty of Arts were also open to medical students; chemistry, physiology, biology and natural philosophy. In addition, another competitor, McGill's Medical Faculty, had moved onto the McGill Campus (Abbott 1931: 61) and received a large endowment. Trinity College had little money to spare but it offered to return 25% of the net fees paid for medical degrees. (Spragge 1966:88)

Again the Medical Faculty called on the generosity of the Corporation for help in making certain improvements and additions to the buildings. The reason given was the powerful competition of the University of Toronto Medical Faculty which received support from the Provincial Government. (Spragge 1966:88) Once again the Corporation supported its medical faculty with a grant of \$1,500.

In spite of assistance Trinity was not receiving the same degree of help that Toronto's Medical Faculty was and therefore could not keep up in the competition. In 1888 the University Biological Building was begun. Unknown to the Minister of Education, the Board of Trustees of the University of Toronto and even the Senate of the University; the Vice-Chancellor of the University had made provisions for rooms for the University's medical faculty. Dean Geikie sent a protest to the Attorney-General Mowat, pointing out the inequity of favouring the students in the University of Toronto Medical Faculty. (Spragge 1966:89) Sir Daniel Wilson was asked to comment on Dr. Geikie's comments. Here is an excerpt.

I have repeatedly had letters from old students who, after beginning their medical studies at one or other of the Toronto Medical Schools, have gone to one of the great schools of Europe, and their expressions relative to the contrast between the inadequate and petty provisions in the little buildings alongside of our Toronto General Hospital, and the ample appliances they found available for them at Edinburgh, London, Paris or Berlin would furnish an amusing commentary on Dr. Geikie's self-complacent estimate of his school...

In truth the great evil of the multiplication of such "self-supporting" medical schools is that their pecuniary interests are in conflict with the necessary expansion to embrace the important new applications of modern science.

(Spragge 1966:90)

At the turn of the century, the executive of Trinity College decided in favour of federation with the University of Toronto. It had become apparent that the University, with mounting deficits, could not be carried on as a separate institution. (Spragge 1966:90)

Although Trinity Medical College was opposed to merging with the University of Toronto's Medical Faculty it entered into an agreement with Trinity College, while the College was negotiating with the provincial University, whereby the Medical College would surrender the Charter of the College to Trinity University to hold in trust in return for \$50,000 towards the erection of a new medical building. (Spragge 1966:92) It was obvious from one of the Dean's (Dr. Geikie) letters that he expected Trinity would remain as an independent College.

However, when the Charter of the Medical College was surrendered to Trinity University in 1903, the Trinity Corporation was able to speak on behalf of the College in negotiations regarding the amalgamation of the Medical College with Toronto's Medical Faculty. (Spragge 1966: 93) On the same day that the Trinity Medical College formally became the Medical Faculty of Trinity University the Corporation of Trinity decreed that when Trinity federated with the University of Toronto, the Medical Faculty should amalgamate with the Medical Faculty of the University of Toronto. (Spragge 1966:93) The Corporation had decided that the interests of medical students in Toronto would be better served by the cooperation of medical facilities with the provincial University in lieu of competing institutions in the same city. There were other, more selfish reasons, for Trinity's withdrawal of support

for a separate medical faculty. "As long as Trinity found it impossible to federate with Toronto it was to her advantage to retain and support a medical faculty." (Spragge 1966:93) By the summer of 1903 an agreement on Federation had been reached and under the terms of this agreement a separate medical faculty would have been highly unusual. It was also going to be very difficult to raise the funds for a building which had to compare favourably with the University of Toronto's medical building (built on the same plans as Harvard's medical facilities). In addition, it seemed hopeless to try to compete against a Medical Faculty which was receiving Government support. (Spragge 1966:94) In 1903 the medical students of Trinity became students of the University of Toronto, and the members of the faculty, with the exception of Dean Geikie, became members of the Faculty of the University of Toronto. (Spragge 1966:95) Fighting against increasingly poor odds, Trinity's loss of independence was inevitable. The only reason that she was able to last as long as she did was because she "had a distinctly brilliant group of men on its teaching staff who had the support of social Toronto and later became the controlling influence in the Toronto General Hospital..." (Reed 1952:57)

After dealing with Trinity for thirty-three years of its life we are going to go back to the time of Confederation to see how another medical school, Victoria, is faring. At this time it was flourishing. The student enrollment was up to 120 and a branch of this school was established in Montreal. This shot student totals up to 222 for the 1866/67 session. (Spragge 1966:80)

It appears that Victoria was thriving on Trinity's period of inactivity. In 1868 the College waived its right to its portion of the examination fee (ordinarily it received two-thirds of the fee) to give the Medical Faculty a little extra income. (Sissons 1952:124)

Unfortunately though, a split had occurred between members of Victoria's faculty. While Rolph excelled as a teacher he was not so successful at handling staff or financial affairs. (Sissons 1952:124) Judging from two comments made by two ex-faculty members Rolph imposed his decisions on who should graduate on the School and thereby maintained low academic standards.

Dr. Hodder - the Hon. the Dean of the Medical Faculty of Victoria College was the chief examiner of those desirous of graduating - that the examination was anything but a fair and open one - in short it was a complete hole-and-corner affair. Dr. Rolph and another gentleman had quietly gone into a room with his intending graduates, and after a private hole-and-corner examination, given them their degrees...

Dr. Richardson - Yes, that is the way Dr. Rolph acts; his old trick....One of the present staff of professors, who was himself a student of Victoria College, last year, had stated that he was ashamed of the degree conferred upon him by Victoria College; but as it gave him the license to practise, he did not care a d - m.

(Spragge 1966:79)

One will never know whether it was the low academic standards or a personality clash with Rolph which caused Hodder and Richardson to leave. Since Dr. Hodder had done post-graduate medical training in Paris and Edinburgh his judgements on the standard of education were relative to the best available. (Cosbie 1968:7)

The remaining Faculty at the School sought to remedy some of the financial and managerial problems by suggesting that an assistant

dean be appointed. Rolph however, insisted that he was capable enough to carry on without help. This was questionable because the next year he died of natural causes. The staff persisted and when the assistant dean was appointed Rolph resigned in 1870. (Sissons 1952:141) The same year he died.

After the appointment of Dr. Caniff as Dean, disputes broke out amongst the Faculty. The College closed its Faculty of Medicine six years later, transferring its students to the new Toronto School of Medicine with Dr. Hodder as Dean. (Bull 1934:115; Sissons 1952:142; Spragge 1966:84) (Note: Sissons and Spragge claim that the school only lasted four not six years).

The New Toronto School of Medicine began as an independent school and remained so for thirty-one years. (Bull 1934:115) Judging from the history of Trinity Medical College, it appears that the Toronto School could bring a great deal of pressure to bear on the Provincial Legislature. As you will recall, the Government in 1877 agreed to change the terms of affiliation of all medical teaching bodies with the Provincial University. (Spragge 1966:84) It may at first glance appear to be a regressive step in the process of professionalization to have medical schools break ties with Universities and Colleges in order to remain affiliated with the University of Toronto. When one stops to consider the ultimate intention however, it fits in with the scheme of things. The elimination of overt and destructive competition between medical schools would be vital for medicine to maintain a professional image and affiliation under the University of

Toronto would help achieve this goal. Affiliation was the first step towards eventual amalgamation.

It appears that Toronto also had a good reputation for keeping abreast of recent developments in the field of medicine. Dr. William Oldright was established as the Professor of Sanitary Science. When the Provincial Board of Health was created by the Provincial Legislature in 1882 Dr. Oldright was asked to chair a general survey of the sanitary conditions of Ontario. Committees of observation were sent to Europe and leading American cities. Recent epidemics in the province were investigated, and attempts made to discover their origin. (Bull 1934:194)

In 1887 the Toronto School of Medicine was invited to join with the Trinity Medical College in forming the teaching faculty of the University of Toronto. When Trinity turned down the offer the staff of the Toronto School had all the advantages of affiliation to themselves. (Spragge 1966:87) As one example, the new Medical Faculty had access to professors and lecturers in Chemistry, Physiology, Biology and Natural Philosophy by their affiliation with the University of Toronto. Trinity on the other hand, had to pay for these positions herself. (Spragge 1966:88) The Vice-Chancellor of the University of Toronto had also made certain that the Medical Faculty were given their own rooms in the new University Biological Building. (Spragge 1966:87) Thus what the Toronto School lost in identity it gained in facilities for staff and students.

The amalgamation of the medical schools in Toronto with the University of Toronto appeared to me to have motives other than a

search for the science of medicine. From the inception of proprietary schools in Toronto in the 1850's the University of Toronto attempted to eliminate them by raising the standard of examination. (The Librarian 1906:176) At mid-century the science of medicine was not being stressed. When William Osler graduated in medicine at McGill in 1872 there was the barest suggestion of medical research. (Careless and Brown 1967:553) Osler bought microscopes to demonstrate in his histology and physiology lectures.

Therefore although the excuse was made that the schools needed to join the University of Toronto to benefit from the research facilities available at the university, this appears to me to be a facade for other motives. Heagerty states that during the era of proprietary schools the University of Toronto made several attempts to raise the standard of examination. The implication made by Heagerty was that the exams became more scientifically oriented. He adds that it was not until 1882 that the University was finally successful. As a result the number of students graduating in medicine dropped from 32 to 15 and eventually to 10. (The Librarian 1906:176)

A shift in emphasis towards science was part of the "modern movement of university development" which had already greatly influenced German, British and American schools. Within this movement the physical and biological sciences were immensely extended as were the spheres and methods of all other studies. (The Librarian 1906:42) I suspect though that along with the people who really believed that medicine stood to gain from greater emphasis on basic science there

were others who saw that an emphasis on basic sciences in medical exams could be used as a weapon to eliminate proprietary schools.

I am suggesting that the University of Toronto wanted to assimilate as many proprietary schools in Ontario as possible for financial rather than academic motives. From the 1850's onwards the University of Toronto had to continually justify the endowments it inherited from King's College. From its very inception the outlying Colleges and particularly Victoria, felt that they should receive a share of the endowment which the University of Toronto and University College inherited from King's College. Their demands seem justified on the basis that in the first few years University College (the teaching section of the University of Toronto), had only a handful of annual graduates and in 1855 there was no graduating class at all. (Bissell 1953:7) Eventually these ill feelings culminated in a hot debate in the Senate of the University 1863. Afterwards the administration of University College decided to take John A. Macdonald's advice and put the endowment inherited from King's College into the University College Building "since not even the opponents of the College could steal bricks and mortar." (Bissell 1953:7)

The University had quite a bit to gain from both the federation of Colleges and also from the affiliation of the medical schools in Toronto. Both developments would quell the Colleges' complaints that the University of Toronto received special treatment. Low enrollments had been a problem from the University's inception. When King's College closed in 1850, many undergraduates of King's

deserted to Trinity rather than stay with its secularized successor (the University of Toronto). (Bissell 1953:4) While King's had been desperately unpopular with its exclusively Anglican constitution, by the same token, the populace were not ready to accept a separation of education from religion.

The University Act of 1853's provision for the affiliation of Victoria, Trinity, Queen's and Regiopolis with the University of Toronto demonstrated the University's desire to gain a higher rate of attendance and a more secure position. Not one of the Colleges however, showed a desire to join. (Bissell 1953:4)

The amalgamation of even just the medical schools would help the University of Toronto's position vis a vis the other Colleges by significantly increasing the University's attendance which meant not only more money through fees, but also an excuse to ask the government for more money. In the 1891-2 enrollment figures for the Federated University of Toronto, the Faculty of Medicine with 286 students accounted for over one-quarter of the total student body of 1901. (The Librarian 1906:69)

The second advantage to affiliation lay in the fact that by offering specialized courses such as medicine the University could justify financial help from the government. Particularly from the 1870's on, the University was in great need of financial help. The "modern movement of university development" necessitated the building and equipment of laboratories, museums and libraries. (The Librarian 1906:42) This need came at a time when the University of Toronto's

financial resources were dwindling. The endowment from the sale of lands was decreasing as was the rate of interest on investments. There was only the sale of some of the University Park lands and an increase in students fees left by which to increase their revenue. While doubling the students fees helped, a collapse in real estate eliminated the option of leasing or selling large portions of the Park. In addition the latter was not a wise idea if the University planned to grow. (The Librarian 1906:61)

Faced with an inadequacy of resources the University of Toronto had to appeal to the Legislature for direct assistance in 1883. In light of a past history of bad feelings over the sources of funding between the Colleges and University, the University should have foreseen that the Colleges would object. This was to be expected when the Colleges were handling over one-half of the student population of the Province and all public aid had stopped for them in 1871. (The Librarian 1906:41) If the University could claim to be offering specialized courses the Colleges would not have a solid argument to oppose the University's plea for government assistance.

Judging from the University Act of 1887, the University probably felt that it would not incur additional expense with the amalgamation of the Medical Faculty but rather stood to make money by attracting funds and students on the basis of a prestigious name. The University Act of 1887 stated that the professors, the scale of fees and the student body should be completely under University regulations. The Act also imposed the cost of the Department of

Physiology upon the University. (The Librarian 1906:284) The latter would not be an additional expense as this chair would be used for other scientific disciplines. The financial scheme to support the Faculty from year to year was as follows: a percentage of the fee was given to the University to cover the training of medical students in Arts subjects; of the remainder of the fees, 40% paid the working expenses of the Faculty and 60% was intended for the salaries of the teaching members. Payment for additional equipment was to come from the money intended to pay salaries. Thus over a long period of time professors deducted the cost of equipment from their salaries. (The Librarian 1906:284) In short, the cost of any help which the University gave to the Medical Faculty in terms of chairs and facilities was to have been covered by the other departments of the University and would have been present even without the Medical Faculty. It is questionable whether the Faculty realized the cost involved in equipping laboratories.

The Federation Act of 1887 made the University a teaching body with the power to constitute faculties in Arts, Law, Medicine, and Engineering; three very specialized courses. (The Librarian 1906:58) During the year, the Senate entered into an arrangement with the Toronto School of Medicine whereby its professors became the Medical Faculty of the University. Negotiations with the Medical Faculty of Trinity fell through as did arrangements with the Law School. (The Librarian 1906:58)

While my explanation for the amalgamation of the medical schools in Toronto with the University of Toronto is not verifiable,

it provides a more satisfactory explanation to the University of Toronto's insistence on amalgamating the two medical schools. It fits in with the President of University College's complaint that the Federation compromise of 1889 "ignored purely educational considerations and was an outcome of a political point of view." (Bissell 1953:45)

In 1881 the Medical Faculty of the University of Western Ontario was founded, although the history of the facilities dates back to the 1860's. (MacDermot 1967:102) Archdeacon Isaac Hellmuth established two large and expensive schools in London; the London Collegiate Institute in 1863, and the Hellmuth Ladies College in 1869. (Seaborn 1944:251) The London Collegiate Institute, renamed the Hellmuth Boys' College, was the private property of the Archdeacon Hellmuth. (Seaborn 1944:254) In spite of its magnificence the school could not raise funds to keep operating. By 1881 it ceased to exist as a school for boys. Pursuing an alternative plan Isaac Hellmuth brought into force the charter for a university he had obtained many years before and converted the school into a university and organized faculties of Divinity, Arts, Law and Medicine. (Seaborn 1944:259)

The university was under the guidance of the Church of England in Canada. (Seaborn 1944:259) As with most of the Medical Schools in Ontario and Quebec, relations between the University and the School were loose. The school was self-governing and independent of the University, and had no representative on the Senate. (MacDermot 1967: 102)

The Faculty of Medicine was formed by the practising physicians of London and neighbouring towns. "It is said that not one of these gentlemen was entirely a specialist in any medical subject and that not one had ever delivered a lecture on a medical subject." (Seaborn 1944:260) The Medical Faculty used both the College and the janitor's cottage as classrooms. To give you some idea of how makeshift facilities were I offer the following description. As the "Lecture Room" contained the tank for chemical experiments as well as the "telescopes and theodolites," Practical Chemistry was given there. A few lectures were delivered in the chapel and a few in the gymnasium, which was partly underground and so capable of being heated more easily than other parts of the school.

Turning to the cottage, the back bedroom contained a few chairs, a table with one microscope. Histology and pathology were taught here by Dr. Moorhouse, professor of Histology and Dermatology. He brought his own specimens with him. (Seaborn 1944:263) In the front bedroom hung a skeleton belonging to Dr. Waugh, professor of Anatomy. The dining room became the dissecting room. It contained two tables, a few chairs, a pile of sawdust, a shovel in a corner, old coats and aprons on hooks along the walls. A trap-door in the floor led to the

cellar where two large vats, filled with ancient wood alcohol and other things, permeated the whole building with their odours. (Seaborn 1944:264)

At the opening of the Medical School the freshman class was made up largely of men who were teaching in the schools in the city and in nearby towns. For their convenience one lecture was given at eight o'clock in the morning and four lectures in the evening, beginning at four. (Seaborn 1944:270) After the first lecture in the morning those students who did not go out to teach spent the rest of the morning in the dissecting room and in the early afternoon they could visit the Victoria Hospital for clinical experience.

The most pressing problem which the Medical Faculty had to deal with was the facilities provided for them by the University. Depending on the fees of students for their entire revenue the Faculty were unable to undertake the repairs to the Boys' College building which were becoming increasingly necessary. (Seaborn 1944:270) Unable to adequately heat even the small part of the building, they moved the entire Faculty over to the cottage. This may have damaged the image of the Faculty as hinted at by the following narration on the cottage.

To prevent the peering of the morbidly curious, anxious to see the "Cuttin' up Place," its windows had been whitewashed on the inside,...Wagons came to it at night. Strange lights would appear and in a moment disappear. Even stranger noises, cries and groans had been heard. More terrifying than the noises had been the noiselessness with which a bent figure would disappear into it carrying a heavy burden on his back. Teamsters disliked delivering fuel to it. One of them ...came face to face with the cadaver of a Negro. He drove away incontinently and refused to return with his load.

(Seaborn 1944:273)

The most pressing need of the Medical Faculty was more money. In 1882 for example, school receipts were \$460.50 and expenditures \$295.51. (Seaborn 1944:272) It quickly became clear that the seven staff members were not running the school out of a profit motive. Each contributed an assessment fee of five dollars but only four received a remuneration of six dollars per student. (Seaborn 1944:272) Without a good source of revenue the school could neither improve the existing facilities nor purchase new ones. Although they did not have the means to implement the latter, the increasing problem of transporting students between the school and city hospital (Seaborn 1944:273) forced the faculty into going that route. The Medical Faculty appealed to the City Council for a grant of land. The site of land was at the corner of York and Waterloo Streets. (Seaborn 1944:273) Having little money, the Faculty drew up its own plans and specifications for a modern building and made donations to a building fund. To meet the deficit, a loan was negotiated and the building was erected. (Seaborn 1944:273)

This was not the first time that the City Council had lent a helping hand to the Medical Faculty. It had made an agreement with the Faculty from its initiation that the wards of the hospital would be open for clinical lectures forever. Out of this agreement a working arrangement emerged whereby the clinical staff of the School would serve the public wards in the winter and a staff of doctors outside of the school would serve in the summer.

Friction grew between physicians unconnected and those connected with the school. The former demanded that the staff alternate

every three months which in effect limited the school's time of teaching in the wards to three months. To compensate for the consequential loss of public ward patients private patients were induced to act as substitutes. This situation did not last very long because the outsiders, disliking ward patients, privately agreed to have the school physicians tend to them. Then the latter sent their private patients to St. Joseph's Hospital. (Seaborn 1944:274)

For the first two years at their new location on York Street the members of the Faculty worked for free. Aside from the annual contributions of five hundred dollars each from Adam Beck (Chairman of the Hospital Trust) and Thomas Beattie, the Faculty depended solely on the students' fees to run the school. This could not cover the taxes and installments of interest which had not been paid. The school was insolvent and was put up for sale. A sympathetic individual bought it and resold it to Dr. Moorehouse. Individuals in the Faculty donated enough funds to settle outstanding debts and the School was on its feet again. (Seaborn 1944:277)

Fortunately for the financial sponsors of the Medical Faculty of the University of Western Ontario, the main University itself underwent reorganization. It became non-sectarian and a ward of the Ontario Government. The transformation reverberated to the Medical Faculty. It was reorganized and refinanced and provided with a new building almost opposite to Victoria Hospital. (Seaborn 1944:277)

In addition to institutionalized education there was also informal tutoring to supplement classroom work. As an example, both Osler and Graham met at Dr. Bovell's (Dean of King's College Medical

Faculty, lecturer in Trinity College and the Toronto School of Medicine [Spragge 1966:98] every Saturday morning to work with the microscopes. (Bull 1934:262) Graham kept up the tradition. From a diary kept by the house surgeon of the Toronto General Hospital 1872:

This afternoon...went to Dr. Graham's to have lessons in the primary subject....To spend two hours 'grind' with him three nights in the week; \$12.00 for the whole.

(Editorial, The Canadian Journal of Medicine and Surgery, 1922).

Thus while education continued on an informal basis it was carried out gratuitously and no longer qualified the recipient to take medical examination before a Board.

VI. Medical Education in Quebec from 1867 to 1900

Until 1870 McGill Medical School ran on a proprietary basis. (Cushing 1940:82) Nevertheless, Cushing claims that Montreal in the '70's and for some years to come had unquestionably the best medical school in Canada and the opportunities offered to students were rivalled only by Philadelphia. McGill continued to follow the educational methods in vogue at Edinburgh. The Montreal General was in close affiliation with the school and students were given more freedom than in any other North American hospital. (Cushing 1940:71) Clinical clerks had to report cases of special interest in the local medical monthly, the Canadian Medical and Surgical Journal. (Cushing 1940:70) Cushing neglects to explain why McGill ceased to be a proprietary school in the 1870's. From other sources though, we discover that relatively strong competition from three other medical schools in Montreal led the Medical Faculty to establish itself on the grounds of

the university, (Abbott 1931:61) and that during the seventh decade McGill was given a large endowment by the University (Spragge 1966:88) which enabled it to add on in 1885 a large extension containing plenty of laboratory space.

To expand on the situation of medical schools in Montreal, after the Medical Faculty of Bishop's College was organized in 1871 there were four medical schools in Montreal city (Abbott 1931:89; MacDermot 1967:10); McGill, Bishop's, l'Ecole de Medecine de Montreal (the medical faculty of Victoria University) and Laval. Bishop's had been established in 1871 by doctors who could not get teaching positions at McGill University. (MacDermot 1967:108) Two of the staff had had ties with the former St. Lawrence School of Medicine during its short existence. Dr. Campbell had edited the Canada Medical Journal and Monthly Record of Medical and Surgical Sciences with George Fenwick (a faculty member of the St. Lawrence School) from 1864 to 1872. (Abbott 1931:70) Dr. David had edited the Canada Medical Journal 1852-53 and with MacDonnell had openly supported the St. Lawrence School of Medicine. (Abbott 1931:67) Bishop's had another prominent physician, Dr. Hingston, on staff but when he was appointed President in the first year of operation he had to resign in order to maintain his connection with Hotel Dieu. (Abbott 1931:67) Four years later he became mayor of Montreal. (Abbott 1931:89) At the turn of the century the school succumbed to its economic difficulties and in 1905 amalgamated with the Faculty of Medicine of McGill University. (Abbott 1931:67)

The Medical Faculty of Laval University at Quebec may have seen the futility of having four competing medical schools in the city of Montreal when it asked l'Ecole de Medecine de Montreal (now the Medical Faculty of Victoria University) in 1877 to consider affiliation with Laval. This proposal had the support of the Church because it wanted to have a Catholic Medical School in Montreal. Through negotiations in 1878, the members of l'Ecole became part of the Laval Faculty of Medicine in Montreal. Nevertheless, disputes arose and the Rector of Laval made Laval at Montreal an independent branch, while l'Ecole de Medecine retained its autonomy. Thus, there were two French Medical Schools in Montreal, one associated with Laval and the other with Victoria. (Abbott 1931:65) Relations between the two were not good and over the years a serious misunderstanding arose. As a result l'Ecole was debarred by the Church from Hotel Dieu. The Faculty and student body were excommunicated from the Church on the grounds that they had disobeyed authority and associated with a Protestant University (Victoria was supported by the Methodist Church). Dr. Desjardins on behalf of l'Ecole, sought the help of the Pope. As a result of their interview the Pope ordained in 1883 that the School be continued and all bans removed. (Abbott 1931:66) Dr. Hingston replaced d'Orsonnens as President of l'Ecole.

In 1889 Rome gave the Branch of Laval at Montreal a new constitution which made it entirely independent of Laval at Quebec, except that its degrees were granted by that University. (Abbott 1931: 66) The same year a petition was presented to the Quebec legislature

asking for an amendment to the Act of Incorporation so that l'Ecole de Medecine could absorb the Laval branch at Montreal and the constitution granted by the Pope could be implemented. (Abbott 1931:66) After some delays a Bill, under which l'Ecole retained its corporate status and absorbed the Faculty of Montreal branch, became law (around 1890). (Abbott 1931:66)

Therefore, even as late as the turn of the century there were three medical schools in Montreal as compared with two in Toronto. The occupation of medicine had to wait until the twentieth century for further assimilation to take place in both Toronto and Montreal.

VII. Summary of Medical Education in Ontario and Quebec

Several transitions occurred in the characteristics of medical education and it is difficult to unravel the initial causes of change and whether these shifts were causes or effects of subsequent transitions.

First of all, medical education became secularized. Trinity ceased to require religious tests in 1871 (Spragge 1966:81); in 1876 the new Toronto School of Medicine was established as an institute independent of Victoria College (and thus the Methodist Church) (Sissons 1952:142); the primary secular college, the University of Toronto, was absorbing schools, and the Medical Faculty of Western Ontario followed its University's secularization in the 1880's. (Seaborn 1944:277)

Centralization of educational institutes accompanied secularization. At last medical faculties came to see the futility of

maintaining proprietary institutions in competition with government supported schools. Therefore the Toronto School amalgamated with the University of Toronto and Trinity eventually followed suit; the Royal College of Physicians and Surgeons became the Medical Faculty of Queen's University (MacDermot 1967:100) and the London School of Medicine established much closer ties with the University of Western Ontario. (Seaborn 1944:277)

The inequities in funding became particularly acute when new expectations were placed on medical education by the elite of medicine. At this time German medical schools and medicine were presented as role models for the rest of the world to emulate. This was part of the reason why new expectations were placed on medical school facilities and why proprietary schools were denounced as inadequate. Canada was influenced by attitudes in the United States. As Stevenson explained the situation, American medical leaders who saw deficiencies in their system, inferred from the dazzling success of German medicine and their medical schools' connection with universities, that the American deficiencies could be remedied by university affiliation. (Stevenson 1967:23) What the American medical men did not see was that university affiliation in and of itself was not enough. Germany was the only country to provide the chairs, money, facilities and encouragement necessary for an intertwining of medical science and education. (Stevenson 1967:31)

Acting on the assumption that the deficiencies of the medical system could be remedied by the medical schools' affiliation with universities, advocates needed to depict, as dramatically as possible,

the virtues of a university connection or complete integration. One way was to show that the proprietary medical school had become "Anomalous and monstrous." (Stevenson 1967:23)

While the presentation of the inadequate proprietary school was overdramatized, self-supporting schools were having a difficult time keeping abreast of demands. Medical curriculum was expected to be based on several branches of science. No longer was didactic learning acceptable, students had to gain their knowledge first of all in the laboratories and then in the wards. Self-supporting schools found that they could not build and equip adequate laboratories using only the fees of medical students. Thus the need for additional funds pushed schools out of the proprietary category and into university affiliation accompanied by government assistance.

The University affiliated medical schools were transformed from self-governing, financially independent institutions with little interest or participation in University affairs (MacDermot 1967:102); into a medical faculty who perceived the University as an integral part of their survival. The University housed them, gave them laboratories and equipment; considered the medical faculty to be part of the staff of the university, it gave them access to lectures and facilities of other faculties (Spragge 1966:88; The Librarian 1906: 304) and gave them representation on the Senate. (The Librarian 1906: 315)

Why did medical schools remain under seemingly unfavourable conditions as independent institutions for as long as they did?

Lloyd Stevenson has suggested that the influence of Parisian medicine in Canada may have kept Canadian medical schools basically independent from universities. When Canada adopted the Parisian emphasis on the science of post-mortem pathology it was carried out in the morgues rather than the universities. (Stevenson 1967:30) The other possible reason was the school's insistence on remaining independent. Affiliation with a university would reduce the school's power because as a faculty under the University's administration they would have to have approval on policies and their implementation. As you will recall, the first closing of Trinity Medical School was due to an inability on the part of the faculty and administration to agree on the amount of freedom which the medical faculty could have.

The reduction in competition accompanying amalgamation was quite likely a goal of the medical community's elite. For years leaders had been striving for harmony within the community and the constant rivalry between schools must have made them cringe. One can see that their push towards the science of medicine produced two results; one was the eventual elimination of proprietary schools and the other was the concentration of medical education with a great reduction in competition. Both of these attainments were important to professional autonomy. Highly visible competition was harmful to the image which medicine wanted to portray to the public. Rival schools only pointed out the inequalities in medical education and their graduates. Medicine wanted the public to assume that all physicians were equally competent. Going one step further, they wanted the public to perceive doctors as equally qualified scientists,

rather than technicians. The scientific element of medicine gave medicine the esoteric character it needed to maintain a social distance between itself and the public in order to keep its professional autonomy.

The greater stress on the scientific content of medical school courses came at a time when Canada was undergoing an increasingly more complex division of labour and giving recognition to the category of specialist. Both would aid doctors in establishing an appearance of being experts in their field. Therefore, a new scientific approach to medical education could be one of several rationalizations used when asking for a conferment of autonomy on the regular occupation of medicine. (Johnson 1972:58) Medicine was no longer simply medicine, it was medical science. Here is one doctor's presentation of medicine's new image:

In the days when young John Barnhart had enrolled at Fairfield Academy in New York (approximately 1830) a bright, industrious student had been able to learn all there was to be known about physic, surgery and midwifery in about twelve months. By the end of his career, at the beginning of the new century, so much knowledge had been accumulated that the student of medicine could hardly scratch its surface in four years.

(Bull 1934:268)

VIII Epilogue

To finish this section I thought it might be interesting to see how an outsider viewed medical education in Canada at the turn of the century. Abraham Flexner conducted a survey of the one hundred and fifty-five medical schools in the United States and Canada during 1909. He found that the schools in Canada fell into three categories:

the first included those requiring two or more years of college work for entrance; the second demanded graduation from a four year high school or its equivalent and the third asked for a common school education. (Flexner 1960:28) Canada, with the exceptions of Western and Laval, was found to be more stringent than the United States in entrance requirements. Some schools admitted special students without a diploma from an accredited high school if the student sat a series of 3 hour written examinations held in advance of the school's opening. (Flexner 1960:35) Flexner claimed that the stringent entrance requirements guaranteed a better student and that students would be equal in qualification and competency. Flexner used the mortality rates of ten of the best schools in the United States and compared them with the rates from McGill and Toronto to prove his point.

Three Schools Requiring Two or More Years of College for Entrance
John Hopkins, Harvard, University of Minnesota

| Total Enrollment | Dropped before Examination | Failed and Conditioned | Passed without Condition |
|------------------|----------------------------|------------------------|--------------------------|
| 757 | 2% | 17% | 81% |

Seven Schools with High School or Equivalent Requirement
Jefferson Medical, New York University, University of Maryland, Medico-Chirurgical, Tufts, Yale, University of Pennsylvania

| | | | |
|------|-----|-----|-----|
| 2280 | 11% | 38% | 51% |
|------|-----|-----|-----|

McGill and Toronto

| | | | |
|-----|----|-----|-----|
| 945 | 5% | 28% | 67% |
|-----|----|-----|-----|

(Flexner 1960:38)

Flexner's report reflects the emphasis on the science of medicine. Therefore any medical course must be constructed upon an adequate pre-medical scientific training. Schools which only required high school could not offer as high a calibre of education because laboratory courses are impossible for students who have had no preliminary training in physics or chemistry. (Flexner 1960:77)

Some of the medical schools added a fifth year to their curriculum to compensate for their lower entrance requirement. (Flexner 1960:78) In terms of laboratory facilities, Flexner found that Toronto and McGill had well-equipped, ideally constructed laboratories. However, while Toronto had full-time instructors, McGill was less fortunate. (Flexner 1960:78)

Turning to clinical facilities, McGill and Toronto were the only medical schools to have adequate clinical facilities. There has to be an adequate number of hospital beds accessible to the medical schools to ensure a proper weighting between internal medicine and surgery. The fewer the beds the school has the more overweighted surgery is. (Flexner 1960:116)

Flexner felt that schools required \$100,000 to \$150,000 to pay the minimum cost of a four year course accommodating 250 students and organized along sound laboratory and clinical lines. (Flexner 1960:133) If student fees amounted to \$40,000, then the other 70% of the expense would have to be made up from other sources. (Flexner 1960:133) As you will notice from the chart (on page 250) some Canadian schools had no sources other than fees. Flexner felt that

both London and Laval at Montreal had no place in providing education. (Flexner 1960:150) Thus, according to an outsider who measured standards in terms of John Hopkins Medical School, Canada had two top notch schools, 2 average institutions and 2 totally unacceptable schools around the turn of the century.

IX. The State of Medical Knowledge in Canada

No discussion of the professionalization of medicine in Ontario and Quebec would be complete without a section on the state of medical science. As Freidson argued, any profession must have a relatively monopolistic hold over the exercise of its work and this was not possible until a secure and practical technology of work was developed: (Freidson 1970a:16) For medicine this meant the creation of a systematically scientific foundation from which improvements could be made to medical procedures. Advances in the latter would bring about better rates of improvement which would provide convincing proof of the efficacy of treatment. Nothing would convince the public more of medicine's worth than to have friends and relatives improve under the care of a regular physician.

There are several aspects to medical knowledge and I will begin my discussion with a brief description of the facilities available to Canadian researchers at the time. This will provide an explanation as to why we borrowed most of our theories and techniques in the nineteenth century and how external ideas were introduced to Canada.

Before the discovery of insulin in 1921 medical research on a full-scale level was non-existent in Canada. Canadian physicians brought back findings they had come upon in their travels in Europe; some physicians used their own money and leisure time to pursue research, or a medical school might have squeezed in a small budget for exploratory studies but there was no institution set up to distribute resources in money, equipment and technical assistance to maintain large, time consuming projects. Thus, beginnings were made in the nineteenth century in Canadian medical research but direction and support were lacking. (MacDermot 1967:167)

From the inception of the Canadian Medical Association members made repeated requests to the Government for a National Research Laboratory. (Heagerty 1928:383) Each year members of the Canadian Medical Association introduced motions into the House of Commons "for a select committee on vital statistics and public health." (Heagerty 1928:382)

Medicine's willingness and desire for the Government to take over some of its tasks and financial responsibilities in the area of research was significant to me. I perceived it as an indication of the increased confidence medicine had; it was no longer fearful to relinquish jurisdiction over some matters pertaining to medicine. Both the provincial and national medical associations seemed to follow a policy of transferring certain financial responsibilities to the Government. In 1886 the President of the Ontario Medical Association suggested that the Government undertake the collection of statistics dealing with preventable diseases. (Ferguson 1930:11) Rather than

establishing research institutions independent of outside agencies, the President of the Ontario Medical Association for 1894 urged the establishment of an institution similar to the ones Koch and Pasteur were associated with, under government control but outside the influence of party politics. (Ferguson 1930:23) After twenty-five years of pleading for aid to scientific endeavours, the Provincial Diagnostic Laboratory was established in 1892 to examine specimens sent in from all parts of the province. (Ferguson 1930:21)

Although the science of medicine was stressed as an ideal for medicine after Confederation, as mentioned above facilities and actions did not keep pace with ideology. While the President of the Ontario Medical Association claimed that the real foundations of medicine were anatomy, physiology, pathology and the kindred sciences (Ferguson 1930:23), when William Osler graduated from McGill in 1872 there was the barest suggestion of medical research. As part of McGill's faculty in 1874 he bought microscopes to use in demonstrations in his histology and physiology courses. (Careless and Brown 1967:553) During his ten years at McGill he made a vital contribution to Canadian medical science by establishing the first systematic autopsy service in Canada and by performing more than 750 carefully recorded autopsies. (Abbott 1930:82)

While Canadian medical historians may point out that Canada maintained a higher standard for medical education during the nineteenth century, they fail to mention that the United States had made more progress in establishing centres for medical research. American

physicians who had received post-graduate training in German speaking universities created an issue out of the mediocrity of medical education when they returned home. (Shryock 1966:29) They tried to use medical associations to secure reforms for education. While certain members of the medical community were not responsive to their pleas because they had vested interests in maintaining the substandard schools, the social milieu was favourable to upgrading. Following the decade of the seventies the public was beginning to see that medical science offered a means of preventing and even hope for curing disease. (Shryock 1966:30) As vaccines were introduced powerful individuals could see that investments in medical research yielded worthwhile gains. At the same time an increase in the wealth of the nation from rapid industrial development made money available for medical science. Thus both an increase in investment money and a change in attitude towards the worth of medical science led wealthy individuals to contribute generously to the support of research. Johns Hopkins Medical School was the manifestation of the ideals of German-trained American physicians. Established in 1893, it was to be a research centre as well as an institution of teaching. Johns Hopkins' birth only increased demands for an evaluation of medical schools in the country.

Since it was too difficult for the American Medical Association to operate a systematic rating program for all medical schools in the country the Carnegie Foundation for the Advancement of Teaching hired Abraham Flexner to conduct a survey of all medical schools in Canada and the United States in 1909. Although my thesis ends at the turn of the century, a small discussion of Flexner's findings on the

standards of medical science found within Canadian schools will show the reader that the United States was ahead of Canada in medical research.

Flexner measured all schools relative to Johns Hopkins and therefore we can form an impression of where Canada stood in relation to the leading research centre of the United States. Flexner's ideal was to have medical schools with a sound scientific basis. He felt there should be at least four separate laboratories for anatomy, physiology, bio-chemistry, pharmacology, pathology and bacteriology and that the student should have adequate scientific training before entering medical school. Flexner felt that schools requiring high school or its equivalent could not meet this ideal. Since the leading schools in Canada, Toronto and McGill, required High School for entrance, they were not at the same stage as Johns Hopkins in medical research. By 1887 the Medical Faculty of Toronto had access to equipment in Biology, Physiology, Chemistry and Physics. (Ferguson 1930:13) As for McGill, laboratories were added to the Medical Building on campus in 1885. (Abbott 1931:61) Thus in terms of laboratory equipment they equalled Minnesota and Michigan. (Flexner 1960:78) The other Canadian Medical schools were in less satisfactory condition as they were unable to provide adequate laboratory facilities because of a lack of funds. (Flexner 1960:77)

Having reviewed the facilities available to Canadian practitioners let us look at the general state of medical knowledge and the sources from which the Canadian medical community derived its information. I will begin with theories on the etiology of disease.

The development of physics and chemistry made a systematically scientific foundation for medicine possible for the first time. Without a systematic foundation medical practice was only a variety of traditional conceptions supplemented by highly variable clinical judgement. There was no means of sorting and analyzing clinical experience. Without a systematic notion of the causes of pathologies or the causes for the success of a new drug or procedure, progress was halting and confused and the work of individuals varied according to individual opinion and experience. (Freidson 1970:16)

Although it had been recognized as early as the 1700's that disease could be caused by germs it was not until the late nineteenth hundreds that this idea gained general acceptance. It had to wait verification until microscopes and laboratory techniques became available. (Shryock 1966:22) Until that time the popular paradigm of inflammation as the cause of most disease was less threatening to medicine's reputation for competency because with inflammation as the cause they could suggest cures but with germs as the cause they had not been able before the last third of the century to identify the pathogenic germs and develop medications to combat them. (Shryock 1966: 22)

Both Canada and the United States had to depend on European centres with their well-established and prestigious research centres to do the exploratory work. Around the middle of the century Dr. Budd of Bristol concluded that minute organisms were responsible for the spread of many diseases and Davaine discovered a specific rod-like organism in the blood of those who died of splenic fever. When Pasteur

established the connection between minute organisms and disease many French and German bacteriologists used Koch's postulates and his method of cultivating isolated species to identify organisms from many of the critical infections; cholera, typhoid and tuberculosis. (Action, Goldsmith and Shepard 1974:134; Bull 1934:198) After the causes were known the next step was to consider whether this knowledge could be used to develop a medicine to prevent the disease from firmly establishing itself within the body. Koch developed vaccines to help the body fight pathogenic germs of splenic fever, hydrophobia (rabies) and smallpox. (Ferguson 1930:12)

The Canadian medical community slowly accepted the germ theory of disease. (Ferguson 1930:8) Some zealous converts also decided that it would be an excellent idea to try to prevent the occurrence of disease by programs of mass vaccination. When Koch developed the vaccine tuberculin to treat tuberculosis (MacDermot 1967:169) leaders of the Montreal medical community attempted to impose compulsory vaccination on the people of the city. Evidently, the public were not ready to accept without question, the dictums of medicine; riots broke out and the house of the civic medical officer was set on fire. (Careless and Brown 1967:553).

From the minutes of the 1892 meeting of the Ontario Medical Association we also know that physicians were discussing diphtheria in light of the germ theory of disease. Recognizing that diphtheria was very contagious, they recommended that cases should be isolated and the room disinfected. (Ferguson 1930:12)

While Bacteriology was vital to narrowing down the range of theories of etiology of disease, it also helped accuracy of diagnosis for while symptoms or lesions were aids to diagnosis, in contrast, the presence or absence of a particular bacteria unequivocally decided whether the patient had the disease. (Shryock 1966:23)

When medicine came to the point where diseases could be recognized both by symptoms and localized pathology in organs, tissues and cells a reorientation occurred in medicine. With the focus of attention being on organs or organ systems physicians began to focus on a particular part of the body rather than the body as a whole. We know that intensive study of a particular part of the body led to an expansion of clinical and pathological knowledge. (Rosen 1972:28) In the area of deficiency diseases conditions could be divided between those resulting from a lack of substances ingested by the body (malnutrition) and those caused by the failure of certain glands to produce hormones within the body. The use of the biochemical approach helped scientists arrive at the conclusion that minute substances (vitamins) in food prevented the widespread, fatal diseases of beriberi and pellagra. (Shryock 1966:28)

In the last third of the century, the international occupation of medicine had managed to establish a foundation of science. Nevertheless, it was only a beginning and when one realizes the kinds of medications which the average regular was using one gains some idea of the improvements needed in this sphere. MacDermot claimed that by the 1870's bleeding and purging were almost exterminated. (MacDermot 1967:29) It was surprising then, to read in the minutes of the Ontario

Medical Association meeting in 1896 that a Dr. Harvey of Wyoming presented a paper on the treatment of broncho-pneumonia in children which appeared to recommend purging and mercury based drugs, both of which were assumed to have been discarded in this new era.

Good ventilation and steam moistened air, and, if the temperature should rise above 101 degrees, sponge with tepid or cold water every few hours. Give mercury in some form to keep the bowels relaxed, if there is cyanosis, a lethargic state, or bronchial breathing, give emetics. Stimulants are useful in all stages, and strychnia is specially valuable.

(Ferguson 1930:28)

The profession's use of alcohol as a medication prompted members of the Women's Christian Temperance Union to approach the Ontario Medical Association for comment. Although the O.M.A.'s official stance was that alcoholic liquors were never required in health as a beverage and in medical practice only in cases of emergency (Ferguson 1930:10); two years later Dr. Richardson admitted at a meeting that in treating carbuncles and other septic tumors he gave alcoholic stimulants freely. He allowed an adult one bottle or one and a half bottles of brandy per day. (Ferguson 1930:13)

The medical profession was fairing better in the area of surgical treatment. Lister's antiseptic methods began to seep into the Canadian scene in the 1870's. Although it was not widespread, Canadians who had studied in Edinburgh and served under Lister as dressers in house surgeons or as post graduates were convinced that it helped to reduce the number of fatalities. (MacDermot 1967:28) Dr. Roddick of Montreal made several trips to Edinburgh to watch Lister and in 1877 brought back the carbolic spray. In keeping with the new science of medicine Roddick kept count of the number of successes and fatalities he had had after performing sixty-four operations. The results were quite convincing; only two deaths. (MacDermot 1967:29) Still, Montreal surgeons were hesitant to use

antisepsis.

Physicians who adopted Lister's antiseptic method for surgery also applied it to childbirth. In 1870 Stadfeldt at Copenhagen began to use the carbolic acid technique in 1870 and over a span of ten years the mortality rate of childbirth had been reduced from 1 in 14 to 1 in 116. (Wyndham 1968:201) Bichloride of mercury was introduced to the wards of the New York Maternity Hospital on Blackwell's Island in 1883. In three months the mortality rate fell to zero. Even after these convincing results a prominent teacher stated in his address to the 1889 meeting of the Ontario Medical Association that he felt that the best method of preventing sepsis in parturient women was to thoroughly cleanse the hands and maternal parts with warm water and soap but it was not necessary to use antiseptic. (Ferguson 1930:70) There must have been different schools of thought within the Canadian medical community because the next year another physician advocated the use of antiseptic precautions to arrest the spread of puerperal fever. (Ferguson 1930:18)

When the innovators of the medical community began to see that antisepsis made abdominal operations relatively safe, they began to concentrate on improving techniques. Important advances were made in delivery at childbirth; the caesarian section became safe enough to justify its use in critical cases and a new type of forceps was produced in Paris. (Wyndham 1968:202) To further aid surgical prognosis conduction anaesthesia through nerve blocking was available by the 1880's. (Shryock 1947:177) With these dramatic improvements and results the average practitioner who used the new techniques had a definite edge over the average midwife and thus the profession could slowly overtake this area of health care.

Advances in medical knowledge not only changed the approach

to treatment they also helped introduce a new division of labour within the profession. Out of the development and application of the concept of localized pathology came the trend to limit one's specialty to one area of the body. (Rosen 1972:16) In addition, the social milieu of the last third of the century encouraged the emergence of specialism. By this time institutions were firmly established and the specialist had medical journals and societies with which to become well known and he had hospitals and schools in urban centres in which he could carry on his practice. (Shryock 1966:30) In addition, the physicians who trained in Europe or had emigrated after the defeat of 1848 were accustomed to Europe's segmentation of practice and were willing to familiarize Canadian doctors with the concept of specialty. (Rosen 1972:36) Foreign-born specialists played Simmel's role of the "stranger". Whether they emigrated or had Canadians study under them, they acted as a catalyst to introduce innovations into the Canadian medical scene. (Rosen 1972:39) In addition, the more urbanized Canada became the easier it was for a specialist to make a living. In the city the high degree of social interaction and communication made it easier for the public to become aware of several types of medical practice. (Rosen 1972:46) The dispensaries and out patient hospital departments found in the cities helped produce a body of partial specialists. They could exchange time and services with a specialist for training in a specialty, yet they did not have to relinquish their general practice work. Their connection with the clinic gave them a standing as a specialist in the layman's mind. (Rosen 1972:72)

The first specialist in Canada, Dr. Bullen, was an Oculist and Aurist. Dr. Blackader developed in the 1880's the first children's clinic in Canada at the Montreal General Hospital. (MacDermot 1967:165)

Dr. Gardner was the first practitioner to become a Gynaecologist and Dr. Major, a Laryngologist, both in 1883. The first psychology lab was set up at the University of Toronto in 1889 by James Baldwin, a graduate of Princeton who had studied in Germany with Wundt. (Careless and Brown 1967:551)

Looking back over the century, medical knowledge had come a long way. The accumulation of discoveries and insights over the century had allowed physicians by the last third of the century to make a qualitative break with the past. For the first time a wide spectrum of human ills could be predictably and reliably controlled by any well-trained practitioner, not just an outstanding physician, and an average patient treated by an average practitioner had a better than fifty-fifty chance of improvement. The distinction between a physician and a quack no longer rested on merely "the academic certification of one superstition over another." (Freidson 1970:16)

For fear of overstating the competency of the average Canadian practitioner however, I will end with Ehrenreich and English's description of the situation:

"the run-of-the-mill regular doctor did not suddenly acquire a knowledge of medical science...but he did acquire a mystique of science." (Ehrenreich and English 1973a:33)

CONCLUSION

I see the conclusion of this thesis as having one central purpose and that is to consider the value of Johnson's hypotheses to a history of Canadian medicine. While the major aim of this thesis was to discuss the developmental stages of medicine within Ontario (one of the forefathers of Canadian medicine); in using Johnson's perspective I was also considering the generality of Johnson's hypotheses. How applicable are his hypotheses to a country which had had Britain's eighteenth century social-political structure imposed upon it, yet had to modify this structure because of the relatively primitive state of settlement and economic development? Thus as I provide a summary of my findings I will point out where modifications within the Ontario system makes it necessary to further refine Johnson's theoretical structure.

In Chapter One we saw that until the Union of Canada in 1841 medicine was an occupation under Oligarchic control. I was able to substantiate Johnson's claims that where the dominant effective demand for occupational services comes from a small, powerful clientele such as the Family Compact and when the consumer is as educated and competent as the physician in diagnosing and prescribing, then the occupation will be subject to the control of the elite. There is one further factor, the state of scientific knowledge, which Johnson mentions but does not clarify as to whether it is a cause or effect of Oligarchic control. Freidson and I would concur that it is a causal factor. Without a scientific foundation for medicine, regular medical practice was no different from other superstitions. It held a variety of unsubstantiated theories of etiology and treatment which were supplemented

by widely variable clinical skills and judgements. (Freidson 1972a:15) When the average practitioner could not reliably and predictably control illness and thus could not offer a patient any better chance of recovery than a lay healer, then the elite of medicine had to resort to their social skills to convince those in power that the average practitioner should have a monopoly over the field of health care. The non-scientific foundation of medicine left the medical community dependent on the elite, who were also the consumers, for favours and thus left them vulnerable to the elites' decisions. Under the circumstances it was impossible to establish a social distance between practitioner and consumer and without the social distance medicine could not achieve occupational autonomy.

Since the elite exerted a controlling influence over the occupation of medicine, the physicians who were held in respect by the elite were those who had come from prominent families and had been able to train at Edinburgh. These physicians exerted a province-wide influence on the medical community. (Anderson 1926:448) They were able to exert an influence because Government Officials had empowered them to examine physicians and issue successful examinees a license to practise. Thus, when the occupation was given the right to institutionalize a procedure (The Board of Examiners) for differentiating between qualified and unqualified healers it introduced an instrument which a small segment could use as a sanction to gain support from the general medical community for implementing desired policy. (Strauss and Bucher 1961:333)

Strauss and Bucher would agree with Johnson that the institutionalization of a qualifying board, which created a dual system of practice, introduced the potential for conflict and competition. (Johnson 1972:73) Remembering the conflict between Toronto physicians and members of the Board, (discussed in Chapter One, Section One) our data would also support this hypothesis.

As I mentioned in the opening paragraph of this section, Canada as a colony of Britain sometimes adopted and at times had imposed upon her, various norms and customs from Britain. They often needed to be modified to suit the very primitive conditions in Canada. Turning to the occupation of medicine, British naval and military physicians were posted in Canada and they worked hard to improve the means by which their profession could upgrade the calibre of individuals practising medicine.* We also know that physicians from prominent families, who could afford an Edinburgh education, exerted a province-wide influence

*During the construction of my thesis I came to wonder about the motivations which drove the leaders in medicine to push for the removal of irregulars from the field of medicine. While historians perceive it to be based on a desire to improve the calibre of medical practice I am at the point where I would question this as being a perception biased by twentieth century perspectives. Capturing the mood of early Canadian society, the leaders in medicine may have been motivated more by class consciousness. Since this group had held relatively prestigious careers, partly because of their social class and/or partly because of their naval or military experiences, then it would seem reasonable that they would want medicine to be prestigious. This necessitated a differentiation between the kind of profession which they were engaged in and the kind of occupation which the lower uneducated "common masses" were engaged in.

on the occupation. (Anderson 1926:448) In addition to introducing the Edinburgh model with its emphasis on university affiliated medical schools and clinical practise to supplement didactic lectures, there were also physicians who stood by the London model of combining hospital and out-patient clinics with medical schools. (MacDermot 1967:111)

It was not only the wealthier members of the medical community who insisted on British standards. Since the government was composed of British subjects, there were times when they imposed British standards on Canadian medicine. Take the case of McGill's Medical Faculty. When the Montreal Medical Institution wanted to secure a charter for the school, the Solicitor-General refused to grant it one until it had associated itself with a university.

In the transmittal from Britain to Canada modifications were made according to Canada's need. For instance, it was unnecessary for a country as uncivilized as Canada to have as sophisticated a division of labour within medicine's occupational structure as Britain had. Thus the British guild divisions between medicine and surgery were collapsed and all Canadian physicians were practitioners. (McWhinney 1972:231) Knowing that Canada made modifications to Britain's system and Johnson's hypotheses were made on the basis of English data, I began to wonder if his hypotheses were applicable to Canada. To expand on this point, I was hesitant to accept Johnson's claim that graded qualifications are institutionalized to justify the hierarchical organization of the occupation. (Johnson 1972:73) When the only institutionalized gradation in Canada was regular vs. irregular and there were no guilds this hypothesis did not seem to apply.

Alternatively, the wilderness tended to accentuate patterns suggested by Johnson. Although Johnson suggests that Oligarchic control over medicine created a fragmented, locally oriented occupational group, the isolated communities in Canada made this pattern more pronounced. When each community was isolated from others and all aspects of community life were directed by a small, tightly knit aristocracy and the physician had only this group to depend on for patients, then it is understandable that his first loyalty would be to them and not to the community of medicine. When dealing with the early nineteenth century a "community of medicine" is only a theoretical concept, helpful in expressing certain ideas but not an entity. In the first third of the century medicine was a collectivity of scattered, isolated segments, not a community of collegueship. The latter was a characteristic imposed on medicine by society; it was not an innate trait.

The unsettled nature of Canada also made the system of sponsorship, in this case apprenticeship, very apparent. Under frontier conditions apprenticeship flourished. When legislation could not be effectively enforced because policing was impossible and the standards for obtaining a license were low there was no urgency to establishing a medical school.

As the years passed great strides were made in opening up and settling the wilderness. From 1821 to 1850 the population more than doubled through immigration. (Lower 1958:189) While the economic and social life of Ontario was bound by poor transportation to a district level; still, at that level a great deal of development was taking place. Hamlets were growing up around sawmill and gristmill sites

and urban communities were emerging where once there had been only "four corners" with mill, tavern and general store. (Careless 1967: 35) Canals were dug and railways built in the 1950's to transport agricultural goods and timber to ports for foreign markets. (Morton 1964:5)

All of these changes affected medicine. At least there were clusterings of people outside of the nine major cities to provide a few more patients and the widely scattered farms were beginning to be joined by better pathways. Both of these changes made it possible for physicians to see more patients. With respect to the latter, this group was changing in characteristics as a result of the growth of Canada. England was forcing Canada to become much more independent by withdrawing financial and military support. This served to weaken the power of the Family Compact and allow the new bourgeoisie to gain power. This held two important consequences for the direction which medicine could take. As I mentioned above, the characteristics of the consumer group changed; it began to expand to include other groups (for example, the new bourgeoisie). At last a physician's regular patients did not necessarily belong to the group that oversaw government appointments and therefore the advance of a physician's career. This gave the physician more freedom and weakened his loyalty to the consumer who now might not be his patron. In addition, as the consumer group diversified it became possible for them to organize and collectively put pressure on a physician to conform.

Secondly, the diversification of the power elite gave certain segments within the medical community more opportunity to maneuver. If

medicine failed to convince one group to support their desired policies they now had at least one other group with different values, beliefs and goals to approach. In addition, if a physician could not find favour with one group he could approach another to advance his career. Thus variability within the power elite loosened the stranglehold which the Family Compact had had over the affairs of medicine. As a point of illustration, the great number of medical schools established during this time reflected the power plays which were taking place between the Tories and the Reformists. (See Appendix D, p. 252)

The first school opened in Ontario was Rolph's Toronto School. Its affiliations with the Reformist political party disturbed the Tories to such an extent that they introduced a medical faculty in King's College. Then the Government decided in 1849 that education should be secularized and so they disbanded King's College (a Tory and Church of England affiliated institution) and opened the University of Toronto. In response to this the Tories initiated plans to establish Trinity College with a Medical Faculty. Thus in 1850 you had three medical schools in Toronto; one with an obvious Reformist affiliation, the second with more subtle Reformist ties and a third with Tory foundations. When the University of Toronto lost its authority to teach, then there were just the two opposing forces to face one another. As the years progressed however, and the teaching staffs turned over, divisions between the two schools became less obvious than divisions within schools. By 1856, both Rolph's School and Trinity's Medical Faculty found that segments within their own respective faculties held such divergent attitudes, values, beliefs and goals that conflicts could not be resolved and thus both schools were disbanded.

Therefore with the passage of time the schools stood less and less for a political and/or religious body and more for certain segments who had managed to take control of the institution. This is particularly evident in the last third of the century.

Before proceeding to a further discussion of education I would like to return to a step preliminary to the establishment of schools; the establishment and implementation of regulatory legislation. As we have seen throughout this thesis regulatory laws were capable of both helping and hurting various schools. We also know that it was not the laws themselves which encouraged the initial establishment of schools because up until 1865 physicians could still gain a license to practise in Upper Canada with simply an apprenticeship. This was not the case in Lower Canada. The College of Physicians and Surgeons of Lower Canada in 1847 made it mandatory that applicants hold a university degree before being issued a license to practise. For some reason they made an exception with Canada West applicants because they issued licenses to those physicians who had been licensed in Canada West to practise in Canada East. This arrangement was not satisfactory to a number of physicians in Canada East and exploratory attempts were made between King's College and the Medical Board of Montreal to bring about uniformity in qualification for examination. (Heagerty 1928:81)

This brings me to a point which I made above; laws could be used to hurt certain schools. If King's College had been successful in its attempts (and we shall never know how it could have turned out because King's was disbanded in 1849) then all medical students would have needed a university degree to qualify to practise medicine. This

would have meant that King's rival, Rolph's School, would have folded because there was not another college to affiliate with.

It took Canada West eighteen years to catch up to Canada East's standards. It was not until the Parliament of Canada established a General Council of Medical Education and Registration of Upper Canada in 1865 that apprenticeship was no longer accepted as a form of education. Nevertheless, an applicant still did not need a degree, only three years attendance at a recognized school. (The Librarian 1906:172) If one glances at the chart on Medical Schools one will notice that at this time there are only two medical schools in Canada West and both are not affiliated with a university. Regulatory legislation reflected need rather than laxity.

Around the 1860's the State reversed its policy with regard to regular medicine. Whereas before it attempted by means of regulatory legislation to cut down the number of practitioners who could practise medicine, the government turned around and gave approval to medical sects which it had previously outlawed. The Legislative Assembly gave both the Thompsonians and the Homeopaths permission to set up their own Medical Boards. Thus they were given authority to license healers. This suggests that the State did not perceive regulars to be more competent at medicine than the sects and therefore the sects deserved the same amount of power to organize and institutionalize regulation, schooling and communication. Whereas before irregulars practised because the State failed to discover their activities, in this period the State not only discovered but officially recognized their activities. Sectarian schools had been established before the 1860's but it was not until sect Medical Boards were set up that these schools offered a real

alternative in medical education. What was the point of attending a school when one could not be licensed upon graduating?

It is difficult to understand exactly why the government would reverse its policy but several suggestions come to mind. Until 1865 the occupation of medicine in Canada West did not have a strong provincial body to act as its spokesman. As you will recall the Queen vetoed the College of Physicians and Surgeons of Upper Canada in 1841. Thus when the two medical faculties in Toronto, Victoria and Trinity, were engaged in a great deal of conflict there was no organization influential enough to counteract the negative impressions of regular medicine which were presented during the conflict. In other words there was no body to speak on behalf of the community of medicine to persuade the government that in spite of these little tiffs the community as a whole was composed of mature individuals who were motivated by a concern for others ahead of self-interests. When technical competency was generally at a low ebb, other factors such as an altruistic image and a public relations organization were vitally important. Regular medicine at this point had neither. My propositions are supported by the fact that within five years of the establishment of the General Council of Medical Education and Registration of Upper Canada, sectarians had to comply with regular avenues of qualification (three years attendance at a recognized school and one year in the Medical Department of a University).

During its transitional phase from Oligarchic control to professional autonomy the regular medical community displayed more overt anger than in any other period of that century. I would suggest that

this is because in the first third of the century, the occupation was not organized or institutionalized enough to have one group pitted against another and in the last third, certain groups had come to dominate the occupation and to act as spokesman for it so that the internal disputes were not visible to the outsider. Whether the disputes were visible or not, it was the conflicts or differences of interests which brought about changes within the occupation. This stance places me in conflict with Johnson's approach. On the one hand Johnson sees an occupation heading towards professional autonomy as becoming increasingly more homogeneous in values, definitions of role and interests. (Johnson 1972: 55) On the basis of my data I cannot accept this. While I could excuse the differences in values and interests during the transitory period as evidence that medicine had not yet reached professional status, as I entered the last third of the century I became increasingly more uncomfortable with Johnson's theoretical structure. While medicine had attained a professional status there were still several groups with distinct values, beliefs and goals within the community. Strauss and Bucher's perspective is much more satisfactory to me. Unconsciously I had been using their perspective to understand the maneuvers taking place within medicine. An appreciation of the conflicts or differences of interests causes one to delve into the more subtle features of medicine and to extract valuable data. No discussion of medical education is complete without mention of the various coalitions within and between the schools. Moreover, their conflict acted as a catalyst to bring about changes in the condition and standards of education. This is particularly evident in Chapter Three's section on education.

Strauss and Bucher's perspective is also helpful in discussions of associations, journals and Boards of Examiners. Any aspect of medicine which was institutionalized became institutionalized because a group of individuals who shared identities, values and interests worked to set up an organization within which they could advance their goals. Sometimes these original segments were usurped by other segments within the organization. Nevertheless, one segment always dominated and used various sanctions to impose their will on the rest of the membership. The dominant segment also became the spokesman for the group so that friction was hidden and a consistent image was presented to society.

In sum, no history of Canadian medicine would be complete without a consideration of the setbacks and advances made in the process of professionalization because of the manipulations of various segments. Thus we have hit upon the less attractive aspect of Johnson's theoretical perspective. While he mentions some differentiation, still, there is always a steadfast core from which there are only temporary deviations. (Strauss and Bucher 1961:325) To illustrate my point, when he talks of the culturally divisive tendencies of specialization he adds that the disruptive consequences of specialization may be contained by subordinating the new specialisms to the control of the dominant clinician and general practice groups. (Johnson 1972:54)

Johnson's perception of the process of professionalization as a gradual move towards community wide homogeneity in identity, values, definitions of role and interests (Johnson 1972:53) does not mesh with Canadian data. By the time that Canadian medicine achieved occupational autonomy, the community was not a tightly knit group. While the

monopolization of the community of medicine and the regulation of entry into the profession limited the social class of practitioners and thereby made them more similar in values, beliefs and attitudes toward medicine; still, I think Strauss and Bucher's hypothesis of circles of collegueship holding distinct definitions of role and interests, values and identities is more in keeping with Canadian data. Let us turn to the profession of medicine in the last third of the century to see why Johnson's assumption of homogeneity does not fit fact.

It is impossible to affix a date as to when medicine became a profession in Ontario, but using our definition of profession we know that it had gained occupational autonomy by the end of the century. The increasing institutionalization of medicine made it possible for medicine to take over and direct an increasing number of administrative duties. This in itself increased medicine's control over their affairs. The College of Physicians and Surgeons of Ontario (1869) directed education and licensing policies. The Ontario Medical Register (1871) kept track of practising physicians and those who had been dismissed for misdemeanors. Both the Canadian Medical Association (1867) and the Ontario Medical Association (1881) worked at cultivating the science of medicine and surgery; elevating the standards of medical education, enhancing the character of the profession and furthering unity and harmony amongst members. The Ontario Association perceived itself as a link between county and city societies and the Canadian Medical Association. (See Appendix E, p. 254)

These larger associations fulfilled several purposes. First of all, when large bodies administered the daily concerns of the profession they were able to hide many of the petty disputes which

occurred between members so that the public only saw a "united front". Only through the control of the public's image of medicine, could its character and honour be advanced. The executive of these large associations had the power to push for the policies which they considered to be important. Publicization of their goals made it appear to the public as though the whole of the profession were working towards the same goals and thus gave the appearance of unity. In addition, the Executive, as the policy directors of these large institutions, had some means of convincing the general membership that it was to their advantage to support their policies. First of all, the Executive controlled all official communication and thus could control what information the general practitioner received. This is an incredibly useful aid to manipulating the masses into a desired position. Secondly, the prestige of the elite would carry some of the membership. Some members would perceive the elite as deserving of their position because of special skills and therefore would support a policy because it had come from highly competent individuals. In addition the Ontario Medical Association introduced a new ruling whereby members had to be voted into the Association. A member who had displeased the Executive could also be voted out. Finally, by the last third of the century the elite of medicine had taken the place of the power elite in controlling the ambitious practitioner. The medical elite held control over attractive, prestigious and/or lucrative positions in hospitals, journals, associations and schools. By doling out favours they could convince the leaders of various segments within the relevant institution to persuade their followers to support the elite's aims.

The strength and power of the province- and nation-wide institutions came by virtue of their size. Here was a group which could be organized and band together on a provincial and perhaps national level to lobby for legislation which would enhance the position of medicine. The elevation of social class within the medical community also helped medicine's lobbying power. It now contained many members who had ties to wealthy, powerful individuals in government and industry, and could if necessary use these associations as resources of power. The growth in power of the regular community during the last third of the century was reflected in the regular's ability to introduce legislation which drastically reduced the sectarian's power and forced them to undergo the regular's procedures of qualification.

By the end of the century there was a further centralization of power. In 1897 the Ontario Medical Council took over the responsibilities of several institutions. It assumed the Ontario College of Physicians and Surgeon's tasks of appointing examiners and making by-laws and regulations. It kept a register and records of offences and penalties, previously handled by the Ontario Medical Register. The Council also took on the new responsibility of setting a schedule of annual fees and certificates. Immediately after this the Ontario government annulled the right of local districts to set their own scale of fees. This final usurpation of control over policies was not well received by the Ontario Medical Association. At the same time a Dominion Medical Council was formed to enforce the national standards of qualification to practise. Once the physician had been granted a license to practise by the Dominion

Council he/she* could practise anywhere in Canada.

Local societies were not the only group to lose a great deal of their independence during this period. The new emphasis on the science of medicine forced schools to become more dependent on the university they had affiliated with for financial assistance in establishing facilities or they risked getting a bad reputation. At times even the financial assistance was not sufficient. Both the New Toronto School of Medicine and Trinity found that they were unable to continue as independent institutions in competition with a government supported University. Thus some University affiliated medical schools were transformed from self-governing, financially independent institutions with little interest or participation in University affairs into medical faculties who perceived the University as an integral part of their survival. Nevertheless there still remained two proprietary schools at the end of the century; Queen's and Western.

Ontario's standard of medical education around the turn of the century is adequately covered in Flexner's report on medical education in the United States and Canada. Nevertheless a few comments are in order regarding the conclusions he came to. Flexner claimed that Canada had better standards of education because she had outgrown the problem of proprietary schools. I feel that Flexner missed the real issue. The problem did not lie in the type of medical school (i.e. whether it was publicly or privately funded, or independent or university affiliated)

*By the eighth decade women were able to practise medicine in Canada. This was the result of the establishment of separate universities and medical schools for women and subsequently the elimination of rules barring women from entrance to university.

but in the kind of training available to the medical student. Thus the issue really reduced to the different kinds of models which the two respective countries adopted for teaching the principles of medicine. Canada adopted Britain's and Scotland's model of clinical training in hospital wards. In contrast the United States did not employ the model of the teaching hospital. The reason for this essential difference is simple. American physicians harboured extreme anti-British feelings from their War of Independence and therefore chose to study medicine abroad in Paris and later on in Vienna or Berlin. Thus the continental models exercised a more powerful influence in moulding the ethics, education and practise of American medicine than the British model. (Anderson 1926:450) In contrast, Canadian physicians were quite receptive to attending British medical schools and adopting any ideas and models which they thought would be beneficial. In fact it was a Canadian, William Osler, who introduced ward duty as part of the medical student's curriculum to the Johns Hopkins Hospital in 1889. (Means 1967:55)

While I have been talking of the various goals which were reached which allowed medicine to achieve and maintain professional autonomy there is one final ingredient which was essential before the conferment of autonomy was possible. Medicine had to make sufficient progress in medical science and clinical techniques so that the average practitioner had a better chance of helping the patient than the lay healer. Without proof of better results the regular physician did not have the edge and therefore the power to enable him to eliminate or devalue his competition. As we have seen in the section on the state of

knowledge medicine met this precondition in the final third of the century.

This thesis entailed a rewriting of the history of Canadian medicine. My intention was not to devalue medicine but rather to look at medicine in "secularized terms". (Freidson 1972a:13) Having traced Canadian medicine to its roots we can perceive this profession in more objective terms. We are no longer looking at the image of medicine as presented by the occupational community. In contrast to most histories of medicine my data and perspective presents Canadian medicine as achieving professional autonomy as much through political manuevrings as on the basis of technical and theoretical skill. It recognizes the ultimate importance of the socio-political milieu to medicine's development.

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APPENDIX A

Number Of Chartered Banks And Branches, 1820 to 1900

| Year | Number of Banks Active At Year End | Number of Branches In Canada |
|------|--|------------------------------------|
| 1820 | 1 | - |
| 1825 | 6 | - |
| 1830 | 6 | - |
| 1835 | 14 | - |
| 1840 | 13 | - |
| 1845 | 16 | - |
| 1855 | 23 | - |
| 1860 | 31 | - |
| 1865 | 34 | - |
| 1870 | 34 | 123 ¹ |
| 1875 | 50 | 230 ² |
| 1880 | 44 | 295 ³ |
| 1885 | 46 | 335 ⁴ |
| 1890 | 41 | 426 |
| 1895 | 37 | 530 |
| 1900 | 35 | 708 |

¹1868 figure

²1874 figure

³1879 figure

⁴1884 figure

(Urquhart 1965:246)

The State of Medical Education, Ontario and Quebec 1908

| | Kingston | London | Toronto |
|---|---|---|--|
| RELATION TO UNIVERSITY | In transition from Independence to complete integration | Independent | Department of University |
| ENTRANCE REQUIREMENTS | Below that of Arts Department of University | Nominal | Junior Matric. Exam |
| | Course covers five years | 4 year course | 5 year course |
| FINANCIAL RESOURCES FOR MAINTENANCE | Income in fees \$19,978 | Income from fees \$11,590 | Supported out of general funds of university. Income from fees \$64,500 |
| LABORATORY FACILITIES | Laboratory is new Physics, chemistry, physiology taught by University. Anatomy and Pathology taught by medical school. | Wretched chemical laboratory Dissecting Room | Best equipped and constructed labs on continent |
| CLINICAL FACILITIES | Kingston General Hospital - limited facilities 80 beds No dispensary | Inadequate facilities Small number of beds in municipal hospital No dispensary | Close ties with Toronto General Hospital with 500 beds. Free access to all wards, clinical laboratory, dispensary. |

| | McGill | Laval University Med. Dept. (Quebec City) | Laval University Medical Department (Montreal) |
|--|--|--|---|
| RELATION TO UNIVERSITY | Department of University | Department of University | Distant from University |
| ENTRANCE REQUIREMENTS | University School Leaving Examination 5 Year Course | Flexible, depends on student's prospective location 5 Year Course | Nominal |
| FINANCIAL RESOURCES FOR MAINTENANCE | Separate Endowments amounting to \$350,000 Assistance from general University funds Fees amount to \$43,750 Budget of \$77,000. | Fees Appropriation by the University | Fees |
| LABORATORY FACILITIES | Laboratory injured by fire New buildings funded by university | University provides chemistry and physics instruction Medical Department providing some labs for Anatomy, Histology, Bacteriology, Pathology | Chemistry taught by University Anatomy limited to dissecting Meagerly equipped lab for pathology, bacteriology, histology |
| CLINICAL FACILITIES | Association with two large hospitals of about 500 beds Students work freely in wards and laborat- ories. | Clinical Instruction in medicine, surgery; pediatrics given at Hotel Dieu Students work in wards and laboratories Dispensing Facilities | Access to two hospitals Containing 2 total of 250 beds |

APPENDIX D

Medical Schools

| <u>Date</u> | <u>Ontario</u> | <u>Quebec</u> |
|-------------|--|--|
| 1820 | | Montreal Medical Institute affiliates with McGill |
| 1843 | Rolph's Toronto School | |
| 1843 | King's College Medical Faculty begins plans | |
| 1845 | | L'Ecole de Medecine et Chirurgie de Montreal established |
| 1847 | | L'Ecole enters agreement with McGill its students receive McGill degree Incorporated School of Medicine of Quebec City established |
| 1849 | Secularized University of Toronto succeeds King's takes over medical faculty | L'Ecole's agreement with McGill broken |
| 1850 | Upper Canada School of Medicine established. Immediately affiliated with Trinity College | |
| 1851 | | St. Lawrence School established Incorporated School of Medicine of Quebec City becomes Medical Faculty of Laval |
| 1853 | University of Toronto's Medical Faculty disbanded becomes Examining Institution | |
| 1854 | Rolph's School affiliated with Victoria College | |
| 1856 | Victoria's Medical Faculty leaves Rolph and sets up new Toronto School of Medicine Victoria (with Rolph as Dean) replenishes staff | |
| | Trinity Medical Faculty resigns | |

| <u>Date</u> | <u>Ontario</u> | <u>Quebec</u> |
|-------------|--|---|
| 1866 | | L'Ecole de Medecine et Chirurgie de Montreal becomes Medical Faculty of Victoria University in Montreal |
| 1871 | Trinity's Medical Faculty revived. | Medical Faculty of Bishop's College organized |
| 1874 | Victoria Medical School (under Rolph) closed | |
| 1878 | | L'Ecole de Medecine de Montreal became part of Laval Faculty of Medicine in Montreal |
| 1887 | Toronto School of Medicine amalgamated with University of Toronto. | |
| 1903 | Trinity's Medical Faculty amalgamated with the University of Toronto | |

APPENDIX E

Medical Institutions In Ontario

- 1839 College of Physicians and Surgeons of Upper Canada formed.
- 1841 Queen vetoed Act for College, College disbanded.
- 1865 General Council of Medical Education and Registration of Upper Canada.
- 1867 Canadian Medical Association formed.
- 1869 College of Physicians and Surgeons of Ontario founded.
- 1871 Ontario Medical Register established.
- 1881 1st meeting of the Ontario Medical Association.

Number of Physicians And Dentists, Population Per Physician And Dentist, Canada, 1871 to 1901 and 1959

| Year | Physicians | | Dentists | |
|------|------------|--------------------------|----------|------------------------|
| | Number | Population Per Physician | Number | Population Per Dentist |
| 1871 | 2,792 | 1,249 | 319 | 10,928 |
| 1881 | 3,507 | 1,217 | 510 | 8,369 |
| 1891 | 4,448 | 1,065 | 753 | 6,290 |
| 1901 | 5,442 | 978 | 1,310 | 4,064 |
| 1959 | 10,000 | 918 | 5,753 | 2,963 |

From: M.C. Urquhart, Historical Statistics of Canada, 1965:44.