

“HOLDING OPEN THE DOOR OF HEALING,” AN ADMINISTRATIVE, ARCHITECTURAL,
AND SOCIAL HISTORY OF CIVIC HOSPITALS: TORONTO, WINNIPEG, CALGARY, AND
VANCOUVER, 1880-1980

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by

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A Thesis Submitted to the School of Graduate Studies in Partial Fulfillment of the Requirements
for the Degree Doctor of Philosophy

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TITLE: "Holding open the door of healing," An Administrative, Architectural, and Social History of Civic Hospitals: Toronto, Winnipeg, Calgary, and Vancouver, 1880-1980

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ABSTRACT

The following dissertation examines the history of general hospitals in modern, central and western Canada. It follows extensive case studies of the Toronto, Winnipeg, Calgary, and Vancouver general hospitals. The last few decades have seen an expanded interest in hospitals by Canadian medical historians, but the overall literature is thin. Further, many of the extant histories focus on a particular constituent: the medical profession, administrators, or architects. In this dissertation I argue that these general hospitals were contested spaces, and that their organization and layout reflected negotiation between several parties. A further important vector is the role hospitals played in the social life of their communities. As these general hospitals grew, and began treating middle-class patients, they also required large sums of money from the public purse. Administrators had to account for the shape and use of medical space to the general public that helped finance it, as they did to the doctors who worked there. During the period 1880-1945 general hospitals moved from the periphery of medical care to the centre, but not without substantial growing pains. These institutions routinely lacked funds and space, and remained in operation as much through the efforts of medical professionals as by concerned citizens. After the Second World War the Federal Government shifted from a standoffish institution to one ready to release funds and administrative energies towards new ideals of social welfare. Funding increased dramatically for the building of new hospitals, and legislative developments such as Medicare transformed the social and political relationship between hospitals and patients.

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A number of organizations graciously granted permission to use the photos that appear in the appendix. In Toronto the University Health Network provided permission for TGH images. The *Winnipeg Free Press* allowed me to use its photo of Jack Hutchinson. The Vancouver Coastal Health Authority provided permission to use images of the VGH. The Alberta Health Services Archives also allowed me to reproduce images of the CGH.

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LIST OF ABBREVIATIONS

AHA Alberta Hospital Association
AHSC Alberta Hospitals Services Commission
AHSA&HC Alberta Health Services Archives and Historic Collections
BCHIS British Columbia Hospital Insurance Service
BNA British North America Act
CAT Computerized Axial Tomography
CCF Cooperative Commonwealth Federation
CHB Calgary Hospitals Board
CHIA Canadian Health Insurance Association
CMA Canadian Medical Association
CMAIN Canadian Medical Archives Information Network
CMHC Canadian Mortgage and
Housing Corporation
CGH Calgary General Hospital
CPR Canadian Pacific Railway
CVA City of Vancouver Archives
DHS Department of Hospital Service
EPF Established Program Financing Act
FBBW Federated Budget Board of Winnipeg
GA Glenbow Archives
GVRHD Greater Vancouver Regional Hospital District
HBC Hudson's Bay Company
HIDS Hospital Insurance and Diagnostic Services Act
HSCA Health Science Centre Act (Manitoba)
HSC Health Science Centre (Winnipeg)
HSCAM Health Science Centre Archives and Museum
JHB Joint Hospital Building Fund Campaign
JPJC John Price Jones Company
LCLAC London and Canadian Loan and Agency Company
LPSUP Loyal and Patriotic Society of Upper Canada
MCA Medical Care Act (Federal)
MDA Mental Disease Act (Alberta)
MGH Montréal General Hospital
MHC Manitoba Hospital Commission
MHSC Manitoba Health Service Commission
MHSC McMaster Health Sciences Centre
MRI Magnetic Resonance Imaging
NWMP Northwest Mounted Police
OHIP Ontario Hospital Insurance Plan
OHSIP Ontario Health Services Insurance Plan
OMH Ontario Ministry of Health
OMSIP Ontario Medical Services Insurance Plan
PMA Province of Manitoba Archives
RGH Regina General Hospital
TGH Toronto General Hospital

UHN University Health Network
VGH Vancouver General Hospital
VMS Vancouver Medical Society
WAS Women's Aid Society (Winnipeg)
WGH Winnipeg General Hospital
WHASC Women's Hospitals Aid Society of Calgary

Hospital Timelines

A note on timelines; they are neither exhaustive nor argumentative. Rather, they are an artefact of the research process and are included as a rough guide for use as reference. They provide an ‘at a glance’ overview of an institution’s arc, and since the chapters proceed chronologically these offer an easy way to look up a major event without referring to an earlier chapter.

TGH Timeline

1820 – First hospital built at King and John Streets (York General)
1847 – Act of Incorporation passed
1853 – Moved from King West to Gerrard Street into a new ‘modern’ structure accommodating 200 beds. (Moves to College Street in 1913)
1877 – Erection of a West wing
1878 – Erection of ‘Burnside’ Maternity Wing.
1882 – Women’s Pavilion erected (funded by private subscription)
1887 – Special building erected as an addition to the West Wing to provide rooming for nurses
1898 – Emergency Building on Bay Street commissioned.
1902 – The 1887 addition to the west wing, occupancy doubled.
1906 – Bay Street building closed. First psychiatric unit established.
1911 – Laying of Cornerstone of ‘New General’ by Earl Gray on 11 April. Women’s Auxiliary takes over social service department.
1912 – Last year of the Gerrard Street Hospital. New out-patient clinic under construction
1913 – Opening of College Street Hospital ‘New General’ 10 July.
1925 – Psychiatric Hospital opens
1928 – Tenders called for new Private Pavilion on University Avenue. Medical wards enlarged.
1929 – Power house renovation/building. New Laundry erected. 865 bed capacity at this time. Smoking in general wards prohibited (\$1.50 per diem for city patients paid by municipality, \$1.75 after 1 April. \$0.32 paid for indigent non-residents. \$0.50 paid per diem from the Province, \$0.60 after 1 April)
1930 – 24 April formal opening of new extensions, including Private Patients Pavilion.
1931 – American Hospital association Annual Meeting held in Toronto 28 September – 2 October
1932 – Plans being finalized for Radio-therapeutic building (9 floors and basement) As of February bed capacity at 1,068
1933 – Dunlap Bequest leads to purchasing ‘Pathological building’ from the University of Toronto and renamed Dunlap building.
1934 – Out-patient annex being built/tendered
1939 – Hospital Capacity 1144 beds and 174 cots, averaging 1000 patients per day.
1948 - Wellesley Hospital becomes division of TGH
1950 – Tunnel built to hospital for sick children (contract signed December 1949)
1952 – Building Fund Campaign for new Hospital. 1418 bed capacity
1953 – Ward “I” modernized, new single rooms and nurses station. New Nursing home built as condition of acquiring Wellesley Hospital
1954 – Construction begins on Central Building, South Block, and Student’s Wing. New Laundry building opened
1955 – December, 20 feet of south end of medical records department and Dunlap building demolished. (Not whole building) Construction of Urquhart wing begins
1957 – Plumbing strike in fall slows construction
1959 – 15 May, formal opening of new Buildings. Dunlap building to be demolished
1960 – Central Building came fully into operation. 1 January former Wellesley Division leaves to become independent.
1961 – Modernization of public wards (A,B,C) begins. 1400 beds total, 640 private/semi-private and 760 public.

1962 – 19 January, official opening of Cardiovascular Surgical Unit. Modernization of out-patient department (medical clinic 101 college street) completed 10 April. Clinical Investigation Unit open.
1963 – September Contract let to Richard & B. A. Ryan (Mathers & Haldenby Architects on job) for building a medical library on the 9th floor of the private patients pavilion cost: \$136,393.00. Fudger House to be Metro Aged Home
1964 – 1,243 beds in four separate buildings
1967 – 8 June, dedication of the Urquhart building, formerly known as the Central building
1973 - Former Private Patient's Pavilion (then in use as West nurses residence) demolished
1976 - Ontario ministry and City of Toronto approve of new construction
1977 – Construction on David Eaton building begins
1979 – John David Eaton Wing completed, July. (14 floors, 400 patient beds, clinics, offices, diagnostic and teaching facilities)
1981 – 8 July opening of the John David Eaton building

WGH Timeline

1871 – Dominion Government constitutes a board of health to establish a temporary hospital.
1872 – First hospital established, 5 beds.
1875 – Charter granted by Special Act of the Legislative Assembly, building of first two-storey building, 2 private beds 20 public
1883 – Erection of A and B Flats; two storey building
1884 – Opening of first building, 50 beds. A and B Block (13 March) (Ward 2 had 24 beds, Ward one 7 beds.
1888 – Built brick operating theatre, maternity hospital, and nurses home.
1893 – New Isolation Hospital opened
1894 – First Nurse's Residence Built, Isolation Hospital opened (started construction in 1892, was later used to house internes)
1895 – Power House Opened
1897 – Surgical Wing, C,J,K Block. Training school for nurse established
1898 – Jubilee Wing 20 September (E, F, G Flats)
1903 – 'C' Ward completed (formerly known as 'medical wing' and 'JFK')
1908 – Children's Pavilion under construction
1909 – Children's Hospital Established
1910 – Nurse's Home Repaired and improved
1911 – East and Central Wings begin construction
1912 – Central Section and East and West wings erected
1913 – New wings to be known as "east (B)" and "west (E)" opened 1 November
1915 – At least through December orderlies roomed on 'B' Flat
1917 – 650 bed capacity
1918 – Nurses Residence Built – Psychopathic building nearing completion
1919 – Psychopathic Building opens
1923 – Nursing Home addition (five storeys) begins
1925 – McDermot Street section added to Nurse's Residence
1927 – Added a wing which cared for crippled children at Shriner Hospital
1935 – Semi-public service begins
1936 – Preparation for Demolition of A and B Flat
1943 – 658 patient occupancy
1944 – Mention of A and B ward planned demolition in near future
1945 – 7 April, Provincial Legislature incorporated Manitoba Medical Centre
1950 – Opening of Maternity Pavilion (6 May – Northwood and Chivers Architects)
1952-1953 – Joint Hospital Fundraising campaign carried out.
1953 – 800 beds 97% in use daily. At this point all buildings at least 41 years old
1954 – Medical centre Apartments "A" complete 1 May
1955 – Medical centre Apartments "B" completed 1 September
1956 – Building begins on 'new North Wing' (A and D) on 6 January.
1957 – Nursing student housing moved to space in the department of gynaecology, previously being housed on 5th floor of Maternity Pavilion. WGH Alumni Association founded
1958 – 'new North Wing' completed. North known as A and D, East became B and C, West became E and F. North wing also contains G wing. (Old A and B still standing, known now as H2 and H3)
Superintendent's residence demolished

1959 – Original Brick Building (A and B wing) demolished 20 June, beginning of construction Lennox Bell House
1960 – Conversion of steam boilers from coal to gas/oil
1961 – ‘H’ Wing (Service Wing) built between ‘C’ and ‘F’
1962 – Old Isolation Hospital Demolished (contained internes quarters)
1963 – “B” wing renovated. Plans for teaching and emergency wing (J wing) put out for tender. 919 beds
1964 – Ecumenical chapel built – first such space on the grounds. “H” Wing being built above service wing
1965 – “C” wing renovations. New Laundry Building construction begins.
1966 – ‘H’ wing only expanded from two to seven storeys. (five floors added for wards) ‘E’ wing renovations
1968 – Patient occupancy at 968
1971 – Demolition of Amalgamated Electrical Building – 791 Notre Dame Avenue
1972 – Centennial. Health Sciences Centre Act passed
1973 – Basic Medical Science Building completed, acquired financial service building
1974 – Central Energy Plant completed

CGH Timeline

Calgary General Hospital I – 1890-1895 “Cottage Hospital” four small wards.
Calgary General Hospital II – 1895-1910 built on 12th Avenue and 6th Street East
Calgary General Hospital III – 1910-1953 “Old General”
Calgary General Hospital IV – 1953-1998 ‘New General’

1890 – CGH Organized and incorporated in a rented building known as the ‘Cottage Hospital.’ It was a small-storey-and-a-half- frame house located near Louise Bridge containing two rooms and a kitchen on first floor and four small wars on the second.

1894 – Board announces plan to erect Hospital at South-west corner of 12th Avenue and 6th street Wet. The cornerstone was load by Honourable T. H. Daly. Hospital accommodation, 25-30 patients.
1895 – Hospital building completed and opened. Child & Wilson were the architects, Nursing School established

1898 – First Nurse Graduated from the training school

1899 – Maternity Hospital erected immediately west of CGH. Now used as Isolation Hospital Nurses’s Home

1900 – Maternity Hospital and New Nurse’s Homes officially opened in July

1905 – New Maternity Hospital Erected (5 September), South and west of maternity hospital erected in 1899. Building now used as Isolation Hospital.

1909 – Completion of General Hospital

1910 – 1 February, General Hospital North of Bow River opened. (Referred to as “Old General”)

1913 – 28 April, by-law of the City of Calgary #1472 approved; \$10,000.00 to purchase site, erect and equip smallpox hospital to be operated by the City of Calgary. 15 October, Agreement executed between the City and the Calgary General Hospital providing for the transfer of each party’s hospital properties to a Joint Hospital Board to be a corporate body, known as the Calgary Hospitals Board. First X-ray machine installed

1914 – Act to incorporate Calgary Hospitals Board passed. 1914 – March 5th agreement between the City of Calgary, the CGH and the CHB executed. Under the terms of this agreement the Hospitals Board assumed control over the CGH, the Mountview Hospital, the Isolation Hospital and the smallpox Hospital.

1917 – New Poultry house was constructed for 1000 hens.

1919 – Hospital Annex completed and furnished. Administration of General, Isolation, and Mountainview hospitals as a City Department commences. Construction of an Emergency Hospital begins

1921 – Hospital Annex remodelled as Nurses’ Home. Dr. L. E. W. Irving becomes superintendent

1924 – Original 1895 building now serving as Isolation Hospital

1933 – Patient occupancy at 215 beds

1934 – Hospital Board reinstated.

1937 – Mangle for steam laundry purchased. Department of medical records begins

1938 – Formal complaints mad by administrator to the province about the inadequate space/obsolete buildings. New X-ray equipment purchased

1939 – “B” Block, an addition to the nurse’ residence is built.

1940 – Board Agrees to build residence for internes

1941 – Old Smallpox Hospital sold for demolition. Construction on Perley Wing begins. Power Plant built

1942 – By December new wing under construction (Perhaps Perley Pavilion) Another student residence “D” Block built.

1944 – Perley Wing opened (two floors)

1947 – Final drafting of CGH IV plans

1949 – Sod-breaking for CGH IV

1952 – Patient capacity at 320 beds during construction

1953 – Planned completion of New CGH, erection of three level laundry, conversion of Perley Pavilion to maternity facility. Opening of new CGH (IV) 628 beds. Section of basement set aside for the care of Psychopathic patients. Architects of new CGH were Mr. W. L. Somerville, Toronto and Mr. J. M. Stevenson Calgary Alberta.

1954 – Construction on nursing school and residence begins. Opening of a new psychiatric ward with 20 beds. Stevenson and Dewar architects for renovations and alterations to Perley wing.

1955 – North and South Extensions endorsed by Finance Committee. Boiler plant extension. Perley Pavilion renovated and rebuilt to double bed capacity

1956 – Official opening of new Nurses Residence (M-building) and School, May (ten-storey building)

1958 – 648 beds available. North Wing Chapel completed and to be furnished (in a non-denominational manner) by the Calgary Council of Churches. New Convalescent Wing to be built adding 175-200 beds. Alberta Hospitalization Benefits Act comes into effect 1 April. North and south extensions completed on main building.

1959 – Dental Operating room opens, reputed first of its kind in a Canadian General Hospital

1960 – Patient occupancy at 728 beds

1962 – 4 February Official opening of Convalescent-Rehabilitation building. 952 beds total. (built on site of CGH III)

1967 – Ground breaking for two additional buildings: a new educational facility adjacent to the main entrance, and a four storey Service Wing (F-building) which housed administration, surgical suite, clinical lab and more. B and D Block slated for demolition in spring. Establishment of Mackid Lectures to provide up-to-date information on medical issues and a forum for discussion on current areas of interest at the CGH.

1969 – Construction begins on the Gertrude. M. Hall Education Wing

1970 – 7 June, the number 911 comes into effect. New education wing, the Gertrude M. Hall Memorial Wing opens.

1971 – School of Nursing ordered to close. Completion of the addition to the South Service Wing (F-building) accommodating clinical labs, surgical suite, radiology, emergency and other services.

1972 – Service Wing addition begins (Obstetrics)

1973 – Patient occupancy at 952 beds. Official opening of the three-floor addition to the (south) service wing. New maternity unit complete with neonatal intensive care facilitates. Construction on Centennial Wing begins.

1974 – Perley building to be demolished in June. Final class of nurses graduates.

1975 – Discussion of a new psychiatric wing to be tendered soon

1977 – The Psychiatric wing (Centennial Wing G-building) completed and opened. The hospital’s capacity to 960 beds and 63 bassinets.

1979 – Plan for expansion and renovation presented again in a publication entitled forward to 100. Proposal tabled in 1980, in favor of spending funds on new projects. The decision was to fund two new 400-bed hospitals for the city, one to be built in the northeast (to be a satellite of CGH) and the other off Macleod Trail north of Midnapore.

1980 – Alberta's First Alternate Birthing Centre opens on 4-South

1981 – Hospital-wide computerized information system initiated

1983 – Completion of \$4.4million renovation program for upgrading electrical and mechanical systems in C, D, E buildings

1988 – Opening of Peter Lougheed facility; the CGH become "One Hospital on Two Sites" with a combined total of approximately 1,000 beds.

VGH Timeline

1888 – First VGH built replacing temporary CPR building
1891 – New Wing added
1902 – Incorporated as a hospital, 35 beds.
1906 – Wooden Isolation Buildings erected, moved from Cambie Street Location to Fairview
1907 – South east wing of Main building completed
1911 – South-West Wing Commenced
1912 – Construction commenced new Power House and Laundry. New Nurses Home Built. South West wing of Main building completed
1913 – South-West Wing occupied. Bid to build Central/Service wing accepted. New Power House and Laundry completed.
1914 – Service Wing completed (centre wing on south side) of main building completed – Pathology building under construction. Experiment with semi-public wards. Nurses Home on Heather Street completed
1915 – Enlarged operating room suite completed, Ward X for chronically ill completed, pathology building opened.
1916 – Funds gathered from citizens/businesses to build military hospital on VGH grounds. Removal of Isolation (wooden) buildings from 1906.
1917 – Opening of Marpole facility – 300 beds, total capacity around 1200 for all hospital buildings which is very high for this time period. (300 from Marpole, and 300 from Military Annex is half the number alone) Twelfth Street Annex opened (Military Annex at the time)
1918 – Heather Street Annex constructed for emergency influenza cases
1923 – Province takes over the Marpole Annex as a home for the incurables
1925 – New Infectious Disease Hospital begins construction
1927 – Building for TB Hospital, previously occupied by university authorities, renovated. infectious diseases building completed. Fairview Pavilion opened
1928 – Maternity and private ward blocks underway
1929 – Closing of Twelfth Street Annex. Private Ward and Maternity (Willow Pavilion) building completed.
1930 – Demolition of Twelfth Street Annex (1930-1935 no progress on building programme due to depression)
1932 – Extension of X-ray department completed
1936 – New Tuberculosis Wing opened 30 October
1937 – Sketch plans prepared by the Provincial Architect for the construction of a 587 bed acute Unit.
1938 – New Intern Residence opened, 51 beds
1939-1940 – No further progress on the building programme was made due to the war
1941 – Plans commenced for the Semi-Private Pavilion
1942 – New unit begins construction; semi-private pavilion
1943 – Two floors of New Semi-Private Pavilion opened. Health Cents for Children Pavilion Completed
1944 – Provincial Government agrees to contribute \$400,000 and the municipal government passes a by-law to provide \$800,000 toward the construction of a nurses's residence and a power plant.
1946 – First phase of power house extension commences. J. A. Hamilton & Associates engaged to survey present Plant and advise on expansion.

1947 – Work commenced on new power plant. East/West halves of main operating suite re-ventilated. Hamilton report received. Prelim rehabilitation of main building facilities commenced. In absence of sufficient funds to build a complete nurses' residence it was decided to proceed with one unit.

1948 – Addition to Power Plant completed. First unit of Nurses' Residence completed, steps taken to prepare plans for 900 bed acute unit

1949 – Plan for one storey added between Ward R and old Ward X approved. BC Hospital insurance begins. 1300 beds in use

1950 – Schematic plans for 900 bed unit completed. Due to lack of funds programme revised to change Chronic to acute (Main building Addition) and Renovate Main building, and reduce new Acute Unit to 500 beds. New plan commenced. New by-laws removing standing committees, including building committee. Alteration to main building to tie-in addition commenced.

1951 – New Addition to main building completed (North wing) Major rehabilitation of original Main building, completion of two student residences. Renovation of old Wards A, B, C commenced and completed Preparing to let contract for a 500 bed acute care building. Main building addition completed providing 328 beds.

1952 – 2nd & 3rd units of Nurses Residence completed, providing 407 beds.

1953 – Power Plant completed. Semi-private pavilion begins to be converted into 'Health Centre for Children' Work commenced on alterations to west wing of semi-private pavilion to paediatrics. New East entrance and elevator completed.

1954 – Opening of Health Centre for Children 7 August. Plans and specifications for proposed 504 bed acute unit completed. Work on alterations to main building essentially completed. Majority of power plant expansion completed. Alterations to one wing of semi-private pavilion to paediatrics completed and area officially opened as the Health Centre for Children, increased by 42 beds.

1955 – Work commenced on the centennial pavilion (formerly acute block) Alterations to Hospital Annex (Heather Annex) Alterations to Willow Pavilion (formerly women's pavilion)

1958 – Money spent on renovation, new building and equipment since 1947 - \$19,300,000

1959 - Opening of Centennial Pavilion, 20 June. 500 beds. Private Ward Pavilion renamed Laurel Pavilion

1962 – Planning for new Building on site of Laurel Pavilion

1964 – Laurel Street Pavilion demolished

1965 – Child Outpatient Psychiatry project complete

1966 – 1,578 beds. City approves \$4.8 million for VGH, also voters approve the Vancouver Five Year Capital Work plebiscite, offering \$3 million for long-term illness and Obstetrics and Gynaecology facilities.

1967 – Name of Recreation building (formerly the old laundry) changed to In-Service Education Centre because it was primarily used for staff training. The Greater Vancouver Regional Hospital District incorporated and becomes responsible for hospital planning and construction in the region. Completion of adult outpatient psychiatry building. Regional referendum passes to spend \$51 million on hospital improvements in GVR.

1968 – 24 October, first kidney transplant in BC performed at VGH

1972 – Banfield Pavilion. Second regional referendum passes to spend \$95 million in GVR

1973 – Plans for Canadian Arthritis and Rheumatism Society Extension. New psychiatric facility opens – formerly the women's lounge on the mezzanine floor of the laundry building, opening was 2 May 1973.

1975 – First floor addition to Centennial Pavilion substantially completed 26 May – 1800 beds.

1976 – Surgical Day Care Unit under construction Building on site of Heather Annex

1977 – Surgical Day Care Unit completed

1982 – Opening of Emergency Trauma Centre, largest in the province (Part I of Laurel Street project)

1989 – Estimated completion of Phase II of Laurel Street project

Introduction – The General Hospital and Canadian Society

Today the hospital is medicine's most recognizable institution, but this was not always so. In the 18th and 19th centuries hospitalization was primarily a way of removing destitute citizens from city streets; to house rather than to heal. Historians have associated the rise of middle class hospital usage with early 20th century refinements in methods of antisepsis and anesthesia—the alleviation of infection and pain—which began replacing physician visits to patient's homes and domestic nursing. However, the 20th century general hospital did not become a bastion of medical and scientific efficacy through professionalization alone. As important as medical advancements were, the building, arranging, and organizing of general hospitals owed to an array of influences as varied as the societies these institutions served.

In recent decades, historians have begun to explore why this process occurred. In 1987 Roy Porter questioned the tendency of medical historians to dismiss 'pre-Listerian' hospitals as 'gateways to death,' asking if this was so why they were "founded and funded," and "[w]hat more oblique functions" they may have fulfilled.¹ In the Canadian context Rosemary and David Gagan demonstrated that the change in hospital perceptions owed to more than conquering pain and infection, and must include the process of medical professionalization, monetization, and, scientific standardization occurring in the early 20th century.² Additionally, David Gagan noted that hospitals served as symbols of civic pride, order, and security.³

The 'Western' hospital is a complicated institution—the quintessential seat of medical and surgical expertise and education, a political battleground for issues of funding and legal regulation,

¹ Roy Porter and Andrew Wear. "Introduction," in *Problems and Methods in the History of Medicine*, ed. Roy Porter and Andrew Wear (London: Croom Helm, 1987), 3.

² For their seminal monograph see David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950* (Montreal: McGill-Queen's University Press, 2002)

³ See David Gagan 'A Necessity Among Us' *The Owen Sound General and Marine Hospital 1891-1985* (Buffalo: University of Buffalo Press, 1990)

and a dispensary of scarce resources. In the public imagination, it is a structure perched between the poles of hope and dread. Scholarly research into the history of hospitals intensified from the 1970s onward with publications by Roy Porter, Guenter B. Risse, David and Rosemary Gagan, John D. Thompson, Lindsay Prior, Annmarie Adams, George Rosen, Morris Vogel, Lindsay Granshaw, and others whose contributions demonstrate that hospitals cannot be understood without fusing societal perceptions with the motives of politicians, doctors, nurses, patients, and administrators.⁴ A less studied area is how these factors affected the spatial expansion, layout, and management of hospitals. In fact, there has been no major study into the spatial ordering of late 19th and 20th century Canadian hospitals.⁵ My dissertation scrutinizes changes in hospital layout, urban location, architecture, services, funding, and usage by social class in four major Canadian general hospitals, demonstrating that patronage, social expectation, and politics affected medical design in addition to architects, administrators, consultants, and doctors.

Hospitals figured prominently in a late 19th and early 20th century change to the ‘medical marketplace.’⁶ For centuries a cast of medical characters including bonesetters, barbers, apothecaries, druggists, tooth-pullers, physicians of varying repute, and a miscellany of quacks

⁴ Lindsay Granshaw. "Fame and Fortune by Means of Bricks and Mortar": The Medical Profession and Specialist Hospitals in Britain 1800-1948." in *The Hospital in History*, ed. Lindsay Patricia Granshaw and Roy Porter. (London: Routledge, 1989), 199-221. Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (New York: Oxford University Press, 1999). George Rosen, and Charles E. Rosenberg. *The Structure of American Medical Practice: 1875-1941*. (Philadelphia: University of Pennsylvania, 1983). David Rosemary Gagan, *For Patients of Moderate Means*. Annmarie Adams, *Medicine by Design: The Architect and the Modern Hospital, 1893-1943* (Minneapolis: University of Minnesota Press, 2008). Gagan 'A Necessity Among Us'. John D Thompson and Grace Goldin, *The Hospital: A Social and Architectural History* (New Haven: Yale University Press, 1975). Morris J. Vogel, *The Invention of the Modern Hospital: Boston 1870-1930* (Chicago: University of Chicago Press, 1980)

⁵ The closest work is G. Harvey Agnew's *Canadian Hospitals, 1920-1970 A Dramatic Half Century* (Toronto: University of Toronto Press, 1974). Agnew was a medical doctor and administrator with the Canadian Medical Association. His perspective on the development of hospitals is of great import to this project, but would serve as a poor companion study. Its chronology is shorter, but primarily for adhering closely to a whig model of achievement and progress endemic to an older generation of medical history written by doctors.

⁶ Sally Wilde, "The Elephants in the Doctor-Patient Relationship: Patients' Clinical Interactions and the Changing Surgical Landscape of the 1890s," *Health and History* 9:1 (2007): 2-5, 11-14. Roy Porter, "Introduction," in *Patients and Practitioners: Lay Perceptions of medicine in pre-industrial society*, ed. Roy Porter (London: Cambridge University Press, 1985), 5, 12.

competed for the health dollar of consumers. The patient had the power of selection in an economic exchange. Sally Wilde has argued how prior to the supremacy of general hospitals patients held a real advantage in that their advocates—family members, friends, neighbourhood clergymen, and competing medicos—outnumbered their adversaries. However, she argues that as hospitals became the primary source of care this relationship inverted. The presence of so many nurses, orderlies, physicians, and medical students swung the balance of power towards professional, clinical medicine.⁷ A social history of general hospitals must keep this backdrop in perspective. In addition to improving community health, hospitals also transformed the experience of sickness, healing, and treatment.

The following discussion about administrators, nurses, architects, planning, legislation, and patients demonstrates the extent to which multiple interests met within the hospitals to create a contested space. This further justifies the use of case studies. Despite some broad trends in hospital management and civic use there is an overriding value in studying these institutions at an individual level.⁸ First, the supporting communities are very different. This thesis describes and explains how a community's wealth shapes its general hospital in a multitude of ways. Secondly, hospitals are political sites. The forces or interests that won out on any given issue vary. Sometimes the words of doctors carried the most weight, while at other times it was the women's auxiliary, or city council. On other occasions the desires of architects or administrative consultants won out. More often decisions came about through a compromise or mixture of these differing interests. Thus, the ways influence could be exerted and how decisions were made becomes important. So too does the rhetoric employed by administrators when it came time to share their decisions with the general public.

⁷ Wilde, "The Elephants in the Doctor-Patient Relationship: Patients' Clinical Interactions and the Changing Surgical Landscape of the 1890s," 5.

⁸ Risse, *Mending Bodies, Saving Souls: A History of Hospitals*, 4.

Balancing analytical attention to these actors is a challenge when it comes to patients. It is tempting to attribute spatial changes to administrators, doctors, architects, and consultants. For example, the post-1945 push to centralize auxiliary services offered economic relief, increased medical efficiency, and added accommodation. In those areas administrators, doctors, and consultants have left a rich record, but there is little in the way of patient complaints about the placement of medical supply rooms. Here the interconnected nature of the hospital and society helps locate patient voices. Voices plural; there was no one patient. It is important to remember that everyone was a potential patient, including wealthy philanthropists, pioneering surgeons, and medical researchers. As paying patients became more prevalent in the 20th century there was a natural degree of economic agency that came with them, but even those with limited means had a role in the negotiation of ward rules and visiting hours. The general ward patient had value to medical students which gave them some standing in negotiation. However, this was limited to a point by chronic overcrowding. After Medicare came fully into place, class distinctions ceased to matter. Increasingly, too, architects and researchers sought to produce hospitals that catered to patients's emotions and sped up recovery.

How administrators organized space demonstrated limitations in terms of resources, knowledge, and social expectations. Despite an increase in hospital histories that go beyond offering an institutional biography the historiography remains fairly thin. Graham Mooney and Jonathan Reinartz's study of hospital and asylum visitation is a fine example of how medical historians should view these institutions as nodes in social as well as medical networks. As they rightly note: "compared to doctors, patients and institutions, visitors are an understudied constituency in medical history."⁹ The importance of non-professional expectations and influence over hospitals and those

⁹ Graham Mooney and Jonathan Reinartz "Introduction," in *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting*, ed. Graham Mooney and Jonathan Reinartz (New York: Editions Rodopi B. V., 2009), 7.

who administered and built them has yet to be studied in detail.¹⁰ Technologically sophisticated hospitals are unquestionably important to the sick, but they also provide benefits to the well such as health maintenance and care for friends and family. There is also the question of political legitimacy and control. As historian Alison Bashford argued, a state's ability to govern is largely proportional to its ability to heal.¹¹ The hospital is a medical space, a patient environment, and research institution; however, further historical understanding requires decentring it away from a bastion of medical technocracy toward a divided space where 'health' and 'healing' are negotiated, social, and dynamic concepts rather than scientific constants or hard truths.¹²

The innovative approach of Mooney and Reinartz has yet to realize its full potential. Patients are important, as is the historiography that arose around their place in the medical past, but they are only one node in a network of administrators, nurses, doctors, and architects. Except for patients, this list contains mainly authority figures. Instead of returning to an approach predating the social turn in medical history, where doctors held supreme authority, this project treats administration as a locus of power and tension. In sum, this is an expansive history of hospitals that aims to place health concerns as a central category of analysis in understanding moments of institutional design, change, and organization.

I have selected the years 1880 to 1980 for several reasons. 1880 marks a reasonable point in the broader history of medicine when antiseptic and anaesthetic techniques were refined, and lays a foundation for the 20th century surge in middle and upper class patients seeking hospital care. Among the four case study hospitals, two opened before 1880 and two shortly after. Hospitals that

¹⁰ For a recent study that begins to address this lacuna see Janet Miron, *Prisons, Asylums, and the Public: Institutional Visiting in the Twentieth Century* (Toronto: University of Toronto Press, 2010).

¹¹ Alison Bashford, *Imperial Hygiene: A Critical History of Colonialism, Nationalism, and Public Health* (London: Macmillan Ltd, 2004), 1-5.

¹² For examples of older "Whigish" histories see Edward B. Krumbhaar, "The Pennsylvania Hospital," *Transactions of the American Philosophical Society, New Series*. 43:1 (1953): 237-246. H. E. MacDermot, *One Hundred Years of Medicine in Canada 1867-1967* (Toronto: McClelland and Stewart Limited, 1967)

finished construction around 1880 provide insight into the types of buildings administrators and doctors wanted, and the local realities that sometimes dashed their hopes. Noting regional inconsistencies and situational context help enrich the history of health services in Canada. Hospitals that stood for decades before 1880 offer context in terms of how they differed and what specific changes were happening to them—which new developments did administrators deem necessary, which could they go without, and why.

The bulk of the narrative and analysis covers most of the 20th century. This scope has the advantage of seeing changes in design and management across significant historical epochs: the Depression, World Wars, coming of the Welfare state, socialization of medicine, and the Cold War. The thesis ends in 1980 for practical reasons. Records for these institutions post-1980 are less accessible, and a thirty year buffer between the time of writing and end of project helps maintain historical distance. The decision to keep chapters to 20-30 year periods is an attempt to carve out sections of time which are short enough to allow for a reasonable level of detail, but long enough to reveal developments and change.

In organizing the chapters I opted to follow a chronological rather than thematic layout. This approach helps highlight the local and unique history of each general hospital. The case studies reveal institutions that changed and expanded through a process of constant negotiation and reaction. Not all factors were local, such as the First and Second World Wars or the Depression, but many were. Until the 1950s much of the financial capital also came from municipal sources. A thematic approach would be less sensitive to the almost year-by-year unfolding of these hospitals. By unpacking the analysis chronologically the dialogue between architects, administrators, doctors, patients, and the public is clearer and more rooted in the institution's development and local context.

Despite a growing secondary literature on the history of hospitals scholars have seldom focused on architecture and spatial orientation. Older hospitals endured demolition, extensive rebuilding, relocation, and renovation. Rarely are the influences on these material changes studied in detail; although it seems essential to track the cultural influences on such a prominent social nexus. My dissertation approaches this question through four case studies: Toronto General Hospital (TGH) opened in 1829; Winnipeg General Hospital (WGH) opened in 1872; Calgary General Hospital (CGH) opened in 1890; and Vancouver General Hospital (VGH) opened in 1886. These reveal how different regions, politics, economies, and social pressures influenced the spatial orderings, expansion, and administration of hospitals. These institutions left behind a rich vein of primary materials in the form of annual reports, committee minutes, correspondence, procedural manuals, public relations releases, and some architectural drawings and floorplans. These records are part of each hospital's major historical collections, which were frequently split between public and private archives. Other sources to add social context and outside perspective include the writings and memoirs of doctors, nurses, hospital administrators, architects, and newspapers.

The internal documents of case study hospitals are often silent or vague about patient's race. Annual reports tallied patients by race and ethnicity; however, it is unclear on what basis these distinctions were drawn. Ward rules and policy aggressively segregated patients on the basis of gender and class, but did not refer to race explicitly. In some cases this hid sinister actions; the VGH kept Chinese and Japanese individuals in basement wards set aside for 'undesirable' patients such as the incurable or mentally ill.¹³ Maureen Lux's history of federally-funded, "Indian hospitals" reveals how hospitalization was not experienced in a uniform manner, and that the nascent welfare state

¹³ David Gagan and Rosemary Gagan, *For Patients of Moderate Means*, 167.

actively segregated patients by race.¹⁴ Lux's work on the "Indian hospital" system helps explain the relative absence of First Nations in case study documents. Federal and provincial policy that denied per diem payments for these patients ensured their participation was limited. Race affected the staff too. In a rare racial reference the WGH house committee agreed in May 1917 to "bring in a couple of Chinamen from Vancouver," to work as cooks.¹⁵ The committee paid for their travel in exchange for a commitment of one year's service.

Annual reports confirm that most general hospital patients in the early 20th century were—or were recorded as being—white. Race is difficult to pin down because administrators had an interest in receiving per diems and recording inaccuracies were one way to ensure they came in. Records do not exist—or perhaps are restricted—that demonstrate on what basis a patient's race was recorded. It must be assumed that there was at least some middle broker who translated the individual from the ward into a number in the report. In some cases absence can still be telling. Racism on the west coast directed at Asians is well-documented.¹⁶ The omission of this topic in VGH documents can suggest assumed contempt as easily as it can suggest indifference. The frontier status of cities like Winnipeg and Calgary is also important. As of 2011, both cities remained roughly 75% white. Race, naturally, interfaced with class and gender. By no means is the argument that race should not or does not matter; but it is not the focus of this dissertation.¹⁷

The place of the hospital in modern society was forged by the perseverance of medical professionals and lay people alike. The doctors, nurses, architects, patients, and administrators who experienced general hospitals between 1900 and 1950 comprised the formative generation of the

¹⁴ Maureen K. Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s* (Toronto: University of Toronto Press, 2016), 140.

¹⁵ "Minutes of the House Committee," 10 May 1917, 3. File 2, Box 18 WGH Fonds PMA

¹⁶ Kay J. Anderson, "The Idea of Chinatown: The Power of Place and Institutional Practice in the Making of a Racial Category," *Annals of the Association of American Geographers* 77:4 (1987): 580-598.

¹⁷ Constance Backhouse, *Colour-Coded: A Legal History of Racism in Canada, 1900-1950* (Toronto: University of Toronto Press, 1999).

contemporary image. These institutions were, at best, latent. The sums of money, volunteered hours by professionals and lay people alike, and political support in the sense of funding, by-laws, and grants become more significant in this light. These institutions had no assurance of survival, and there were many moments of distress. Yet none were abandoned. The staff never walked out, and the public never turned away. These hospital projects—especially in the west—had no precedent, many were taken over from private or non-medical enterprises.

It is important to remember that what made a hospital was the way space was used, not what it was built for. One of most important schemas presented in John Thompson and Grace Goldin's pioneering book *The Hospital: A Social and Architectural History* (1975) was the distinction between medical buildings that are *designed* and those that are *derived*.¹⁸ Derived hospitals refer to repurposed buildings ranging from institutional structures like prisons to private homes. Beginning in the early 19th century, and largely completed by the 20th, deriving hospitals fell increasingly outside the preference of hospital administrators. Many individuals—including prominent historical figures such as Jeremy Bentham and Florence Nightingale—influenced the design of hospitals and custodial spaces in the 18th and 19th centuries. Along with lesser known sanitary reformers and architects they contributed to a ferment of research into the nature of sanitation, discipline, and organization.¹⁹ These authors were early discussants in an important conversation on human experience within space, and what exactly the goals of these institutions should be. Conversely, architects such as Henry C. Burdett, Henry Saxon Snell, and Edward F. Stevens and Frederick Lee who crossed into the early 20th century, influenced the design of health care institutions and

¹⁸ John D. Thompson and Grace Goldin, *The Hospital: A Social and Architectural History* (New Haven: Yale University Press, 1975), xxvii.

¹⁹ See Jeremy Bentham, *Panopticon; Postscript; Pat II: Containing a Plan of Management for a Panopticon Penitentiary-House* (London: T. Payne at Mews-Gate, 1791) or Florence Nightingale, *Notes on Hospitals* (London: Longman, Green, Longman, Roberts, and Green Publishers, 1863).

furthered the bent toward designed space.²⁰ Henry Saxon Snell was a proponent of the pavilion design and a hospital architect. He designed some Canadian hospitals as Annmarie Adams discussed in *Medicine by Design* (2008).²¹

The maturation of the medical profession into a scientific and specialized community demanded spaces that were more conducive to the finer points of their craft. In turn architects and planners began specializing in medical design, and created the professional and academic foundations from which flowed trained hospital administrators in 1930s. However, there are hazards to applying high architectural thought too liberally. The ideas of Burdett, Snell, Lee, or Stevens found purchase in the 19th century. But they tended to apply in large urban contexts such as London and Montreal. The hospitals in this dissertation eventually inhabited designed spaces, but began as homes, unused buildings, or tents. The TGH, predictably, was the first to move into a designed space. Winnipeg, Calgary, and Vancouver all followed its example by 1914.

Nightingale's influence over professional nursing has become the stuff of legend, but her writing on hospital design was influential too. The pavilion design—that is series of wings or pavilions separated from one another and designed to provide fresh air and a feeling of openness to patients—became the standard layout for hospitals in much of North American and Europe in the late-19th and early 20th century.²² In October 1858 Nightingale presented two papers at a Liverpool meeting of the National Association for the Promotion of Social Science. One was entitled “Sanitary

²⁰ For expansive treatises written by some of these architects see Henry C. Burdett, *Hospitals and Asylums of the World: Their Origins, History, Construction, Administration, Management, and Legislation: With plans of the Chief Medical Institutions Accurately Drawn to a Uniform Scale in Addition to those of all the Hospitals of London in the Jubilee Year of Queen Victoria's Reign* (London: J. & A. Churchill, 1891), Frederic J. Mouat and H. Saxon Snell, *Hospital Construction and Management* (London: J. & A. Churchill, 1883). Stevens and Lee had more direct roles in Canada including work at the Royal Victoria in Montreal. For research on this subject see Annmarie Adams and Thomas Schlich, “Design for Control: Surgery, Science, and Space at the Royal Victoria Hospital, Montreal, 1893-1956,” *Medical History* 50 (2006):303-306.

²¹ Adams, *Medicine by Design: The Architect and the Modern Hospital*, 10-11.

²² Risse, *Mending Bodies, Saving Souls: A History of Hospitals*, 368-369, 469. Thompson and Grace Goldin, *The Hospital: A Social and Architectural History*, 130.

Condition of Hospitals,” and the other “Hospital Construction.” Content from these was later presented to the Royal Commission on the Sanitary State of the Army, and other portions were incorporated into an article for *Builder*. In part, what Nightingale wrote was an exposé on the conditions she observed in hospitals. This included her famous quip, “It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm. It is quite necessary, nevertheless, to lay down such a principle.”²³ It also included quite thorough analysis—and architectural suggestions as the published version contains several ward drawings—addressing the dangers of improper ventilation, overcrowding, and understaffing in addition to mismanagement and the frequent inaccuracy of hospital statistics.

The most important component of Nightingale’s commentary, from an architectural perspective, was her argument for the relationship between spatial shortcomings and patient recovery. “I have known a case of slight fever received into hospital, the fever passes off in less than a week, and yet the patient, from the foul state of the wards, not restored to health at the end of eight weeks.”²⁴ Such was the classic 19th century example of the patient who was made worse by a hospital visit. The comment went to the heart of the problem and the growing drive for sanitation—from which a veritable movement followed and lasted into the 20th century outlined perhaps best by Nancy Tomes—and how buildings and space had a profound influence on patient recovery, and the ability to frustrate medical technique no matter how sound.²⁵ There was great confidence in Nightingale’s work. Indeed, she made many arguments that resurfaced in the 1940s. One was that with proper nursing techniques there was rarely a need for infectious hospitals or segregation beyond what happened on a ward or room basis. She connected the architecture of existing buildings to the

²³ Nightingale, *Notes on Hospitals*, iii.

²⁴ *Ibid*, 7.

²⁵ Nancy Tomes, *The Gospel of Germs: Men, Women, and the Microbe in American Life* (Cambridge: Harvard University Press, 1998).

deleterious effects on patients and staff: “To build a hospital with one closed court with high walls, or what is worse, with two closed courts, is to stagnate the air before it even reaches the wards.”²⁶ In turn she argued that future construction had to consider the effect of the physical structure on the patient’s environment.

She found this in practice at a military hospital in Vincennes, France. “The pavilions are completely cut off from each other by a large, special ventilated staircase, carried above the roof. Each ward has a profusion of windows opposite each other offer an abundance of light and of ventilation, quite independent of the ventilation of the adjoining pavilion. The wards moreover, run nearly north and south, and receive the sunlight freely throughout the day.”²⁷ The hospital at Vincennes was not perfect; she took issue with where its administrative buildings were located. The employment of its pavilions had ransomed the hospital from the problems she saw in England such as ventilation, drainage, and laundry facilities being overtaxed to the point of uselessness. Furthermore, Vincennes took advantage of natural lighting with its windows and location, and avoided crowding the wards with so many patients as to render them useless. As important as developments with antisepsis and anesthetics were, much could be accomplished through adjusting behaviour and organization.

By the post-Second World War building period administrative preference shifted away from the pavilion model toward double corridor design. It offered an effective way to increase patient occupancy without doubling up on the ancillary services. Further, mechanical ventilation had undercut one of the main advantages of the pavilion model. With contagion easier to control spatial arrangements could cater to other goals. The Depression and Second World War significantly reduced the amount of hospital construction in Canada. As a result, the immediate approaches to

²⁶ Nightingale, *Notes on Hospitals*, 21

²⁷ *Ibid*, 22.

building in the early 1950s were more beholden to earlier ideas of trying to meet spatial requirements of patients.²⁸ It was a dual problem with staffing, as there were times when beds had to remain unused due to inadequate personnel. By the 1960s this approach was becoming misaligned with new tenets of hospital architecture. As hospitals became more entrenched in the urban and social milieu their size and access to capital expanded. Patient demand grew, and with it came increased scope of care.

The 1960s and 1970s saw a development in architectural practice focused on designing buildings that could be renovated with ease. This notion of building ‘hospitals of the future’ was a phrase used by architects at the time and by architectural historians subsequently. In essence this movement sought to create flexible structures that could be modified continuously to meet the changing needs and spatial expectations of the medical profession. One of the most written about examples of this type of building is the McMaster Health Sciences Centre (MHSC) which opened in 1972. In chapter five of this dissertation planners for all four case study hospitals engaged with the notion that flexibility was crucial for any prospective structure. A fear of obsolescence and a desire for flexibility on the part of administrators and architects became increasingly prominent in the 1960s, but it was not an entirely new phenomenon. Administrators complained about antiquated buildings for most of the 20th century, and as new technologies became available there were similar concerns that they could not be accommodated in older facilities. For architects the climax came with the concept of ‘design after’ hospitals. These were structures that were built under the assumption that by the time they were completed technological and medical needs would have

²⁸ Stephen Verderber and David J. Fine *Healthcare Architecture in an era of Radical Transformation* (New Haven: Yale University Press, 2000), 28.

surpassed their capacities. Thus, they had to be malleable shells capable of major changes post completion.²⁹

Architect of the MHSC, Eberhard Zeidler, exemplified this ethos in 1974 describing it as “opened,” but not “completed, because it has been designed never to be finished.” At times the expression of this idea appeared cold, almost dehumanizing “part of this purpose is to create a space that does not become obsolete in fulfilling the changing economic and social needs of our time.” However, a blanket judgment to this end is misleading. As the idea that spatial needs changed there was also a sense that this process served the people who relied upon it. Zeidler followed his comment on economic need with the pronouncement that he had to “create an environment for man. We are only now beginning to understand the powerful interaction we create between man and space, but this interaction is as important as the other factors that involve men with their environment.”³⁰ Like society and medicine, design culture evolved. Builders, hospital boards, and architects did not retain a static understanding of hospital space. For architects like Zeidler, as well as hospitals administrators and bureaucrats within newly-empowered health ministries, the idea of renewable, malleable spaces captured their imaginations and drove design research throughout the 1960s and 1970s.

Zeidler saw himself as adding a fifth dimension to architecture—Sigfried Giedion having dubbed time the fourth dimension—which was ‘life.’ Buildings had to be flexible and adaptable in order to be useful. The use of interstitial space in the MHSC is one such example. Interstitial and shaft spaces surrounded human-use space on each floor. This produced an area for the location of

²⁹ David Theodore, “Planning the Hospital of the Future: Montreal’s Royal Victoria Hospital, ca. 1970” (paper presented at Hospital / Hôpital IHSP 2015 Conference, Montréal, Quebec, October 1-2, 2015). Stephen Verderber, *Innovations in Hospital Architecture* (New York: Routledge, 2010), 153-154.

³⁰ Eberhard H. Zeidler, *Healing the Hospital: McMaster Health Science Centre: Its Conception and Evolution* (Toronto: Zeidler Partnership, 1974), 2, 5-6. Above quotation appears on page 2.

mechanical and electrical services where they could be easily adjusted or changed.³¹ As a result partitions in MSHC could be moved to create different room arrangements. Lighting, air supply, exhaust registers, electrical outlets, plumbing fixtures, equipment, and furnishings could be altered as required without making major changes to the structure itself or the core services.³² Promising as it sounded the implementation of interstitial space was awkward. In some cases, this was due to shoddy material; such as the presence of asbestos in the MHSC's interstitial space. Even without mishaps the design could increase initial construction costs by as much as 40%.³³ Between 1880 and 1980 hospital design shifted from models heavily influenced by controlling contagion to ones that emphasised efficiency and productivity. In broad strokes this may be observed in the shift from 19th century pavilions, where protocols and nursing techniques worked in concert with architecture to stand a fighting chance at controlling illness, toward double-corridors in the middle of the 20th century, and finally into interconnected, adaptable megastructures that became in common the 1960s and are still being built.

Important as architects and architectural theory are, hospitals are institutions oft-governed by medical and political exigency. This dissertation contends that hospitals never 'arrive,' or complete construction. To view them solely as architectural exercises would reveal an institution that is never built, but rather locked in a perpetual series of renovations, demolitions, and rebuilds. The TGH, WGH, CGH, and VGH were in constant flux, development, and impending disaster. For that reason space must be analysed from social and political vectors. The need for health care, and social expectation that it would be provided, meant that hospitals often could not choose an 'ideal' design or layout. Architects, and later consultants, could advise and suggest as much as they wanted, but the board had to answer to its accountants, alderman, and tax payers.

³¹ See Fig 1.1.

³² Zeidler, *Healing the Hospital*, 14-16.

³³ Verderber, *Innovations in Hospital Architecture*, 153.

For much of the 20th century there was no ‘model’ Canadian General Hospital. In part this derived from the type of institution itself; too big to be run directly by the municipality, but too important to be left to private enterprise. It was crucial to the sick, but at times forgettable to the well. Of the interested parties scholars typically associate with hospital design—architects, doctors and administrators—it is important to also consider patients and the general public. In the esoteric realm of architectural thought and ‘administrative science,’ as professionals applied them to hospital design, these parties can slip from view. However, by examining the building process itself, where space was divided, re-divided, traded, lent, and modified to accommodate new services the importance of the patient who would justify these areas, occupy, and at least in theory pay for them reminds scholars that the shape and organization of hospitals has a humanistic as well as professional side. This project presents the dialogue among boards of governors, administrators, architects, doctors, nurses, patients and planners, exposing interrelated forces that determined hospital layout and organization.

Medical and hospital historians focused on the late 18th and 19th centuries have made much of the French Revolution’s role in realigning medical orthodoxy and education, ushering in an era where the hospital ward became central to clinical education.³⁴ Some scholars such as Lindsay Granshaw and Guenter Risse have challenged this approach by demonstrating that education and hospitals had a longer history, and doctors had social motivations to work in these places.³⁵ Still, the

³⁴ See Erwin H. Ackerknecht, *Medicine at the Paris Hospital 1794-1848* (Baltimore: Johns Hopkins Press, 1967) or Michel Foucault, *The Birth of the Clinic: An Archeology of Medical Perception* (New York: Vintage, 1963). Both view the French Revolution as having an important change in hospital use, though Foucault focused more on diagnosis and evaluation while Ackerknecht emphasised technique and hospital conditions.

³⁵ Lindsay Granshaw, “The rise of the modern hospital in Britain,” in *Medicine in Society: Historical Essays*, ed. Andrew Wear (Cambridge: Cambridge University Press, 1992), 214-217. Granshaw also notes that British historians—the English language writers influencing Canadian and American historians—had paid insufficient attention to the Low Countries and other parts of Europe that urbanized more heavily in the early-modern period and thus began building hospitals earlier. This observation dovetailed with comments made by Roy Porter cited above, questioning why these institutions were appearing if they truly were ‘of no use.’ Also see Guenter B. Risse, *Hospital Life in Enlightenment Scotland: Care and Teaching at the Royal Infirmary of Edinburgh* (Charleston: Createpiece Publishers, 2010), 2. Risse

rise of the hospital as a didactic space in the 18th century echoed into the 19th and 20th centuries when it came to how wards were arranged and utilized. General hospitals largely followed a ward model reflecting this change.

The most basic arrangement was public wards, where patients paid a nominal fee—often partly subsidized by municipal and provincial funds—in exchange for accepting the presence of medical students. These wards were initially quite large, but shrunk during the 20th century to roughly 4-8 beds. The category began disappearing after 1957 with the passing of federal hospital insurance. Private wards were typically single bed, more expensive, and off-limits to students. The dichotomy of public and private affected the medical staff. Physicians who were members of the ‘honourary attending staff’ saw to public patients. In private wards the patient hired their own doctor. In the middle were semi-public, and semi-private wards. Semi-public were rarer, sometimes offering a nicer space but most importantly allowed the patient to bring in their own doctor. Semi-private rooms were smaller, and became the norm after 1957. These rooms allowed for an outside physician and usually had 2-4 beds. Patients almost universally demonstrated a preference for privacy in their rooms, and it became an increasingly important component for architects and administrators. However, there were also larger processes influencing demand for general hospitals such as populating national territory and establishing the welfare state.

Historians have approached the question of Canadian nation building in myriad ways: railways, empires, settlements, and city growth; provision of health runs parallel with all of these.³⁶

notes how “from its inception [in 1729] the infirmary was meshed into this education program.” An earlier version of this book was published by Cambridge University Press in 1986.

³⁶ The literature on railways and Canadian nationhood is a library unto itself but as three examples see. Harold Innis, *A History of the Canadian Pacific Railway* (Toronto: McClelland and Stewart, 1923) is the canonical example but also consider Ken Cruikshank, *Close Ties: Railways, Government, and the Board of Railway Commissioners, 1851-1933* (Montreal: McGill-Queen’s University Press, 1991), or for a more popular work that had much cultural significance see Pierre Berton, *The Last Spike* (Toronto: McClelland and Stewart, 1971). For empire consider Carl Berger, *The Sense of Power: Studies in the Ideas of Canadian Imperialism, 1867-1914* (Toronto: University of Toronto Press, 1970). For settlement see Doug Owsen, *Promise of Eden: The Canadian Expansionist Movement and the Idea of the West, 1856-*

All enterprises need healthy functionaries, and the case study hospitals can all claim ancestry to these processes. The TGH developed from a philanthropic effort to care for veterans of the War of 1812, the WGH used Hudson's Bay Company buildings for some of its earliest wards, the CGH developed from a surgery set up by the North-west Mounted Police, and the VGH was originally a Canadian Pacific Railway (CPR) medical tent. While originating in the 'hard' tasks of nation building—war, infrastructure deployment, projection of political power, and exploitation of natural resources—they connected with another related prong of this process which was 'peopling' a vast geography. To expand a population was to keep it alive, but health was not a federal power. On a case-by-case basis the history of a general hospital often requires following its funds. Until the late-1940s this typically led to the municipality or province. Hospital administrators, designers, and patients were often hostage to their local circumstances.

The origins and formation of the welfare state in Canada is familiar historical ground. Certain aspects connect with the hospitals and regions under consideration in important ways. For the first half of the 20th century the federal government held to a 'poor-law tradition' which left most forms of relief up to localities and private charity.³⁷ The British North America Act (BNA) charged provinces with health and hospital provision. In practice this responsibility was often foisted onto the municipalities, or the citizenry. Hospitals faced a period of local, charitable organization before entering into a constellation of services that were hallmarks of the welfare state. These included

1900 (Toronto: University of Toronto Press, 1980). For a collection focused on city growth that does a good job covering multiple provinces and regions—Maritimes, Quebec, Ontario, the prairies, and British Columbia—see Gilbert A. Stelter and Alan F. J. Artibise eds., *The Canadian City: Essays in Urban History*. (Toronto: McClelland and Stewart Limited, 1977)

³⁷ James Struthers, *No Fault of Their Own: Unemployment and the Canadian Welfare State 1914-1941* (Toronto: University of Toronto Press, 1983), 8-9. Struthers's argument about the persistence of a Canadian 'agricultural frontier' into the 20th century when other western countries were more urbanized is an interesting point, and accords with the late-19th century founding of the prairie hospitals.

services such as old-age pensions and employment insurance.³⁸ After the Second World War the increased willingness of Ottawa to spend on local needs—in particular hospital construction—liberated the hospital from its heritage as a charitable dispensary.

The Canadian welfare state—or system—is not without critics who point to problems ranging from accessibility and efficacy of aid to whether it was even redistributive.³⁹ Municipalities could squeeze support from the province, but usually went no further. The world wars were interludes when general hospitals provided care for soldiers and veterans, but had only an indirect effect on private citizens. The passage of federal hospital and health insurance legislation in the 1950s and 1960s, however, brought hospitals into a central position within the welfare state.

Cities and communities funded hospital construction to care for the sick. As these institutions became more important, questions of access arose and one aspect of this debate was insurance. Prior to the 1930s Canada largely lacked a commercial health insurance industry. Between 1880 and 1910 hospital construction boomed as antiseptics, anaesthetics, and a growing consumer demographic emerged. In this period hospitals became bifurcated institutions that retained a charitable impetus while acquiring a paying constituent. The federal government established a Department of Health after the First World War in response to the needs of returning soldiers, in particular those suffering from tuberculosis and venereal disease.⁴⁰

³⁸ James G. Snell, *The Citizen's Wage: The State and the Elderly in Canada, 1900-1951* (Toronto: University of Toronto Press, 1996), 78. Shirley Tillotson, *Contributing Citizens: Modern Charitable Fundraising and the Making of the Welfare State, 1920-1960* (Vancouver: University of British Columbia Press, 2008), 6. Tillotson's argument about the import and business-like nature of charities is especially important in relation to community fundraising of later chapters.

³⁹ Donald Swartz, "The Limits of Health Insurance" in *The 'Benevolent State': The Growth of Welfare in Canada* Allan Moscovitch and Jim Albert ed. (Toronto: Garmand Press, 1987), 255-257. Alvin Finkel, "Origins of the Welfare State in Canada," in *The Canadian State: Political Economy and Political Power* Leo Panitch ed. (Toronto: University of Toronto Press, 1977), 345-347.

⁴⁰ Kellen Kurschinski, "State, Service, and Survival: Canada's Great War Disabled" 1914-44 (PhD diss., McMaster University, 2014), 132. Desmond Morton and Glenn T. Wright, *Winning the Second Battle: Canadian Veterans and the Return to Civilian Life, 1915-1930* (Toronto: University of Toronto Press, 1987), 14-16.

Historian Aleck Ostry argued that the use of federal cost-sharing grants to help provinces establish venereal disease hospitals and tuberculosis sanatoria led to Ottawa playing an increasingly important role in health care. The federal government had begun to shape policy in the provinces on a matter for which it had no constitutional authority. By the onset of the Second World War this method became increasingly common as Ottawa began financing more health programs.⁴¹ Ostry's larger argument is that federal spending through conditional grants was the main 'fiscal instrument' through which the national welfare state was assembled in the 1950s and 1960s. Provinces were unaccustomed to providing funds. In 1913, for instance, municipalities expended \$8.2 million on health and welfare, compared to \$4.3 million by provinces and \$2.6 million by the federal government.⁴²

Medicare originated in 1963, but it was not until 1972 that all provinces and territories were participating in the program. The Yukon Territory was the last holdout. Medicare was an important development for Canadian hospitals, but this can be overstated. The 1957 Hospital Insurance and Diagnostic Services Act (HIDS) was the most significant federal act that linked Ottawa with hospitals across the country. The initial plan called for a fifty-fifty arrangement whereby half of the hospital's expenses would be reimbursed by the federal government to the province, which in turn provided cash to the administrators. Importantly, this was *hospital insurance* not universal health care. Private physicians and other medical services were not included until 1963 or later. This gap has led to the convention by historians of health policy in Canada not to refer to Medicare with a capital until after the 1963 act, and use the lower-case 'medicare' for earlier legislation.

HIDS fundamentally altered the relationship between provincial governments and Ottawa, and provided hospital administrators—to say nothing of patients—with a renewed sense of economic

⁴¹ Aleck Ostry, *Changes and Continuity in Canada's Health Care System* (Ottawa: CHA Press, 2006), 4.

⁴² Jane Ursel, *Private Lives, Public Policy: 100 Years of State Intervention in the Family* (Toronto: Women's Press, 1992), 121.

security and institutional stability. HIDS was unique, however, only in that it was a federal act. The federal government had never before sought to insert itself so completely in health care matters. The innovation was a prominent part of Ottawa's altering of constitutional arrangements by cost-sharing. At the provincial level a dog's breakfast of legislation had been tried throughout the country.⁴³ In the early 20th century most general hospitals—certainly the TGH, WGH, CGH, and VGH—received per diem payments from the municipalities they serviced. This naturally produced a degree of anxiety about who used the hospitals. Early records contain much handwringing about out-of-town use, and hundreds of letters were sent between municipalities hounding one another for payments. Soon provincial governments began to fund hospitals not only in construction but in operation and per diems. The development of province-wide hospital insurance schemes was linked to the fact that tax payers already shouldered much of the cost that came with treating indigent patients.

Open-ended transfer payments worked well between 1945 and 1970. The federal government grew wary of health expenses in the 1970s as the economy slowed. When each dollar spent by a provincial government was matched by one from Ottawa 'have-nots' had an interest in spending as a means to raise capital. Ostry argued that finance ministers on Parliament Hill had become used to a booming post-war economy and went along until the troubles of the 1970s.⁴⁴ In response, the 1977 Federal-Provincial Fiscal Arrangements and Established Program Financing Act (EPF Act) replaced the previous funding structure with an annual transfer based on tax points.

The historiography of Canadian health policy coalesces around the work of Malcolm G. Taylor who chronicled in great detail the development of Medicare. He placed particular focus on the relationships, bargaining, and debates between provincial and federal governments. A central pillar to Taylor's argument is the important role the federal government played as a facilitator in

⁴³ Gregory P. Marchildon, "Editors Preface and Acknowledgments," in *Making Medicare: New Perspectives on the History of Medicare in Canada*, ed. Gregory P. Marchildon (Toronto: University of Toronto Press, 2012), ix

⁴⁴ Aleck Ostry, *Changes and Continuity in Canada's Health Care System*, 48.

developing a universal system. He suggests that many provinces, the canonical example being Saskatchewan, were moving in the direction of providing universal coverage insurance. The energy that drove the project towards universal coverage came from the federal government.

The Depression had done such damage to the economic health of most provinces that there was simply no way they could provide for medical relief. The municipalities were theoretically responsible, but when they fell short they appealed to the province. Municipal health officers had admitting privileges in most cases and were obliged to send people to the public wards if they demonstrated an inability to pay.⁴⁵ The result was that doctors provided a great many services on credit, payment in kind, or pro bono.⁴⁶ During the 1930s and 1940s the Canadian Medical Association (CMA) was constantly bending the ear of the federal government, and only willing to support a universal plan if certain conditions favourable to its constituents, such as the professional body of each province retaining sole discretion in setting a fee schedule, were retained.

It should be noted as well that Taylor does not necessarily view the outcome as inevitable. Indeed, one of his longest chapters examines the aborted attempt at health insurance that almost came to pass under Mackenzie King's government.⁴⁷ The various models for payments that developed had changed in 1956, 1966, and again in 1977 were preceded by a variety of other grants for specific projects or programs. Federal money was going to be spent in an attempt to make the country healthier and medical facilities more accessible, but how this would happen was uncertain. The beginnings originated in the 1930s and 1940s and took time to become truly universal.⁴⁸ Some

⁴⁵ Malcolm G. Taylor, *Health Insurance And Canadian Public Policy: The Seven Decisions that Created the Health Insurance System and Their Outcomes* (Montreal: McGill-Queen's University Press, 2009), 4-9.

⁴⁶ Margaret W. Andrews, "Medical Attendance in Vancouver, 1886-1920," *BC Studies* 40 (1979): 32-34.

⁴⁷ Taylor, *Health Insurance And Canadian Public Policy*, 66-68. A fascinating section, it demonstrates how health was one plank of a broader program to build the welfare state, and demonstrates a strong impetus coming from public refusal—and fear—of returning to Depression-era conditions. An argument made by other Canadian historians such as Alvin Finkel.

⁴⁸ *Ibid*, 40-60.

of these federal grants were for construction and are mentioned in later chapters of this dissertation. Construction was an important aim of post-war funding in the late 1940s.

Other historians have turned their attention to how the legislation developed. Ostry presents a largely federal process, except for the events in Saskatchewan. There the Douglas administration began providing medical care, particularly in rural areas, with tax-payer funds during the Depression and Second World War. While this argument is effective it does not provide much appreciation for the proliferation of province-based approaches. Undoubtedly the involvement of federal government mattered and improved the lives of Canadians, but it would be remiss to ignore how provincial governments dabbled in this area for decades.⁴⁹ There was a tradition of political involvement in medicine, and a citizen expectation that tax dollars should address healthcare.

The advent of federal funding was instrumental in ending municipal and regional grievances over fees and local taxes. Provinces perpetuated a colonial-era practice of letting municipalities support general hospitals until the early 20th century. The result was an understandable aversion to treating travellers or people who lived—and more importantly paid taxes—elsewhere. By the 1950s this narrative was collapsing, in part due to more reliable statistics. A hospital survey of Manitoba found in 1961 that for “every five beds that are built [in Winnipeg], at least one will be used by Manitobans living outside of Winnipeg.”⁵⁰ Consultants in Vancouver reached a similar conclusion in 1947, suggesting that much effort had been wasted in the attempt to preserve this model: “To an institution considered the ‘mother hospital’ for the whole Province for several decades there was truly no geographic boundaries to some of its function and service.”⁵¹ Hospitals grew more technologically sophisticated and the haunt of specialists. Thus, they became impossible to restrict to

⁴⁹ Ostry, *Changes and Continuity in Canada's Health Care System*, 52-53.

⁵⁰ Joseph W. Willard, J. D. Adamson, and J. A. McNab, *Manitoba Hospital Survey Board Report on Hospital Services*, (Winnipeg, 1961), 73.

⁵¹ “A Study of the VGH By James A. Hamilton and Associates, Hospital Consultants” 1947, I-1. (Hereafter Hamilton Report) Box 1, File 24 VGH Fonds CVA.

municipal, provincial, and even national boundaries. For the TGH, this trend had been established earlier due to its greater resources.

The history of health policy has been approached from several directions. David Naylor's monograph *Private Practice, Public Payment: Canadian Medicare and the Politics of Health Insurance 1911-1966* (1986) emphasised the relationship between the medical profession and legislators, with a particular focus on the Royal Commissions on Health reports in 1962. He does not stray from Taylor's argument that medical policy had been piecemeal and provincial until federal funding began propelling the process. He does break new ground by shifting focus away from governments to the medical profession.⁵² After the Second World War the medical profession and allied organization such as the Canadian Health Insurance Association (CHIA) remained dubious about public insurance. The 1962 doctor's strike in Saskatchewan—a response to the Douglas Government's provincial implementation of Medicare rather than hospital insurance—remains a poignant reminder of this schism. Naylor does not pretend to represent all voices in his analysis, even going so far as to mention that hospital administrators are one group that fell outside the bounds of his research. However, the full-time commitment of doctor's organizations and insurance interests reminds historians that general hospitals remained local almost to a fault. Administrators often lacked the time to be off lobbying in Ottawa.⁵³

The quintessentially provincial nature of hospital and medical insurance implementation offers many new opportunities for historians. Gregory P. Marchildon's recent collection *Making Medicare: New Perspectives on the History of Medicare in Canada* (2012) focuses on antecedent programs—or attempts—at the provincial level or related negotiations. British Columbia receives significant attention, but there were others too. Between 1930 and 1960 there were similar attempts

⁵² C. David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance 1911-1966* (Montreal: McGill-Queen's University Press, 1986), 5.

⁵³ Ibid, 112.

in Alberta, Newfoundland, Ontario, and Saskatchewan.⁵⁴ The provincial nature of legislation aligns with Taylor's argument, where he examined Saskatchewan and Ontario in detail. Doubtless, this major chapter in modern Canadian history will attract future inquiries. This dissertation does not seek to contribute directly to the history of health policy, but it brings some information to light.

In the following chapters I emphasise the way in which the varied constituencies of doctors, patients, planners, architects, administrators, and the general public played a role in creating and shaping medical space in a given time period. Chapter one provides a historiographical framework in three parts: commemorative histories, the challenge of critical or skeptical institutional studies, and the development of the social history of medicine and hospitals in Canada. Commemorative histories offer a glimpse into how staff members and administrators wanted their institution to be remembered. They are often the only works published on these hospitals, though the TGH is a notable exception. The next portion examines the critical or skeptical approach associated with scholars such as Michel Foucault, Ivan Illich, and Thomas Szasz. Canadian general hospitals engaged in acts of discipline and instruction at times; however, I argue neither of these approaches accurately capture the design, function, or role of Canadian general hospitals. Before pivoting to a discussion on the existing Canadian hospital historiography this chapter provides a brief overview of the development of the social history of medicine which draws on American and European sources. Hospitals have received some reconsideration in light of this historiographical turn, but these institutions must be discussed within regional contexts.

The second chapter covers the years 1880-1910. It examines the founding and early operation of the TGH, WGH, CGH, and VGH. Parts of this chapter examine events prior to 1880; however, the bulk of analysis takes place once the hospitals are formally established and administrators were

⁵⁴ For examples see Robert Lampard, "The Hoadley Commission (1932-1934) and Health Insurance in Alberta," or Gordon S. Lawson and Andrew F. Noseworthy, "Newfoundland's Cottage Hospital System: 1920-1970," in Marchildon ed. *Making Medicare*, 183-207, 229-249.

seeking permanent buildings. General hospitals in Canada's West were closely linked to the CPR. For example, the VGH began as a company hospital for rail workers. In other cases the line's extension led to population growth which made hospitals all the more necessary as was the case in Calgary. The constituents and medical options of these 'frontier' hospitals were initially limited to employees as they were not set up to serve the 'public good.' As the population of these cities expanded the populace demanded inclusion, as there were few other sources of medical care. Civilians rallied around these facilities by providing funds, volunteer labour, and votes on by-laws. By 1910 these hospitals had shifted from private to civic or public administration.

Chapter three examines the years 1910-1945. General hospitals played an important role in caring for Canadian soldiers during the First and Second World Wars. In 1914 Ottawa was unprepared to deal with the medical requirements of raising a large force, and expected that private charity and municipal health care would be sufficient. Both wars strained hospitals immensely. By 1938 the federal government was willing to allocate more resources towards medicine, but still not enough. In the aftermath of the First World War a brief building boom for general hospitals commenced. It lasted into the 1920s before slowing, and then stopped entirely during the Depression. The Depression produced the longest period of stagnation for Canadian hospitals in the 20th century. It was a period during which almost no buildings were erected, and renovations were sharply curtailed. As the Second World War neared its end administrators began abandoning plans for minor additions. Instead they came to believe federal money would be available for hospital construction and began preparing for substantial expansion.

The fourth chapter focuses on the years 1946-1960, which was one of the most critical periods in the history of Canadian general hospitals. At the end of the Second World War municipal hospital care was in a state of crisis. Most campuses relied upon 19th century main buildings, and

patient beds had not kept pace with the rate of population growth. Further, the federal government had ascended to a new height of power, and voters were unwilling to return to ineffectual, private-charity, social services of the 1930s and earlier. The result was a dramatic outlay in terms of funds for hospital expansion. Hospital campuses swelled during the 1950s. The post-war period was also marked by an increased role for hospital consultants and architects since these projects were less rushed. Late in this period legislative developments, such as the 1957 HIDS Act, brought general hospitals into the lives of all citizens.

Chapter five covers the years 1961-1980 when hospitals experienced an ambivalent trajectory. On one hand, there was more money and professional advice available to administrators than ever before. Further, the general public had never been more convinced in the need for general hospitals. The 1960s saw some hospitals seize the initiative and expand. Others planned and were caught flatfooted in the 1970s when the economy stagnated. These decades were characterized by a paradox of progress as hospital needs seemingly advanced faster than architects or budgets could manage. As a result, administrators and designers sought flexible spaces in the hopes of evading obsolescence. By 1980 most hospital campuses were in a state of partial completion. The post-1960 bent of hospital construction was towards longer-term development and phased plans. It was a departure from earlier decades where the funding and ability to expand was often transitory and new buildings were added when possible with minimal future consideration. Citizens were now more dependent on hospitals than ever. It was where most were born, and where many would die. Yet there was mounting frustration over cost, and administrators were again engaged in the task of justifying the institution and its functions.

Over the course of the 20th century Canadian general hospitals grew substantially in civic, medical, political, and educational import. However, the country's vast geography and thinly-spread

population ensured widely varying contexts and no small measure of economic difficulty. In Toronto—the most developed and populated of the four cities examined in detail—hospital building and administration had a long association with the University of Toronto and its medical education department, and relied on wealthy donors for injections of capital and expertise in steering the institution. Meanwhile Winnipeg, Calgary, and Vancouver had a frontier setting where the founding of hospitals related to broader national efforts such as building the CPR. These institutions took different courses during the 20th century, but shared a common origin in derived buildings and community efforts. These structures are not only medical spaces but nodes in local networks.⁵⁵ The most dramatic change in hospital clientele was the influx of middle-class patients described by Rosemary and David Gagan.⁵⁶ The conflux of a broad—eventually universal—clientele, medical and technological advancement, architectural specialisation, and increasing state involvement elevated general hospitals in the 20th century from charities to an important institution for all citizens.

⁵⁵ Nick J. Fox, "Space, Sterility and Surgery: Circuits of Hygiene in the Operating Theatre." *Social Science & Medicine* 45.5 (1997): 649-57, Thomas Schlich, "Surgery, Science and Modernity: Operating Rooms and Laboratories as Spaces of Control." *History of Science* 45.3 (2007): 231-56,

⁵⁶ Gagan and Rosemary Gagan, *For Patients of Moderate Means*, 12.

Chapter I - “hospital history is cultural, social, and medical history:” Hospital Historiography, Social History of Medicine, and Skeptical Science.

Between 2014 and 2015 the Canadian Federal Government transferred \$32.1 billion to the provinces to cover health care expenditures. The final budget passed by the Government projected an increase of \$27 billion over five years. By 2019-2020 the transfer was projected to reach approximately \$40.9 billion. Building large, urban hospital campuses is a fixture of municipal and provincial politics in Canadian cities. Universities throughout the country have tied their medical faculties to hospitals. Despite the growth of clinics and health centres, general hospitals remain a central node of community and public health just as they are the main site for surgery and major procedures. These buildings have grown in many ways beyond their physical bounds or budgetary lines to represent spaces of civic pride, reassurance, profound joy, but also sadness, fear, and uncertainty. In Canada—to say nothing of its southern neighbour—health care has become a significant political issue, where access and cost become debated. It is worth questioning, then, how an institution that was once mired in scandal and derision emerged over the span of approximately 100 years—1880-1980—to become the locus of a \$40 billion debate.

Compared to their counterparts in other economically advanced countries, Canadian medical historians have paid relatively minor attention to hospitals. Prior to the 1970s, hospital history in North America and Britain tended toward the institutional biography. These works, often written by doctors or nurses who had worked at the hospital they wrote about, assembled anecdotes about ward life and capsule biographies of administrators and medical staff. As the individual’s narrative unfolded so too did that of the hospital, usually ending in triumph.⁵⁷ These works contributed slightly to the political history of their respective municipalities, as well as the development of modern professional medicine. However, they paid scant attention to patient experiences and

⁵⁷ For a quick overview see James T. Connor, “Hospital History in Canada and the United States.” *Canadian Bulletin of Medical History / Bulletin canadien d’histoire de la médecine* 7 (1) (1990): 93-104.

architecture. The early days of medical history arched toward doctor narratives, ideas of discovery, and the conquest of science over quackery.⁵⁸ Hospitals fit uneasily into this framework since prior to the early 20th century there was relatively little to celebrate.

Two epochs of medical historiography loom large over the study of hospitals. One is the appearance of Foucault's work, especially the 1963 English translation of *Birth of the Clinic*, and the emergence of the patient-centric social history of medicine exemplified by Roy Porter.⁵⁹ Foucault dragged institutions into historical focus, but not as civic triumphs or forerunners to the scientific nirvana of 20th century medical centres. Instead, he presented a sinister and often dangerous space. His hospitals were prescriptive environments where patients were examined, defined, 'treated,' but not necessarily helped or healed. Foucault engaged with the patient experience but in a manner different from Porter. He focused on the way power related to diagnosis, and the construction of disease. In that process, it was necessary for doctors to construct the patient, to employ the 'clinical gaze,' and define boundaries between sick and well.

Porter's academic origins were in the history of science where he became fascinated with human curiosity and desire for knowledge. His interest expanded to medicine, but not the advancement of the field as a science. Rather, he focused on the human element. What did patients experience? How were they treated? How did they understand what was happening to them? Who were they, and perhaps more importantly, how many types of patients were there?⁶⁰ Porter was an early-modernist whose findings did not influence the history of 20th century Canadian hospitals, but his influence is writ large upon medical historiography.

⁵⁸ Recent critiques by social historians of medicine display skepticism about relegating older medical histories to the realm of 'Whig' drivel. See Frank Huisman and John Harley Warner, "Introduction" in *Locating Medical History: The Stories and Their Meanings*, eds. Frank Huisman and John Harley Warner (Baltimore: Johns Hopkins University Press, 2004), 2. Huisman and Harley argue medical historians have built a 'straw man' out of older histories, to enhance the stature of their work. Ludmilla Jardanova, who is discussed later, embraces this position by calling for a rework of older histories.

⁵⁹ Michel Foucault, *The Birth of the Clinic: An Archeology of Medical Perception* (New York: Vintage, 1963), x, 196.

⁶⁰ Roy Porter, "The Patient's View: Doing Medical History from Below," *Theory and Society* 14 (1985): 176-178.

By way of historiographical introduction this section intends to bind three literatures: existing work on my case study hospitals, skeptical health studies, and Canadian hospital history. Much of the extant publications about the TGH, WGH, CGH, and VGH are commemorative. These monographs rarely meet scholarly standards, but are worth examining due to their origin, typically from within the institution. Furthermore, they are often the only histories written.⁶¹ The next section examines the influence of scholars such as Foucault, Ivan Illich, and Thomas Szasz. While there is some merit to that stream of critical thought and its emphasis on power relations, and the often inhumane treatment of the sick and mentally ill, it is narrow to characterize Canadian institutions solely along these lines. In 20th century Canada this skeptical approach does not represent reality, but its imprint on institutional studies is too large to ignore. Finally, there is a small body of hospital history in Canada, to which this dissertations seeks to contribute.

Pioneering hospital historian Brian Abel-Smith lamented in 1964 how little was known of “what hospitals actually did for particular patients, about the cost of implementing new developments, the number of staff required or the floor space allotted different purposes. Detailed case studies of individual hospitals are needed before any generalizations can be attempted.”⁶² Nearly all subsequent hospital histories make some mention of the physical space, and consider the construction process, administration, or challenges of fundraising. However, architectural histories of hospitals were rare until the 1980s. One of the earliest works to do so was John D. Thompson and Grace Goldwin’s *The Hospital: A Social and Architectural History* (1975), a survey of American and European hospital design that did not touch upon Canada.⁶³

⁶¹ Toronto, Winnipeg, Calgary, and Vancouver General Hospitals. (TGH, WGH, CGH, VGH) They are introduced more formally in the second chapter as well as the introduction. There are some exceptions, see J. T. H. Connor, *Doing Good: The Life of Toronto’s General Hospital* (Toronto: University of Toronto Press, 2000)

⁶² Brian Abel-Smith, *The Hospitals 1800-1948: A Study of Social Administration in England and Wales* (Cambridge: Harvard University Press, 1964), ix-x.

⁶³ John D. Thompson and Grace Goldin, *The Hospital: A Social and Architectural History* (New Haven: Yale University Press, 1975), xxvii.

Thompson and Goldin's work served as a reference for many studies of hospitals, but it lacked the critical edge of a monograph. Influenced by Thompson and Goldin is Stephen Verderber and David J. Fine's *Healthcare Architecture in an era of Radical Transformation*. These historians begin their study in 1970 where the Goldin study ended. They trace the course of hospital architecture into the 21st century, providing more of a historiographical argument. Verderber and Fine contend that the hospital as an institution is too narrow a topic for medical historians, and instead that a whole constellation of healthcare architecture ranging from the office spaces for consultations, to hospices, to food courts, and entertainment areas, must be considered in order for scholars to fully grasp the relationship between space and healing. Their work is also helpful since it touches upon Canada, specifically the McMaster Health Sciences Centre, when dealing with state investment in medical facilities and its influence on the design and building of 'superhospitals.'⁶⁴

Canadian hospital history has seen some growth in the last two decades. The two scholars most closely associated with this development are Rosemary and David Gagan. Although they are less architecturally focused, their research produced insights on the development of Canadian hospitals. Specifically, they stressed that hospitals were important to civic pride and a node in the local economy.⁶⁵ Thus the social history of the hospital becomes one that is sensitive to patient experience, but also sufficiently expansive to include its role in the community, its municipal funding, and the civic pride that helped it grow and develop alongside medical science.

Recent work in the Canadian field has also embraced architecture more fully, largely due to Annmarie Adams. Adams's background in history of architecture, women, gender, and health made her well-suited to apply herself to the study of hospital buildings and the experiences of those inside.

⁶⁴ Stephen Verderber and David J. Fine *Healthcare Architecture in an era of Radical Transformation* (New Haven: Yale University Press, 2000), 3-4, 116, 134-135.

⁶⁵ David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950* (Montreal: McGill-Queen's University Press, 2002)

Her research has a bent towards stressing the role of the architect, but the one does not eclipse the other. Perhaps the most important of these is the argument that space is not truly static. Rather, experience within space varied widely depending on who moved—or tried to move—through it.⁶⁶ Her argument examined the arrangement of wards, access to hallways, and privileges bestowed on certain groups of patients. Much of this dissertation builds upon her methodology, paying frequent attention to the rules, ordering, and designations that made up and defined general hospitals.

I give somewhat less credit to architects than does Adams. The case studies in my thesis rarely found them driving design, although of necessity they often sat on building committees. Typically, these professionals refined or responded to administrative requests. That does not undermine their importance as consultants and sources of information for early administrators, nor should it downplay their role in design. In the second half of the 20th century architects become more influential, especially when partnered with consultants who specialized in long-term planning. But it is important to note that they did not drive the process in a singular fashion.

The following sections explore commemorative institutional histories, skeptical or critical health studies, and finally Canadian hospital and medical history. These three bodies of literature address the existing, public knowledge of the Toronto, Winnipeg, Calgary, and Vancouver general hospitals, the pitfalls of institutional analysis, and developments in social and medical history that have raised hospitals to a position of import. Commemorative histories are not academic, and the point of examining them is not to locate a particular methodology or school of thought. Instead they demonstrate the existence of serious histories related to these institutions. Intended for a popular audience, the consumers of these works tend to be those with intense interests in local history or people with a close professional or emotional attachment to the hospital. These works occasionally

⁶⁶ Annmarie Adams, *Medicine by Design: The Architect and the Modern Hospital, 1893-1943* (Minneapolis: University of Minnesota Press, 2008), xxi.

provided material or leads for my account. The skeptical or critical approach to institutional history merits attention due to its influence on the field. The Canadian hospital was not a workhouse, but it was not without discipline. However, hospital administrators and staff were more often reactive than proactive when enforcing disciplinary actions. Their ability to exert power was often hemmed in by lack of funds, sufficient employees, and social expectations. Thus, adherence to rules and routines was necessary to remain productive rather than an end in itself.

Institutional Literatures

The breadth of commemorative institutional literature is inconsistent among the four hospital case studies. Further, there are a few academic projects on these buildings addressed in the final section on Canadian hospital history. Given the uneven nature of extant institutional histories, this section examines specific works and provides background and context. Often these histories originated within the hospital rather than a commercial publishing house. Many are the hard-fought realization of nursing alumnae or of retired doctors devoted to researching and writing about their former employer or educational experience.

Commemorative histories typically reflected the times in which they were produced, navigated a fine line between glorification and criticism, and attempted to justify contemporary expansion. Such histories reliably begin with genesis stories. With the VGH, that has always been the CPR and the 1886 Vancouver fire.⁶⁷ In his book—which was more of a pamphlet—Donald Luxton discussed the growth of the VGH primarily from the standpoint of population growth. His use of statistics hinted at a somewhat more sophisticated study, but numbers were rarely followed by analysis. The doubling of population from 50,000 to 110,000 between 1906 and 1911 is significant, but rather than weave that statistic into an analysis of hospital growth it is simply stated, as though

⁶⁷ Clare Marcus *History of the Vancouver General Hospital: 75th Anniversary Edition* (Vancouver: Vancouver General Hospital Public Relations Department, 1977), 1-5.

the inference was sufficient.⁶⁸ Some comments on the health concerns of urban life in 1911 would have helped demonstrate how the hospital was a community organ, and a part of the networks that made it function rather than merely a response to population growth.

The process of fact selection vexes historians of all stripes, but is especially problematic in commemorative pieces. Nora Kelly's history of the VGH and its school of nursing began with two objectives. It sought to elucidate the founding of medical and training facilities, while presenting a narrative about the role of nurses and their plight in the past and present. Kelly loaded her history with descriptions of poor conditions, understaffing, and disrespect. "In her selflessness and poverty, she [the nurse] was to represent the ideals of womanhood. This was a conception which took a great deal of time to change and it is in many places still in the process of being eroded."⁶⁹ Kelly's thesis was not that nurses in the 1970s were treated as poorly as those in the 1880s, but she used these harsh descriptions to glorify the profession, partly by dwelling on specific VGH issues. Exposing her rhetoric does not invalidate her insights. But there are questions of balance as she overplays some aspects in furtherance of a political goal.

Kelly's book captures many of the issues with alumni and in-house commemorative histories. They are political documents. The value in these sorts of books is generally not the conclusions, as there is often no analysis. Of all such commemorative histories written on the hospitals in this thesis none deviated from empirical analysis, typically lending enormous influence to the words—or memories—of nurses and doctors. Much of their value, then, comes in two forms. The first is the incidental facts and anecdotes that escaped formal record keeping. Information such as the colour of the walls, or the changes in décor come through in these works as do anecdotes about ward

⁶⁸ Donald Luxton, *Vancouver General Hospital 100 Years of Care and Service* (Vancouver: Vancouver Coastal Health, 2006), 16

⁶⁹ Nora Kelly, *Quest for a Profession: The History of the Vancouver General Hospital School of Nursing* (Vancouver: Vancouver General Hospital School of Nursing Alumnae Association, 1973), 7.

experiences that, even if false, are worth consideration given they are what an individual *wanted* to believe or found plausible enough to include in print. The second is the political motivations themselves. For example, in the 1970s the VGH was adding new surgical and psychiatric facilities. It suited the purposes of those promoting growth to commemorate nursing education and the hospital more generally. Together they had struggled, persevered, and come out stronger.

Peter Walton's *The VGH Story* (1988) is a classic example of 'Whig' history. Each chapter focused on an aspect of VGH history: origins, buildings, nursing, medical education with the exception of the final chapter which discusses the VGH's future expansion projects. Additionally, the concluding portion of each chapter connected with more recent developments. In the 'humble beginnings' chapter, which included the CPR and the 1886 conflagration, Walton diverges to note, "Today the emphasis is not on size, but on the Hospital's role as the major referral, teaching, and research hospital in the province for specialized care. The number of acute beds has been reduced and the physical plant is changing to provide a more compact, modern hospital facility."⁷⁰ Walton noticed that 19th century complaints had been about lack of space, primarily because bed counts were so small that the hospital struggled with overcrowding. The pivot at the end of the chapter revealed not only a change in how hospitals were built and utilized, but the true aim behind writing such a history. As a product of the VGH's public relations department, it prepared the community for expansion. It also justified a subtle shift in the hospital's mission from primarily patient care to education and research.

In his final chapter on the future of the hospital Walton described the VGH's future and how space and architecture were central to its success. "The new structures reflect a decision of the Board of Trustees to build up instead of out for the Hospital of the future. The concept will create a more

⁷⁰ Peter Walton, *The VGH Story: A History of the Vancouver General Hospital, A Century of Caring* (Vancouver: Vancouver General Hospital Public Relations Department, 1988), 2.

compact and efficient physical plant, and will help the Hospital develop in an increasingly competitive environment using the most modern technology required for specialized diagnostic services and treatment.”⁷¹ His use of the word competitive is important. It was surely an accurate descriptor of the internal processes as the institution vied for funding, publications, specialists, and students. However, using it in a public relations message reminds us of the Gagan’s argument about civic pride. Walton had calculated that referencing the VGH’s need to stay current would appeal to citizens. Words such as modern and future remained fixtures of professional and public hospital literature throughout the 20th century.

Two other VGH books bear mentioning. Clare Marcus’s 1977 *History of the VGH* marked the hospital’s 75th anniversary, touching on the standard subjects of early administrators, the CPR, buildings, nursing education, and technological advancement. Perhaps the most interesting aspect of this history is references to citizens. Marcus cultivated the same sense of civic pride as Walton. She highlighted recent building projects, and spent a large amount of the book examining recent involvement with hospital consultants such as Agnew Peckham and Associates who surveyed the plant in 1965.⁷²

Beverley Du Gas’s history of VGH School of Nursing pursued an entirely different approach. It is a newer work, published in 2009. More importantly the intended audience consisted of individuals who had been involved with, taught at, or graduated from the school rather than the general public. The scope of the history was less to justify some contemporary expenditure or project, than to reminisce with a particular constituency, and entrench cultural myths of that experience. Du Gas commented on the perceptions of nurses and the sexism many students faced. A skilled writer, she masked many complaints rather than addressing them directly as a central theme.

⁷¹ Ibid, 39.

⁷² Clare Marcus, *History of Vancouver General Hospital*, 12.

She offhandedly mentioned the lack of a new teaching building noting, “Of course, it would be nice to have a new building for the school. Always felt, however, that the learning that took place in the classroom—the interchange between teacher and student was more important than the room where the class took place.”⁷³ Her comment reminded readers that the school had struggled, and though new buildings appeared on the medical campus, there were none for nursing education. At the same time there was a humble pride that the school had soldiered on and achieved in spite of hardship—a very nurse-like action.

Calgary has two dominant popular histories: *The Science, the Art and the Spirit: Hospitals, Medicine and Nursing in Calgary* (1975) by Evelyn Hardwick, Eileen Jameson and Eleanor Tregillus, and D. Scollard’s *Hospital: A Portrait of Calgary General* (1981). In *Science, the Art and the Spirit* there is remarkable breadth in terms of temporal coverage and some deviation from the standard mould such as giving attention to patient experiences, albeit usually only to draw attention to the staff’s heroism or perseverance. The bulk of its content is a series of capsule administrator and doctor biographies, all of which move briskly from frontier shack to urban, scientific medical centre.

The Science, the Art and the Spirit is neither an entirely primary or secondary source. It is largely celebratory in its intent. Lacking peer-review or footnotes, it is not scholarly. However, it is a valuable book because documentation from before 1890 is sparse. No annual reports were made prior to 1891 and no trustee records exist before 1894. Additionally, it used oral testimony collected in the 1960s making it one of the only surviving sources the nurses from the CGH contributed to. While often slipping into a popular tone, it examined a substantial span of time, devoting attention to

⁷³ Beverly Witter Du Gas, *The Best Damn School in the Country: The Vancouver General Hospital School of Nursing, 1957-1965* (Vancouver: Self-Published, 2009), 86.

the First and Second World Wars, the Depression, post-war building boom in the 1950s and expansion of medical education.⁷⁴

The Scollard book is problematic too, but for different reasons. It is encyclopedic, listing copious facts, statistics, and random departmental anecdotes. As a resource the book is quite useful, and far less guilty of grandstanding and mythologizing. This is likely due to the Glenbow Archives, rather than oral testimony, serving as its source base; however, none of the documents consulted were footnoted.⁷⁵ The inclusion of photographs suggests the intended, popular audience that would not be satisfied with plain text. The significance of these books comes from the fact they demonstrated a public interest in the hospital, a professional belief that some amount of public relations was necessary, and that history was an effective approach. Further, these books demonstrated a public appetite for information about the hospital. These types of histories cannot provide a historiographical anchor, but provide fact collection and preservation.

The WGH has a relatively small body of commemorative literature much of which centres on Ethel Johns—a nurse trained at its facility—and her rise within the global medical community. Johns was born in England and received her initial education there before coming to Canada. She graduated from the WGH nursing school in 1902. Over the course of her career she became a director of nursing education for the University of British Columbia, was attached to the Paris Office of the Rockefeller Foundation, and oversaw the founding of nursing schools in Romania and Hungary.⁷⁶ Her dedication to the practice and education of nursing became a point of pride for alumnae associations, and subsequently her writings have been published in two volumes. The first

⁷⁴ Evelyn Hardwick Eileen Jameson and Eleanor Tregillus, *The Science, the Art and the Spirit: Hospitals, Medicine and Nursing in Calgary* (Calgary: Century Calgary Publications, 1975), 21, 43, 107.

⁷⁵ D. Scollard *Hospital: A Portrait of Calgary General* (Winnipeg: Hignell Printing, 1981), 1-3.

⁷⁶ Ethel Johns, *The Winnipeg General Hospital School of Nursing, 1887-1953* (Winnipeg: Winnipeg General Hospital School of Nursing Alumnae Association, 1954), xii.

volume contained her account of the nursing programme's history, and the second was a biography by Margaret M. Street containing extracts of Johns's writing.

Margaret M. Street's *Watch-fires on the Mountains: The Life and Writings of Ethel Johns* (1973) is as much a biography as it is an edited collection of Johns's writings. Given the time of its production and niche audience there are plenty of moments where it borders on hagiography, but is more thoroughly researched than similar efforts. Street used archival collections throughout Canada and the United States to gather information, and her access to Johns's papers demonstrated an appreciation for primary sources even though she did not venture her own analysis. One of the medical developments discussed at length in later chapters is the concept of professionalization, not only among doctors but also with hospital administrators and architects specializing in hospitals. One of the most useful and revealing aspects of *Watch-fires* is its emphasis on this process for nurses. Street begins with a brief contextual note on the limited array of career employment options for women and the natural draw of nursing. However, as more women settled on nursing there was a drive—and Johns played a key role by setting up professional periodicals and assisting in the establishment of nursing schools—to form ranks into a proper profession mirroring what other health service workers were engaged in.⁷⁷

Johns's nursing school history provides some details on the WGH, in particular about the importance of properly trained staff and the scarcity of such until into the 1960s, but does not touch upon space or design. It contains a thorough administrative history of the earliest stages of the WGH, before A. G. Bannatyne provided the McDermot Street site and the hospital bounced from temporary building to private home and back again. It made sense to lead into a discussion of nursing from a hospital history, but there was no express reason not to start with the school's founding. Johns saw

⁷⁷ Margaret M. Street, *Watch-fire on the Mountains: The Life and Writings of Ethel Johns* (Toronto: University of Toronto Press, 1973), 42-43.

value in expanding upon the urban context of Winnipeg during its struggles to secure a permanent home for the general hospital. Her focus on the original funding schemes, locations, and conditions served a purpose for her cause. She demonstrated the importance of nurses and their achievements even when lacking proper facilities.

The TGH has received the most attention of any Canadian general hospital—with Montreal and then Vancouver coming in second and third. There are commemorative but also professional and academic histories. The earliest of the commemorative histories appeared in 1913, written by C. K. Clarke, medical superintendent at the time. Clarke's book is discussed more thoroughly in chapter two, but some comments warrant mention now. The appearance of this history in 1913 is remarkable. The TGH commissioned a celebratory history while its compeers in other cities struggled to remain solvent and finance buildings. That in itself says much about the TGH, the city, and the country. Clarke emphasized the deep past of the TGH, namely its tenure as the York General Hospital and how its origins stretched to 1812 as a tent facility for troops. He also provided a fairly detailed examination of the Gerrard Street building, which was used between 1853 and 1913.

Clarke was not a historian, nor did he see himself as such. He saw the book as something between an institutional document and public relations activity that would elucidate “conditions and generalities, rather than persons [as] this was inevitable.”⁷⁸ Clarke's work bears some similarity to recognizable approaches to medical history of earlier generations. For him, the history could only be told through the biography of ‘medical men’ who had worked in the institution. Rather than engaging in a detailed analysis, he chose to study a selection of grant events. His tendency mirrored the long-standing practice of medical historians to focus on doctors.⁷⁹

⁷⁸ C. K. Clarke, *A History of the Toronto General Hospital: Including an Account of the Medal of the Loyal and Patriotic Society of 1812* (Toronto: William Briggs, 1913), 5.

⁷⁹ Some Canadian historians such as Michael Bliss remained proponents of that approach.

Clarke also touched upon a very important element in hospital histories, by arguing that hospitals and medical science became safer and more desirable in the late 19th century due to advances in anesthetic and asepsis. This remains an accepted part of the historiographical understanding of medicine.⁸⁰ As a doctor, Clarke could speak with some authority about the state of professional medicine in the early 20th century. Hospitals were shedding old stigmas, and demand for surgery among the upper and middle classes surged. The reasons for this—‘Listerim’ as Clarke called it—were no mystery to doctors who intimately understood the shift. Thus, what medical historians concluded some decades later was a belief held by doctors in the first decade of the 20th century.

In 1975, former TGH physician W. G. Cosbie published his omnibus history, *The Toronto General Hospital; 1819-1965: A Chronicle*. Where Clarke had lacked space to extrapolate on the daily toils of high-ranked executives and doctors, Cosbie had no such problems. His history is encyclopedic in nature, starting in 1819 with the York General, the aftermath of the War of 1812 and borrowing liberally—often without footnotes—from Clarke. Two themes dominate Cosbie’s offering, the World Wars and the TGH’s relationship with the University of Toronto. Cosbie was not wrong to focus on these, but he framed them in a manner that says much about the contemporary social biases of his profession. His discussion of education is a good example. Cosbie presented two spheres, one composed of doctors and the other of nurses. There is certainly a gender element present in the ways these ought to be approached. However, instead of developing this as a theme in the organization of work and space Cosbie focused on administrator biographies and the medical curriculum.⁸¹

⁸⁰ Though discussed in more detail later in the chapter, the Gagens, Porter, Risse, and Connor all discuss this change in medical technology.

⁸¹ W. G. Cosbie, *The Toronto General Hospital 1819-1965: A Chronicle* (Toronto: Macmillan of Canada, 1975), 208-210.

In fairness to Cosbie the book was not a scholarly attempt to connect with a broader historiography. Until J. T. H. Connor's 2000 monograph on the TGH it served as the source for anyone with an interest in the institution. Cosbie fits—unlike Connor—ultimately into the celebratory model of hospital history. At its core, *Chronicle* is a fond reminiscence of the TGH's role in the community, its survival during the wars, and rise as a leading education and research institution. Cosbie devotes much of the book to doctor biographies, followed by discussion of their role in developing specific programs or departments. While there is historical value in this knowledge, it tends to exist in a realm by itself. No broader image of the hospital appears, nor does it integrate the institution into the urban networks of health. For all the discussion of the world wars, there is little attention to the TGH's interaction with the municipal government and community, compared to the 'selflessness' of doctors and nurses who went overseas.

Though not a celebratory history of a single institution, G. Harvey Agnew's memoir *Canadian Hospitals 1920-1970 A Dramatic Half Century* (1974) is invaluable as a primary source and problematic as a secondary. In 1928 Agnew left private practice for a post within the Canadian Medical Association's new department of hospital service. He was executive secretary of the Canadian Hospital Council—later Canadian Hospital Association—from 1931-1950, and established the first department of hospital administration in Canada at the University of Toronto in 1946. In 1950 he joined a New York-based hospital consultant firm that was expanding into Canada. They formed Agnew, Peckham and Associates. Agnew was a leading voice in professionalization of hospital administration in North America. As a primary source, therefore, his book is not only rich with minutia on the physical environment of hospitals in the early 20th century, but also has insider credibility. Further, it provides a powerful account of how a leading administrative theorist experienced the transition of general hospitals from charitable sick houses to middle-class

institutions. However, one must also contend with his oracular voice, and the accompanying undercurrent of all-knowing and all-powerful administrators who worked with heroic doctors on the forward march of medical progress.⁸²

Despite the ways celebratory institutional histories fail academic expectations, they convey admirably the social significance of hospitals that extends beyond a role in public health, healing, or crisis management. When one considers the exhausting shifts, the gore, the many failures and sadness that must have accompanied a lifetime in medicine as a surgeon, a nurse, or even administrator the fact so many devoted their time to producing books and chronicles of these institutions is telling. It either suggests that the good moments outweighed the bad, or that memory favours the good. All books written by nurses contain a sprinkling of anecdotes on occupation downsides such as how tired they were the sternness of superiors and so forth. But none offer regret or a sense of overwhelming sadness. The consumption of these histories remains largely local as well, in part because of their limited print runs, and their production through the hospital itself. Therefore, one can eliminate profit motive behind these histories. There is something heroic in these testaments. Most likely that is what the authors hoped readers would remember.

With the proliferation of these commemorative histories there is a pattern that stands out. The authors are predominantly former medical staff rather than patients. Admittedly, this is a somewhat difficult line to draw. Every member of the community was a potential patient. Doctors, nurses, and administrators, too, could end up in the wards. In that sense, it is somewhat problematic to act as though there is no crossover between patients and medical personnel. Being a patient was an experience, not an innate quality or aspect of a person. Yet there is a polarity. Essentially all institutional accounts come from medical insiders while almost all critical ones originate from scholars who were only ever patients, or outside observers influenced by academic turns. The

⁸² Agnew, *Canadian Hospitals 1920 to 1970*, 20-22.

skeptical accounts of medicine that encouraged distrust or suggested ulterior motives came primarily from the ranks of patients rather than practitioners.⁸³

Skeptics – The Alleged Dark Side of Medicine and its Institutions

All fields must at times confront their past, and medical history is no different. It has a strand of scholarship focused on the evils of medicine, failures, unintended consequences, and its use as a tool of social control rather than a means to heal or relieve suffering. To quote one of its most ardent voices, Ivan Illich: “Modern medicine is a negation of health. It is not organized to serve human health, but only itself, as an institution. It makes more people sick than it heals.”⁸⁴ Such comments have a polemical ring. It is impossible to doubt 20th century medical achievements, particularly after 1950. A reaction of shock to Illich’s claims helps explain the very sentiment that he was attempting to highlight. The critical analysis produced by scholars such as Illich, Szasz and Foucault arose in part from the ‘hubris’ of medicine. Its practitioners assumed authority, and ability to define and shape human experience. Such claims led to unrealized hopes, from which stemmed critiques that influenced the writing of medical history in general and hospitals in particular.

Illich’s attack on the medical establishment was rooted in a constellation of scholarship popular during the second half of the 20th century that offered critiques of the ‘industrialization’ of society and the ongoing clash between ‘expert’ knowledge and traditional practice. His book *Medical Nemesis* (1975) reads like a rant, stating boldly “the medical establishment has become a major threat to health.”⁸⁵ Essentially, he argued that the goals of health care shifted as the industry grew. Rather than functioning as a professional unit bent toward healing it became a negative influence, one that sought profit and glory without regard for patients. Repeatedly Illich invoked the

⁸³ Thomas Szasz is a notable exception to the ‘big three,’ he earned an MD in 1944.

⁸⁴ Comment made by Ivan Illich quoted in Peter Havasi, *Education of Cancer Healing: Vol. III The Ancients* (New York: Lulu Publishing, 2012), 83.

⁸⁵ Ivan Illich, *Medical Nemesis: The Expropriation of Health* (Toronto: McClelland & Stewart, 1975), 11.

phrase ‘iatrogenesis’ which suggested sickness, harm, or suffering could be—and often was—caused by doctors.⁸⁶ He viewed medicine as a sham used by a minority to enrich and empower itself. Illich also critiqued what he perceived as the proliferation of medicine in daily life. “Whether contemporary doctors intend to or not they perform as priests, magicians and agents of the political establishment.” Illich frequently combined gore and trauma to make his case. “When a doctor removes the adenoids of a child he separates it from its parents, exposes it to technicians that speak a foreign language, instills in it a sense that its body may be invaded by strangers for reasons they alone know.”⁸⁷ The fear of unnecessary, macabre acts pervaded his conception of health care and doctor motives.

Pain filters through nearly all elements of society: religion, law, health, work, and leisure. It is an idea that has motivated large philosophical systems such utilitarianism, and its avoidance underlies central components of social organization such as leisure, rest, and wealth. Illich disagreed with the idea that pain should be avoided, pointing to the 1853 development of the first pharmaceutical pain-killers as a moment of social and spiritual crisis. He believed crucial philosophical and metaphysical ideas such as the evolution of the soul, and man’s burden of original sin stemmed from the experience of pain. “With rising levels of induced insensitivity to pain the capacity to experience the simple joys and pleasures of life declines. Increasingly stronger stimuli are needed to provide people in an anaesthetic society with any sense of being alive.” Thus, “drugs, violence and horror remain the only stimuli that can still elicit some experience of self. Widespread pain-killing increases the demand for painful excitation.”⁸⁸ For Illich medicine designed to eliminate pain was actually the chief cause of spreading it.

⁸⁶ Ibid, 164.

⁸⁷ Ibid, 55.

⁸⁸ Ibid, 106.

Illich argued that older methods of healthcare were more patient-centric, compassionate, and divorced from profit motive. In his inversion of a conventional outlook, Illich had a field-day with the hospital. “The hospital which at the very beginning of the 19th century had become a place for diagnosis, now turned into a place of teaching. Soon it would become a laboratory for experimenting with treatment and towards the turn of the century a place for healing. By now the pesthouse has been transformed into a compartmentalized repair shop.”⁸⁹ Hospitals had become a space where illness existed for the purpose of study, and the idea of a cure related as much to behaviour and class as physiology. For Illich ‘repair-minded’ approach to healing was the medical profession’s ultimate failure. Through these hospitals society became medicalized, beholden to the arcane techniques and language of doctors and clinicians.

Architectural scholar Roslyn Lindheim, a close colleague of Illich, shared his distrust of medicine. Her research, however, assailed the doctor not the architect. She argued that “medical care settings...both reflect and infect our attitudes and behavior; and how in order to change a physical setting, it is necessary to make a fundamental change in our values and activities.”⁹⁰ Her view was that buildings were an important part of the experienced environment, but less so than people. In other words, space meant less in terms of patient experience than interactions with nurses, doctors, fellow patients, and visitors. In miserable conditions a patient could still be treated with dignity, and vice versa. To make the point she quipped: ‘bad architecture does less harm than bad medicine.’ Nonetheless she was scathing in her description of hospitals.

Lindheim levelled her harshest criticism at post-Second World War hospitals. She described design trends of the late-1940s as “accommodating mechanical rather than human needs,” and worsened the lot of staff and patients. “When staff and patients have found the hospital environment

⁸⁹ Ibid, 114.

⁹⁰ Roslyn Lindheim, “Criteria for Creating Environments that Promote Caring,” in *Symposium on Environments for Humanized Health Care*, ed. Roslyn Lindheim (Berkeley: University of Berkeley Press, 1979), 5.

oppressive and inhumane, floors have been carpeted, walls painted bright colors, graphics added but nothing fundamentally changed.”⁹¹ The architect had become the stooge of the medical establishment. On one hand her work is an important, early approach to blending medical and architectural history, but in this method the patient faded into the shadows (and carpets) of the mega-structures that formed the temples of scientific medicine.

Since patients are central to the social history of medicine, scholars must contend with the writings of Foucault. Despite the historical shortcomings of his works few other writers can claim as much theoretical or methodological influence on the writing of medical history. If one were bold enough to try and distill the *Birth of the Clinic* (1963) and *Discipline and Punish* (1973) to a single overarching point, a satisfactory candidate could be the construction of the patient.⁹² In modernity, categorization became an important method to exert power over bodies. The ability to define someone as a ‘cancer patient,’ ‘sick,’ or ‘mad’ permitted certain actions and conditioned behaviour. Foucault’s interest in the creation of these categories was more than historical. He developed a working philosophy on the establishment and use of power, definition, and space to critique

⁹¹See Roslyn Lindheim, *Birthing Centers and Hospices: Reclaiming Birth and Death* (Berkley: University of Berkley Press, 1981) Another example of her scholarship specifically focused on birthing and maternity care. It emphasised how children were separated from their mother, the technological environment, the demonization of home birth as examples of medicine replacing previous customs and rearranging social organization. Lindheim, “Criteria for Creating Environments that Promote Caring,” 25. Lindheim comments on the McMasters (sic) hospital in Hamilton, where she “spent a lot of time” and felt that it personified the failings on this new system. She described it as a towering building with nuclear accelerators that managed to devote merely 51% of its facility to patient care.

⁹² Michel Foucault, *Discipline & Punish: The Birth of the Prison* (New York: Vintage Books, 1977) 184-187. His discussion of examination is especially important, specifically the argument that power of discipline flowed from its invisibility; the subject is seen not the power. When patients or prisoners faced examination their bodies were defined and constructed, any condition they may have was diagnosed. The unseen power structures that observed also judged. Foucault, *The Birth of the Clinic: An Archeology of Medical Perception*, x, 196. By emphasising the history of medical definition Foucault emphasised death as the starting point of medicine, reducing the patient and his symptoms to their most minute parts, from which one could not go further back. His argument, then, became that patient’s role in society, in medical education, and in the hospital was one of near-total servility as medical language grew increasingly esoteric and beyond their grasp. Patients were, in this case, both the object and subject of clinical medicine. Such an approach has obvious incongruities with the social history of medicine as espoused by scholars such as Porter who did not write the history of helpless victims. Foucault often obliterated agency where others looked for it, but his work still broke many boundaries in terms of how medicine was thought of by academics, and provided a firm foundation to problematize the approaches of doctors. What medical historians really owe Foucault is not necessarily any specific fact he unearthed, or spun, but rather, his knack for exposing assumptions about medical and psychiatric establishments, and new ways to approach their history.

disciplinary institutions. The treatment of lepers in the Middle Ages—or as a more contemporary example the bigoted representation of HIV as a ‘gay plague’ in the 1980s—offer ready examples of how sickness reflected social prejudice and justified state action and violence.⁹³ Definitions of sickness were not static. Any scholar interested in the history of the patient-doctor relationship must search for the shifting meaning of healing and ailment. Such an approach does not suggest that sicknesses and diseases are entirely socially constructed. Instead it contends that the ailments society deems require correction, or views capable of preventing, is an important element of the history of medicine.

Foucault’s lasting contribution is not only that he provided theoretical depth to the institutionalization of medicine, patients, and doctors in modernity. He also added to the historian’s understanding of rationality and power. Rather than suggesting rationality contained power, he demonstrated that creating categories, and formalizing behaviour and hierarchies maintained and entrenched mechanisms of social control.⁹⁴ Any attempt to write patients into the history of medicine must ascertain the discourses that underwrote their relationship with physicians.⁹⁵ Mariana Valverde’s use of ‘discourse creation’ in social purity literature is an example of the approach’s value.⁹⁶ Foucault also contributed to architectural history, noting how theory and seemingly

⁹³ Roy Porter, *The Greatest Benefit To Mankind: A Medical History of Humanity* (New York: W. W. Norton and Company, 1997), 121-122. Porter’s discussion of leprosy refers to the disease’s association with lust, an act of blaming the condition on the patient’s immorality.

⁹⁴ Michel Foucault, *The Order of Things: An Archeology of Human Sciences* (New York: Vintage Books, 1970), 136-139. For an insightful discussion on Foucault in the international literature see Roy Porter and Colin Jones eds. *Reassessing Foucault: Power, Medicine, and the Body* (New York: Routledge, 1995)

⁹⁵ Foucault, *The Birth of the Clinic*, 114. For a brilliant endeavour into the history of the doctor-patient relationship see Sally Wilde, “The Elephants in the Doctor-Patient Relationship: Patients’ Clinical Interactions and the Changing Surgical Landscape of the 1890s,” *Health and History* (2007): 2-27.

⁹⁶ Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925* (Toronto: University of Toronto Press, 1991), 34-44. For other examples see Porter, “Laymen, doctors and medical knowledge in the eighteenth century.” Joanna Bourke, *Dismembering the Male: Men’s Bodies, Britain, and the Great War* (Chicago: University of Chicago Press, 1996), and Seth Koven, *Slumming: Sexual Politics in Victorian London* (Princeton: Princeton University Press, 2004). Domestic examples abound as well including: Mary-Ellen Kelm *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-50* (Vancouver: University of British Columbia Press, 1998),

unconnected cultural practices influenced design, rendering built spaces into discursive statements.⁹⁷

The patient is another schism between the two literatures. For social historians, a patient is an agent whose experience is important. For skeptics, the category is problematic, constructed, or designed. For many of these scholars there would be no patients in the absence of medical discourse. The patient is central to both literatures, but in different ways.

The history of psychiatry figures prominently in the social history of medicine, partly due to its longstanding emphasis on patients. Diseases of the mind are rarely contagious. Thus, since at least Robert Burton's *Anatomy of Melancholy* (1621), psychiatrists believed understanding the patient was a necessary part of treatment.⁹⁸ For Foucault psychiatric diagnosis was culturally subjective: "[e]ach culture is seen as producing an image of mental illness whose lines are drawn by the whole set of anthropological possibilities that it ignores or repressed." He noted in exasperation how treatments like isolation were as likely to cause madness as to cure it.⁹⁹

and Sherry McKay and Patricia Vertinsky, eds. *Disciplining Bodies in the Gymnasium: Memory, Monument, and Modernism* (London: Routledge, 2004)

⁹⁷ Paul Hirst, "Foucault and Architecture," *Architectural Association Files* 26 (1993): 53.

⁹⁸ Robert Burton, *The Anatomy of Melancholy: What it is: With all the Kinds, Causes, Symptomes, Prognostickes, and Several Cures of it. In three Maine Partitions with their several Sections, Members, and Subsections. Philosophically, Medicinally, Historically, Opened and Cut Up*, eds. Floyd Dell and Paul Jordan-Smith (New York: Tudor Publishing Company, 1927), 123. In early modern 'psychiatry' madness and its various forms held different meanings at different levels of society (at court, before a judge, in the monastery) and treatments/classification were somewhat more uniform. Melancholy (generally assumed to be clinical depression but doubtlessly comprising many more circumstances both real and imagined) typically was related to an imbalance of black bile, but the patient still needed a personal investigation to root out the behaviour that led to the imbalance. Western psychiatry placed value in the patient as an object of study, though this is not to suggest they were treated kindly. As medicine became more 'scientific' a disease, say cholera, could be studied as its own organism and combated in a general way—quarantine, vaccination, water purification—while psychological conditions continued requiring more direct interaction.

⁹⁹ Michel Foucault, *Madness: The Invention of an Idea* trans. Alan Sheridan (New York: Harper Perennial, 2011), 20-21, 101. First published in 1954, and revised in 1962. Quote on page 101. For a constructive critique and evaluation of the patient in the history of medicine with an emphasis on psychiatry see L. Stephen Jacyna and Stephen T. Casper eds. *The Neurological Patient in History* (Rochester: University of Rochester Press, 2012). Jacyna and Casper point out that historians of medicine and psychiatry have tended to treat patients in a static way, without considering the perspective of 'what made a patient' is a crucial element to a fuller understanding. Their collection emphasises the changing image of neurological patients—chosen because their symptoms are often caused by conditions hardly imaginable to those not afflicted by them—for a time doctors swapped patients for the purposes of study or display, patients found ways of acting in public that differed from in private and indeed depending on their attending physician. In essence they call for a more developed image of patients.

Foucault and Illich originated in the intellectual world of the late-1950s and 1960s and gained prominence in the 1970s and 1980s. However, the critical vein persisted into much more contemporary historical work. In 2007 Szasz argued that the diseases were fictional in nature, and owed to the processes of medicalization and demedicalization. His examples were routinely historical: such actions as masturbation or homosexuality remained medicalized—labelled as illnesses and treatable by medicine and psychiatry—until relatively recently. Conversely, such issues as social anxiety allegedly went unnoticed by professional medicine until late in the 20th century.¹⁰⁰ These examples ring true to the social historian of medicine. It seems unlikely for someone to identify as ill over such things, absent social pressure or conditioning to do so.

The useful elements of critical history have at times found their way into the work of astute and careful historians. Historian of science Charles Rosenberg did so quite palatably in 2006:

The range of human dilemmas that we ask medicine to address has if anything expanded, from depression to anxiety, from bereavement to dysfunctional marriage... So long as we ask medicine to help in doing this cultural work of defining the normal and providing a context and meaning for emotional pain, we will continue to fight a guerilla war on the permanently contested if ever-shifting boundary, dividing disease and deviance, feeling and symptom, the random and the determined, and the stigmatized and the deserving of sympathy.¹⁰¹

A soundly historical explanation, it does not sound polemical, nor does it imply a cynical agenda on the part of medicine. Rather it places the blame—if there is any at all—on society and its broader ills. Rosenberg's explanation provides an ideal contrast to Szasz, whose work required distrust and negativity. Szasz rebutted Rosenberg's argument as “characteristically misleading,” for not differentiating between emotional and somatic pain. “Medicalization is not an impersonal process as

¹⁰⁰ Thomas Szasz, *The Medicalization of Everyday Life: Selected Essays* (New York: Syracuse University Press 2007), xvii

¹⁰¹ Charles Rosenberg, “Contested Boundaries. Psychiatry, disease, and diagnosis: Perspectives in Biology and Medicine,” *Perspectives in Biology and Medicine* 49:3 (2006): 422. Another good example of a middle ground resides in Edward Shorter, *Before Prozac: The Troubled History of Mood Disorders in Psychiatry* (Oxford: Oxford University Press, 2008), 3. Shorter argues certain drugs proved highly effective at solving biologically-based illnesses, but stopped being prescribed as patents expired and profits dried up. In so doing he suggests some illnesses are ‘real’ and can be pinpointed physically and addressed, whereas others, indeed many that appear ‘unresponsive’ to drugs resist treatment precisely because they have been constructed or diagnosed for socially-driven reasons.

Rosenberg pretends. It is psychiatric propaganda not historical analysis. In [his] account there are no agents, no winners, or losers and no one is responsible for how psychiatry—the manufacture of fictitious disease—bleeds into the larger culture. Bleeding may be started or stopped.”¹⁰² For Szasz medicalization and the proliferation of clinical terms and ideas into daily life were no accident or side-effect of larger historical processes. It was—as for Foucault and Illich—a destructive machination of modernity.

Some symptoms and characteristics of mental illness are readily traced to chemicals or traumatic events, while others have more intangible origins such as culture, gender expectations, and racism. David Wright, historian of British and Canadian psychiatry, argued in his history of Down’s Syndrome that “naming a disease, disorder or syndrome carries with it significant cultural baggage and no small amount of controversy.”¹⁰³ He acknowledged the chromosomal origins of the syndrome, while pointing out that doctors describing it as ‘Mongolism’ and ‘idiocy’, presented racist notions and cultural understandings of competency. Names carried assumptions and implied meanings beyond their literal interpretation, illuminated by Canadian advertisement campaigns in the 1970s designed to present those with the syndrome as functional. Wright was not writing in a Foucauldian vein. Instead, he demonstrated how treatments, symptoms, and social expectation shaped each individual's lived experiences.

The greatest drawback of the critical approach is the guesswork involved in determining where the motives and impulses of those with ‘power’ originate. In the following chapters there is no shortage of situations that may seem dark, harmful or even purposefully malevolent. Medicine and

¹⁰² Szasz, *The Medicalization of Everyday Life*, xvii-xviii.

¹⁰³ David Wright, *Downs: The History of a Disability* (Oxford: Oxford University Press, 2011), 10. Note that Down’s Syndrome in the possessive is the British manner of referring to the disorder. On page 15 Wright argues that “Down’s Syndrome is a genetic anomaly, a lived experience, and the invention of the society within which it is framed. The very label of a disorder threatens to obscure our view of the individual and indeed at its most insidious affects the self-identity and behaviour of the persons themselves.”

medical institutions—perhaps for their inseverable relationship with death—have cultivated fear in the public’s imagination. The 20th century—to say nothing of the 19th—witnessed an outpouring of this sentiment in forms ranging from episodes of *X-Files* to the lyrics of bands such as *Twisted Sister*. Popular culture connected death and harm with the idea that, doctors, medicine, and hospitals could cause them.¹⁰⁴ It is a powerful artefact of a time when visiting the doctor—or hospital—was a move of desperation; it should not be forgotten that Shelley’s Victor Frankenstein character was a medical student. The prevalence of fictional examples spoke to a level of plausibility. These ideas resonated with deep-seated fears within popular consciousness that perhaps medicine was dangerous. Such an association is not surprising. Even perfectly-practiced surgery can result in pain, suffering or death. Moreover, modern medicine requires dismemberment and dissection. It therefore takes little coaxing to guide the imagination toward morbid or macabre concerns.

The critical approach to medicine stimulated interest in hospitals by social historians. Roy Porter and Lindsay Granshaw’s collection *The Hospital in History* (1989) addressed this critique. While appreciating it for moving away from the histories of Abel-Smith and Courtney Dainton they stopped short of accepting the larger assumptions of skeptical critiques. They argued—characteristically—for a social response: who went to the hospitals, what did patients experience, eat, drink and do while confined, what treatments were offered and what was considered medically solvable?¹⁰⁵ Porter and Granshaw’s collection showcased the relationship between social and critical history of medicine. The essays in *The Hospital in History* contributed to a re-evaluation of existing

¹⁰⁴ See “Hearing before the Committee on Commerce, Science, and Transportation, United States Senate, 99th Congress. First session on Contents of music and the lyrics of Records.” 19 September 1985, 84. One outrageous moment came in a 1985 Congressional Hearing on Record Labelling when Tipper Gore accused Dee Snider, singer and song-writer for *Twisted Sister*, of glorifying sadomasochism and rape in his song “Under the Blade.” Snider defended the lyrics, arguing they were about “surgery and the fear that instills in people” and had been inspired to write it after talking to a friend who was preparing to undergo an operation. Snider’s use of the hospital and surgery helps this argument whether it is honest or not. If written about his friend’s fear it demonstrates how frightening these institutions were to the public, and if lying he still considered it believable enough to testify with.

¹⁰⁵ Roy Porter and Lindsay Granshaw eds., *The Hospital in History* (New York: Routledge, 1989), 2-4.

academic knowledge. Unlike Foucault and Illich, however, the tone and assumptions therein are not as radical. The collection shows its age in some areas. For instance, Porter suggests it should not be assumed that doctors have much of a historical relationship to hospitals. Very plausible in earlier periods—beyond the scope of this dissertation—but many essays deal with the mid-19th century and into the 20th where such a claim does not hold up. Doctors were involved in the founding and organization of many Canadian general hospitals.

When Foucault was sixteen he confided that he was a homosexual to his father—a doctor—who promptly brought him to a psychiatrist. There he learned he was sick but fixable.¹⁰⁶ Foucault's academic legacy in the form of a scathing critique of modernity, the dangers of categorization, and the dynamics of power gain a distinct weight when viewed in the context of his *patient experience*. The critical approach pushed historians to question institutions, discourses, and power dynamics; however, it does not demonstrate that doctors and medicine are became primarily wrong or evil. The oeuvre of mental health historian Cathy Coleborne attests to the value and excesses of the critical approach. Her early work approached mental illness in the Foucauldian vein, searching for discourses and examining elements of discipline. Recently, she called for appreciation of the impulse of reformers, religious workers, nurses, and doctors to do 'good' for their patients.¹⁰⁷ Scholars such as Michael Ignatieff—whose monograph *A Just Measure of Pain* (1978) was a classic example of Foucauldian institutional analysis—began questioning the approach as well, arguing Foucault was better at describing change than explaining it.¹⁰⁸ Thus the impulse to act on the part of reformers, nurses, and doctors had to be reconsidered and incorporated in institutional history rather than

¹⁰⁶ James Miller, *The Passion of Michel Foucault* (New York: Doubleday, 1993) 62-63.

¹⁰⁷ An example of her early works is C. S. Coleborne, "'She does up her hair fantastically': The Production of Femininity in patient case-books of the lunatic asylum in 1860s Victoria," in *Forging Identities: Bodies, Gender and Feminist History*, eds. J. Long and H. Brash (Nedlands: University of Western Australia Press, 1977), 47-68. For a recent, nuanced offering see C. S. Coleborne, *Insanity, Identity, and Empire: Immigrants and Institutional Confinement in Australia and New Zealand, 1873-1910* (Manchester: Manchester University Press, 2015)

¹⁰⁸ Michael Ignatieff, review of *Histoire de la Sexualité* by Michel Foucault, *Times Literary Supplement* September, no. 4,252 (1984): 1071.

maligned or polemicized. There has been a longstanding conflation between the wrongness of action and wrongness of intention.

The true intentions of practitioners are unknown in an absolute sense, but it is still valuable to question. By the same token there is no cache of secret documents that will expose a conspiracy of malevolence by medicine or psychiatry. Thus, while there is value in questioning, reconsidering, rooting out, and challenging assumptions it is important to reconcile this with the limits of surviving sources. The Foucauldian tack might be, appropriately, likened to medication; the right dose cures the patient but too much can prove fatal. In some ways that echoes the conclusion of German historian Martin Dinges who argued there was value in Foucault's work, but only if carefully read.¹⁰⁹ It is important that medical historians read Szasz, Illich, and Foucault not for the facts they provide, but because they present situations in new light, and reveal perspectives that might otherwise never be attained or considered. A sixteen-year-old boy sat in a doctor's office and listened to a diagnosis of unnaturalness. Could a scholar absent this experience have written *Birth of the Clinic* or *Discipline and Punish*?

Social History of Medicine, Hospitals, Architecture, and the Canadian Context

In the 1960s and 1970s some scholars drifted away from a medical history defined by Whig treatments of discoveries, hagiography, and top-down studies of institutions such as hospitals and medical schools. A new literature emerged, defined largely by historians rather than doctors. These historians were interested in the patient's perspective, the role of nurses, the persistence of folk remedies, the victims of medical professionalization, and later, how medical knowledge was as much a source of healing as a fount of power. This big-tent 'social history of medicine' approach sought to integrate patients, pain, and failures into its narrative and understand how society and medicine

¹⁰⁹ Martin Dinges, "The Reception of Michel Foucault's Ideas on Social Discipline, Mental Asylums, Hospitals and the Medical Profession in German Historiography," in *Reassessing Foucault*, 199.

existed within a dialectical relationship. In the 1980s and 1990s interest in the history of psychiatry and its influence on hospital and asylum history sensitised scholars to the use of medicine for social control and encouraged criticism of the medical profession. Spurred by these developments scholars broadened the field searching for health and healing in aspects of society beyond the hospital, medical school, or doctor's office.

It is important not to turn this historiographical development into its own tale of triumph. Scholars such as Frank Huisman and John Harley Warner recently argued that the uncritical dichotomy of Whig or social, between 'old' and 'new' medical history, was an "...intellectually undemanding way of asserting the importance of one's own work."¹¹⁰ Canada's most eminent medical historian, Michael Bliss, built his career on medical biographies and skepticism of 'patient-focussed' social history.¹¹¹ Medical historians must confront the literature produced since the 1970s, and evaluate to what extent it has improved the field. There are three elements to this task. A brief survey of the literature through the 1980s, a discussion of work from the 1980s and 1990s when the social history of medicine was established in Canadian universities and journals, and an exploration in Canadian and international studies focused on hospitals. Beyond including the perspective of patients, this approach linked medicine with social changes, including state involvement in health care, public health, diet, education, sport, the body, and culture.

The development of medical history in Canada followed trends in Britain and the United States and moved at a slower pace. S. E. D. Shortt, both a physician and professor of medical history, appraised the Canadian field in 1981 as "...American historiography writ small."¹¹²

¹¹⁰ Huisman and Harley Warner, "Introduction," 2.

¹¹¹ Michael Bliss, "Privatizing the Mind: The Sundering of Canadian History, the Sundering of Canada." *Journal of Canadian Studies* 26:4 (1991):5-18. Bliss conceded that women, First Nations, and other groups excluded by the old national histories should be written into new ones. But he also stressed that too much focus on social history had left far too many historians with no sense of "Canada" as their subject.

¹¹² S. E. D. Shortt, "Antiquarians and Amateurs: Reflections on the Writing of Medical History in Canada," in *Medicine in Canadian History: Historical Perspectives*, ed. S. E. D. Shortt (Montreal: McGill-Queen's University Press, 1981), 2

Conscious of shortcomings with studying great doctors, discoveries, and institutions, he compiled a series of previously-published essays that exhibited these characteristics in the Canadian literature. One inclusion was Michael Bliss's "Pure Books on Avoided Subjects": Pre-Freudian Sexual Ideas in Canada" (1970). Bliss was still a business historian, his essay on sexual ideas notwithstanding. For Shortt to include it as an example of promising scholarship demonstrated how thin the field was. The course Bliss eventually took as a medical biographer, distrustful of the social history of medicine Shortt championed, added an ironic twist.

In addition to emphasising the medical profession and the establishment of health-care institutions, many early medical histories reflected the regionalism endemic to most channels of Canadian historiography. Examples include H. C. Jamieson's *Early Medicine in Alberta* (1947), Ross Mitchell's *Medicine in Manitoba* (1954), John J. Heagerty's *Four Centuries of Medical History in Canada* (1928), A. S. Monro's *The Medical History of British Columbia* (1932), Maude Abbott's *History of Medicine in the Province of Quebec* (1931), and later works by W. B. Stewart *Medicine in New Brunswick* (1971) and H. E. MacDermot's *One Hundred Years of Medicine in Canada, 1867-1967* (1967). Abbott's work stands out as one of the first on Quebec written in English, while Jamieson, Mitchell, and Stewart provided snapshots of their respective provinces, singling out 'great' doctors and early hospitals.¹¹³ These scholars shared a narrow focus, in part owing to the fact

This paper focuses mainly on Canadian and British literature, but to provide useful snapshots of medical history in the United States see Richard Harrison Shyrock, ed *Medicine in America: Historical Essays* (Baltimore: Johns Hopkins Press, 1966) and George Rosen, *From Medical Police to Social Medicine: Essays in the History of Health Care* (New York: Science History Publications, 1974). The Shyrock book was well on its way to a more expansive history of medicine, concerning itself with such issues as slave treatment on plantations, the effect of medical professionalization on women, and public health. Rosen positioned his essays as a dialectic between power, health, and the state. These collections support Shortt's contention that Canadian medical history lagged behind.

¹¹³ Herber C. Jamieson, *Early Medicine in Alberta: The First Seventy-Five Years* (Edmonton: The Douglas Printing Company, 1947). Especially pages 53-60 and 88-100. Jamieson also included appendices of medical practitioners and educators. The most commendable aspect was a chapter on women doctors, but on balance told a story of professional medicine. John J. Heagerty, *Four Centuries of Medical History in Canada: And a Sketch of the Medical History of Newfoundland* Vol. 1 and 2. (Toronto: MacMillan Company of Canada Limited, 1928) The first volume covered epidemics and disease, pioneer physicians, surgery, and public health. Heagerty's second volume continued with public health then tackled medical schools and hospitalization. Public health became a popular inroad for the social history of

that they wrote with little secondary literature to guide them. Though lacking social depth one could salvage their connection of medicine with social and civic order, which is an idea that is now embraced by scholars. All authors were medical doctors who wrote for an audience of colleagues.

The 1930s produced some works with a glimmer of new approaches to medical history in W. B. Howell's *Medicine in Canada* (1933) and William P. Bull's *Medicine Man to Medical Men* (1934). Howell's pan-Canadian study, although suffering a clear regional bias towards Ontario, Quebec and the Maritimes, explored the ways medicine moved through geography, and the role of communication networks in professionalization. Aware that the harsh environment and limited resources of early settlements required the modification of European techniques and adoption of some First Nation medicinal practices, he ascribed a greater emphasis to context than many of his colleagues.¹¹⁴ Bull went further, demonstrating the importance of public health as and devoted considerable time to examining tensions between orthodox physicians and folk healers that emerged

medicine, but for Heagerty it remained top-down: vaccinations, municipal meetings, and laxly-enforced legislation. His conclusion found that "the determination of conquer and ability to endure have brought light out of darkness." (vol. 2 pg. 289) Canada's medical history for Heagerty was very much the battle against a savage land, overcome by doctors and their institutions. His volumes had little time for First Nations, women, or the general public. A. S. Monro, *The Medical History of British Columbia* (Vancouver: Canadian Medical Association, 1932). Monro, as did Jamieson and other early doctor medical historians, viewed railway expansion as a major epoch in Canadian medicine. With people came disease, but more importantly, improvements in transportation brought medical professionals. Maude E. Abbott, *History of Medicine in the Province of Quebec* (Montreal: McGill University Press, 1931) 10,11. Though dismissive, Abbott actually provides some analysis on First Nation's concept of healing, both in terms of physical and spiritual ailments. As with many historians of Quebec Abbott noted significant changes in terms of professionalization and education after 1776 and an infusion of British-trained medical workers. However she also emphasised French-Canadian doctors and afforded their government more say than either Renald Lessard or William Canniff. W. B. Stewart, *Medicine in New Brunswick: A History of the practice of medicine in the Province of New Brunswick, and of the men and women who contributed to this history, encompassing the period of time from prior to the arrival of the white man in America to the early part of the twentieth century* (New Brunswick: The New Brunswick Medical School, 1974), 20-27. Coming somewhat later than other works mentioned above, Stewart attempted to tackle some issues associated with professional medicine such as the state of health practices before European contact, though he was ambivalent. On one hand, he suggested that First Nations had a diverse pharmacopeia, understandings of child care that far outpaced those in Europe and experience with surgery such as amputations as well as methods for reviving patients who had swallowed large quantities of water. Yet he also viewed many of their practices as useless, and presented a romantic image of the 'noble' and 'shy savage.' H. E. MacDermot, *One Hundred Years of Medicine in Canada 1867-1967* (Toronto: McClelland and Stewart Limited, 1967), 11-13. In many ways this book is an anti-social history of medicine. Rather than searching for the ways society shaped medicine it suggests that medicine shaped society along with geography and military needs.

¹¹⁴ William Boyman Howell, *Medicine In Canada* (New York: Paul B. Hoeber, 1933), 9,11, 34, 98-99. Medical schools received a somewhat novel treatment under Boyman as nodes of knowledge crucial in the spread of professionalization, whereas most schools viewed them either as scientific institutions or as receivers for European knowledge.

as a by-product of professionalization.¹¹⁵ Howell and Bull were not above mentioning the heroism of doctors, but provided examples for later historians to build on.

One of the first calls for medical history to become broader, and specifically to consider the importance of patients, came from a doctor not a social historian. In 1945 Douglas Guthrie presented an essay to the Royal Society of Medicine titled “The Patient: A Neglected Factor in the History of Medicine.” Guthrie sought “to pay tribute to some patients of the past who have played an important part in the march of medical progress.”¹¹⁶ Whiggish-sounding rhetoric aside, what followed was a remarkable, albeit curt, series of observations on the role of patients in treatment. Guthrie’s most important argument was that patients had not been static, nor had doctors viewed them as such. Guthrie observed that ancient Greek physicians wrote candidly about patients in accounts of healing, whereas Renaissance doctors rarely recorded personal details except for those of high-standing. Ultimately Guthrie’s writing held deep ambivalence about the relationship between patient and doctor, spending several pages on Louis Pasteur’s dread that a vaccine could do harm, without exploring the perspective of the individual as an actor. Guthrie was preoccupied with what he termed ‘the intelligent patient,’ rather than consider all who sought care.¹¹⁷ Still, Guthrie deserves credit for noting a major lacuna and laying a foundation for later historians.

Abel-Smith’s *The Hospitals 1800-1948* (1964) inspired many subsequent hospital histories. As an example of the social history of medicine it is a poor candidate due to its emphasis on the medical profession and to a lesser extent administration. However, it delved into questions relating to the organization of hospitals, management, and some basic spatial organization. Porter criticised

¹¹⁵ William Perkins Bull, *From Medicine Man to Medical Man: A Record of a Century and a half of Progress in Health and Sanitation as Exemplified by Developments in Peel* (Toronto: George J. McLeod LTD, 1932), 115-120.

¹¹⁶ Douglas Guthrie, “The Patient: A Neglected Factor in the History of Medicine” *Proceedings of the Royal Society of Medicine* 38:9 (1945): 490. In the essay’s conclusion Guthrie mused that perhaps his five page effort had been sufficient to fill the lacuna.

¹¹⁷ *Ibid*, 492, 494. The patient became a part of the story, but not as a primary or active actor.

the book for focusing too much on administration.¹¹⁸ From a more recent vantage the book missed opportunities. In recounting the 1871 use of a ship as a convalescent hospital Abel-Smith only briefly engaged with the important social and political elements, namely civic unwillingness to care for so many sick in the city proper.¹¹⁹ Such an event examined in a manner more aligned with the social history of medicine would explore the civil unease, the conditions aboard the ship, who the patients were, why they were being treated in this location, and how similar their experience was to elsewhere. It would be unfair to attack the book vigorously for these short-comings; it is in many ways a remarkably thorough study for a time when there was virtually no comparable literature.

In a similar vein to Abel-Smith's book is Courtney Dainton's *The Story of England's Hospitals* (1961), which sought to complement the small library that existed of institutional biographies. Interestingly—although misleading in relation to later developments—Dainton described his offering as an exercise in the 'social history of medicine.' For him this meant a closer appreciation to municipal politics in an effort to understand how the practical side of hospitals came into being. The monograph also has a truly gargantuan temporal scope, spanning 900-1900, so there is a considerable amount devoted to the transition from monastery and religious hospitals to secular or municipal ones. It has two notable practices for organizing material. One being the decision to use case studies. The second was his hope to establish a broader understanding of hospitals as a social and political phenomenon, rather than isolated institutions. Dainton devoted reasonable attention to concern for the poor on the part of community leadership.¹²⁰ By considering the great underpinning element of municipal politics—society—he treated civic demand as a type of agency, although his chapters fixated on politicians and his case studies read quite like the institutional biographies he sought to complement rather than recreate.

¹¹⁸ Roy Porter, *Disease, Medicine and Society in England 1550-1860* (London: MacMillan Publishers, 1987), 66.

¹¹⁹ Abel-Smith, *The Hospitals 1800-1948*, 119-123.

¹²⁰ Courtney Dainton, *The Story of England's Hospitals* (Springfield: Charles C. Thomas Publishing, 1961), 61-62

A final 1960s monograph on hospital development worthy of note is Mary Risley's *The House of Healing: The Story of the Hospital* (1961). Risley makes a religion-centric argument that hospitals represented a sort of spiritual collectivism, where society chose to engage in helping those in need. She suggested, "despite association with pain and suffering, hospitals are concrete expressions of the world's spirit of loving and giving, a spirit that underlies both the money donated to building them and the services performed under their roofs."¹²¹ The tone of Risley's argument is decidedly too celebratory, almost supernatural. Perhaps she had a more fortunate upbringing than Foucault, for two more contrasting interpretations could hardly be imagined. However, her monograph is significant in another way. By focusing on something other than doctors and discovery she revealed a path to examine the role of the hospital in the community as well as other constituents such as patients.

During the 1960s scholars sounded alarms about the trajectory of medical history. Iago Galdston, a psychiatrist with a strong grasp of Hegel, Marx and Collingwood, described the existing literature as "backward, if not archaic," condemning its indifference to methodological developments in other fields, and obsession with great discovery and the conquest of progress over ignorance.¹²² Fellow psychiatrist Erwin H. Ackerknecht questioned the idea of 'expertise' and propounded upon the idea of 'lag' between discovery and wholesale adoption of medical techniques and technologies.¹²³ Galdston criticised the idea of an internal logic that drove medical progress, or that the form of medicine represented a leg in the journey toward truth. Instead, he argued that economic, technological, political, and social factors shaped medicine in any given historical period far more

¹²¹ Mary Risley, *House of Healing: The Story of the Hospital* (New York: Doubleday, 1961), 13.

¹²² Iago Galdston, "On the Futility of Medical History," *Canadian Medical Association Journal* 93:15 (1965) 807-808.

¹²³ Erwin H. Ackerknecht, "A Plea for a 'Behaviorist' Approach in Writing the History of Medicine" *Journal of the History of Medicine and Allied Sciences* 22 (1967): 212.

than the will of heroic physicians.¹²⁴ Ackerknecht's argument stemmed from his monograph, *Medicine at the Paris Hospital, 1794-1848* (1967). He discovered that medical suppliers routinely sold surgical instruments deemed obsolete by contemporary medical treatises.¹²⁵ Ackerknecht did not oppose studying elite doctors, institutions, and discoveries, but felt the approach was incomplete; hence his argument that the pinnacle of medical knowledge did not reveal the range of actual healing practices at any given time.¹²⁶

Unease about the idea of progress underlay critiques of the 'old' history of medicine. Galdston argued, to an audience of doctors, that the myth of assured progress would ultimately produce two major social problems. First, consumers of health care would come to expect completely unrealistic results, and second, doctors preoccupied with 'great men' and discoveries would be ill-positioned to cater to the needs of 'regular' patients.¹²⁷ To a more scholastic audience, Ackerknecht argued for a 'behaviorist' approach to medical history that focused less on medical writings and more on praxis. Though this methodology smacked of old-fashioned empiricism, Ackerknecht's goal was to understand the act of healing from the bottom-up. For him the medical past was comprehensible in the range of approaches to sickness, the rate at which certain procedures or technologies became accepted, and the disjuncture between practice and theory.¹²⁸ Ackerknecht and Galdston outlined what would become a research agenda for generations of social historians of medicine by rebuking 'great man' history and criticising traditional sources such as medical textbooks and doctors's writings.

¹²⁴ Galdston, "On the Futility of Medical History," 809.

¹²⁵ See Erwin H. Ackerknecht, *Medicine at the Paris Hospital 1794-1848* (Baltimore: Johns Hopkins Press, 1967).

¹²⁶ Ackerknecht, "A Plea for a 'Behaviorist' Approach in Writing the History of Medicine," 214.

¹²⁷ Galdston, "On the Futility of Medical History," 810.

¹²⁸ Ackerknecht, "A Plea for a 'Behaviorist' Approach in Writing the History of Medicine," 213-214. For instance, he asked why battlefield surgeons in the Franco-Prussian War neglected to use anesthetics on their patients, or why bloodletting remained in use into the later 19th century despite being largely condemned in mainstream medical literature. Understanding these types of behaviours were aimed at garnering a more accurate image of the medical past.

During the 1970s scholarly work on hospital and asylum history veered away from commemorative and institutional narratives to focus on class usage, centralization of power, and state involvement.¹²⁹ Sanitation improvements in the early twentieth century transformed hospitals from the last resort of the impoverished to medicine's preeminent institution. As the primary source of healing across class lines, hospitals became a significant—and neglected—nexus of society and medicine. David and Rosemary Gagan, the most significant contributors to Canadian hospital history, argued that nation-wide health insurance schemes of the 1950s intensified the presence of this institution in daily life.¹³⁰ There is more than healing to consider. Hospitals remind scholars why the history of medicine could benefit from a search for influences beyond medicine *per se*. The shape of medical space, the treatments and patient services on offer, even the underlying logic of organization such as triage systems or the regulation of visiting hours arise from a far broader context than can be uncovered from medical journals and textbooks.¹³¹ Guenter B. Risse, an authority on the history of hospitals, summed the significance these institutions effectively as “hospital history is cultural, social, and medical history.”¹³²

Hospitals and asylums often served as lightning rods for scholarly criticism. Andrew T. Scull's classic *Museums of Madness* (1979), or in Canadian literature, Harvery G. Simmons *From Asylum to Welfare* (1984) are examples that, sought to expose how psychiatric care became

¹²⁹ For examples of the commemorative hospital histories that dominated in the first half of the 20th century see Olivier Maurault, *L'Hôtel-Dieu premier hospital de Montréal: D'après les annals manuscrites, les documents originaux de l'Institut des Religieuses Hospitalières de Saint-Joseph et autres sources 1642-1763* (Montreal: no publisher listed, 1942), and Anna B. Montreuil, *Three Came With Gifts: The Story of the First Hospital, the First School and the First Cloister in Canada and Their Heroic Founders* (Toronto: The Ryerson Press, 1955)

¹³⁰ Gagan and Gagan, *For Patients of Moderate Means*, 71-75.

¹³¹ See Graham Mooney and Jonathan Reinartz eds., *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (New York: Editions Rodopi B. V., 2009). Unfortunately none of the essays touch on Canada directly, but for the purposes of positioning the hospital as a social institution as much as a medical one they are very useful. The very idea of visitation reminds historians that patient's social relationships persisted through disease or even confinement, while also demonstrating how regulating entry into hospitals demonstrated increasingly formal demarcations between the sick and the well.

¹³² Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (New York: Oxford University Press, 1999).
4.

increasingly structured, bureaucratic, and impersonal after 1800.¹³³ As the literature on asylums and hospitals become more sophisticated, criticism-based studies ran the risk of producing unwieldy conclusions. Documenting the imbalance of power between practitioner and patient is an important part of the medical past, but it should not imply that doctors, psychiatrists, and nurses as individuals sought and cultivated such power. Some of the most recent work in asylum studies and the history of suicide points toward bias in the historical assessment of healthcare providers.¹³⁴ The critical edge of medical and psychiatric history developed for good reasons, but as the field matures, scholars must be cautious not to replace the quest for a more complete understanding of the medical past with an assault on the practice of healing itself.

The 1980s were a decade of growth and advancements for Canadian medical history, symbolised by some meaningful intellectual integration between doctors and historians. Charles G. Roland, introducing the first Hannah Conference in the History of Medicine in 1982, noted that there had never before been a conference devoted solely to Canadian medical history, that chairs in the field rose nationally from two to eight, and alluded to the establishment of the *Canadian Bulletin of Medical History/ Bulletin canadien d'histoire de la médecine* which released its first issue in 1984.¹³⁵

¹³³ Andrew T. Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (London: Penguin Books, 1979), 17. Scull associated institutionalization with urbanization and industrialization, but perhaps his most interesting argument is the need to turn *the family* of the 'mentally ill' into consumers of psychiatric services and the subsequent branching outward of all those, socially speaking, who could need treatment. Harvery G. Simmons, *from Asylum to Welfare* (Downsview: National Institute on Mental Retardation, 1982), 178. One might also consider Roy Porter, *A Social History of Madness: The World Through the Eyes of the Insane* (London: Plume, 1989). Writing exclusively from memoirs of individuals confined in asylums, Porter wrote critically, prominently displaying Nathaniel Lee's quip from 1684: "They called me mad, and I called them mad, and damn them, they outvoted me," but lacked the systemic view of confinement exhibited by Scull and Simmons.

¹³⁴ For example see David Wright and John C. Weaver eds. *Histories of Suicide: International Perspectives on Self-Destruction in the Modern World* (Toronto: University of Toronto Press, 2009) and Alan Somerville, "Ashburn Hall 1882-1904," in eds Barbara Brookes and Jane Thomson 'Unfortunate Folk: 'Essays on Mental Health Treatment 1863-1992 (Dundee: University of Otago Press, 2001), 83-103. Weaver and Wright's introduction chart developments in the history of mental illness, using suicide as an action that engages with psychiatry but also has social motivations. Somerville employed a nuanced look at asylum conditions. He accepted conditions were not perfect, but tried to be fair to doctors. In effect he argued doctor's primary motivation was to help their patients as much as possible.

¹³⁵ Charles G. Roland, "Introduction" in ed Charles G. Roland *Health, Disease and Medicine: Essays in Canadian History* (Toronto: T. H. Best Printing Co. Ltd, 1982), 11-13

Hannah conferences were especially important as they drew interest from practising physicians, psychiatrists plus members of legal and educational faculties. By fostering collaboration, these academic meetings helped move Canadian medical history away from its older literature written almost exclusively by doctors for doctors.

In 1983 Shortt argued that hospital history in Canada consisted mainly of ‘Whig’ narratives, focused on the inevitability of progress and doctor’s achievements. Referencing emerging British and American hospital historiographies he saw three meritorious discoveries: that hospitals were not ‘gateways of death,’ that they sought moral reclamation of the poor, and that they spurred medical professionalization. Thus, Shortt recommended that Canadian scholars should accept those premises, while also emphasising the therapeutic efficacy of the hospital, the views of attendants and physicians, and the patient’s perspective.¹³⁶ Following Shortt’s suggestions the hospital could move from the periphery of medical history to a position of social and political significance.

Two styles of medical history that flourished in the 1980s were the medical biography and the discovery narrative. While not intrinsically connected—a biography does not need to entail discovery nor does a discovery need to outline the life of the discoverer—these approaches tended towards emphasising the genius of certain individuals and great accomplishments, while minimizing the value of others in the field. Medical historian E. A. Heaman defended biography as a valid way for historians to learn about the past by arguing that when done properly one learned not only about the life of the subject but also the times in which he lived.¹³⁷ Heaman’s argument is fair, since society certainly shaped the lives of historical actors. Unfortunately, medical biographies often fail to

¹³⁶ S. E. D. Shortt, “The Canadian Hospital in the Nineteenth Century: An Historiographic Lament,” *Journal of Canadian Studies / Revue d’études canadiennes* 18 (1983): 4, 10-11.

¹³⁷ E. A. Heaman “Introduction: Michael Bliss and the Delicate Balance of Individual and Society,” in eds E. A. Heaman, Alison Li, and Shelly McKellar *Essays in Honour of Michael Bliss: Figuring the Social* (Toronto: University of Toronto Press, 2008), 5.

integrate their subjects into social milieu, only engaging social relations within the laboratory, medical school, or professional communities.

First Nations's medicine, where the practitioner fit into a different set of power relations, is an instructive example of the importance of social setting. Research by Mary-Ellen Kelm and J. R. Miller demonstrated the practice of medicine was an activity Europeans sought to regulate. In residential schools children were inspected, 'healed,' and medicated. For Kelm, medicine became about power and control over the body; however, she afforded First Nations agency in her conclusion arguing many associated certain illnesses with Europeans and their medicine while relying on traditional practices for ailments that fit within its purview.¹³⁸ Miller's emphasis on the horrors of residential schools placed European medicine along with religion, language, and diet as tools of assimilation.¹³⁹ Social historians of European and North American medicine looked past the practitioner to the patient to upend existing power relations, whereas in the context of First Nations the endurance of traditional practitioners and medical beliefs was the most direct route for upsetting cultural dominance.

In the 1990s scholars began debating how successful the social approach was, where the field was headed, and what it had accomplished. However, other historians were cautious, wondering

¹³⁸ Kelm *Colonizing Bodies*, 155, 161, 175. For a survey on First Nations and health starting at contact see James B. Walden, D. Ann Herring, and T. Kue Young, *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives* 2nd ed. (Toronto: University of Toronto Press, 2006). Two books that explore the history of Shaman medicine in British Columbia include Robert E. McKechnie, *Strong Medicine: History of Healing on the Northwest Coast* (Vancouver: J. J. Douglas Ltd, 1972), 42. McKechnie's language is dated, but does conclude that shamanistic practices were not as illogical or as harmful as some historians had assumed. However as a medical doctor himself he could not fully eschew a belief in the innate truth and progress of Western medicine. Also T. F. Rose, *From Shaman to Modern Medicine: A Century of the Healing Arts in British Columbia* (Victoria: Mitchell Press Limited, 1972), 2. Rose, also a doctor, suffered from the inability to understand how important it was for medicine to fit into social understanding and consciousness. While he applauded First Nations for using mouth-to-mouth resuscitation, he hit a caustic note explaining that they *thought* their actions were really 'putting the spirit back.'

¹³⁹ J. R. Miller *Shingwauk's Vision: A History of Native Residential Schools* (Toronto: University of Toronto Press, 1996), 34, 131-133.

what differentiated the social history of medicine from social history with a medical topic.¹⁴⁰ Locating a divide between medical and social history requires engagement with international literature on the historiography of medicine. The injection of race, class, gender, and ethnicity as major analytical categories influenced the writing of Canada's medical history, but ideas of power and control remained present too.

British medical historian Andrew Wear appraised the social history of medicine in 1992 as having “come of age,” for having washed away the ‘old medical history’ of “great doctors, great discoveries, and great ideas.”¹⁴¹ Wear's argument was threefold: historians were more sensitive to the ways in which society and medicine shaped one another, the literature had shifted away from glorifying ‘great doctors,’ and the definition of medicine within the field was broader than ever before. His assertions hardly seemed controversial, yet within a year Ludmilla Jordanova, a fellow British medical historian, responded in challenge. She argued that Wear's criteria cloaked major deficiencies of the social history of medicine. Jordanova expected a mature field to meet four benchmarks—a body of primary literature known to most scholars, a basic map or mission statement for the purposes of historical inquiry, a diverse secondary literature, and more coherent and sophisticated debates—that she found wanting.¹⁴² Rather than calling for more distance from ‘big histories,’ Jordanova recommended scholars engage in sophisticated analysis of older topics. A major issue for her was the lack of overview histories or medical biographies, believing that despite Whig treatments by an older generation, less triumphant studies would add crucial depth to the current stock of literature.¹⁴³

¹⁴⁰ Thomas Brown “Has the History of Canadian Medicine Come of Age? Personal View” *Canadian Bulletin of Medical History/ Bulletin canadien d'histoire de la médecine* 17 (2000): 14

¹⁴¹ Andrew Wear, “Introduction” in *Medicine in Society*, ed. Andrew Wear (Cambridge: Cambridge University Press, 1992), 1.

¹⁴² Ludmilla Jordanova, “Has the Social History of Medicine Come of Age?” *The Historical Journal* 36:2 (1993): 437.

¹⁴³ *Ibid*, 438.

British debates on the state of their field did not go unnoticed in Canada. Medical historian Thomas Brown applied Jordanova's four criteria to the state of Canadian literature finding similar results. He was optimistic about the future accessibility of Canadian medical archives through projects such as the Health and Medical Archives Information Network (CMAIN, although the project appears to have only survived in British Columbia). On secondary sources Brown's optimism ran dry. He described medical historiography in Canada as "full of black holes," in large part because so many historians focused on the late-19th and 20th centuries.¹⁴⁴ Jacques Bernier observed shortly after Brown's publication that medical history in Canada was "critical, but not very well known."¹⁴⁵ Such a temporal bias most adversely affected the medical past of New France and First Nations. A stronger push for historians to delve into these topics is important for medical history but also for Canadian historiography in general.

The most significant monograph in the historiography of western hospitals is Gunter B. Risse's *Mending Bodies, Saving Souls: A History of Hospitals* (1999). This sweeping account spanning from 145 CE to 1980 established or synthesised virtually all of the major epochs of hospital history. Several of these—priestly medicine, magic cures, monastery hospitals, humoral theory, barber-surgeons, plagues, and the enlightenment and French Revolution's transformation of hospitals and medical education—are not pertinent for this dissertation. No other source contains such a complete survey. Risse's timeline extends into the 20th century and provides a framework for hospital historiography. It covers the major transitions of 20th century hospitals, the advent of antiseptic and anesthetics, the growth of private wards and pursuit of privacy, the expansion of medical education, and a tightening relationship between government and health care.¹⁴⁶ However,

¹⁴⁴ Brown "Has the History of Canadian Medicine Come of Age?" 11-12

¹⁴⁵ Jacques Bernier "Disease, Medicine and Society in Canada: A Historical Overview," *The Canadian Historical Association* 63 (2003): 1.

¹⁴⁶ Risse, *Mending Bodies, Saving Souls*, 339-345, 478-480, 515-520, 571-574

he does not touch upon Canada at all. Indeed, if there is a criticism—and it is a somewhat unfair one given his grand scope—it is that the movement of regions and time periods tend to align with the dominant nations of the day rather than providing a rounded picture. In antiquity he focuses on the Romans and Byzantines, in the early modern period it is predominantly the French and English, by the 20th century American examples dominate the text. For this reason the direct historiographical value for a Canadian project comes from the historical framework and analytical comments.

Risse's framework for hospital history rests upon two key premises. The first is that these institutions cannot be understood without careful attention to religion, society, science, economics, disease, and social attitudes towards welfare and charity. In some ways this is the great divide in hospital histories—do they focus on medicine above all else or do they seek to cast the hospital as a social, political, and cultural locus? Risse's endorsement of the blended approach that insists upon viewing the hospital as a negotiation of these forces goes a long way toward legitimizing that method. The second key premise is that “the generic hospital is an abstraction. In reality, there are only particular hospitals, each with its unique name, patrons and mission, buildings, staff, and patients. Thus, hospitals acquire their own identities reinforced by architectural features and interior furnishings.”¹⁴⁷ In part this aligns with a central argument of this dissertation, that the hospital is not a single building, or even a completed one, but rather a continuously expanding project that embodies community particularities as well as medical science. Risse makes this argument in a broader sense. Hospitals are interconnected with, and products of, their social, political, and cultural milieu. Thus to attempt any sort of totalizing theory or set of expectations will fall short of revealing the true significance of these institutions.

Two scholarly examples from Canada that attempt the ‘institutional’ biography without straying from an expanded view of the medical past are Colin Howell's *A Century of Care: A*

¹⁴⁷ Ibid, 4.

History of the Victoria General Hospital in Halifax 1887-1987 (1988), and David Gagan's '*A Necessity Among Us*' *The Owen Sound General and Marine Hospital 1891-1985* (1990). Howell—unfortunately eschewing footnotes in the hopes of making the monograph more accessible to a popular audience—channelled Shortt and his complaints of 1982 in his preface. “Victoria General did not arise naturally out of the unfolding of some law of progress or technological advancement. Rather, the many achievements of this institution over the past century derives from the human agency of men and women who both served or were served by the Hospital itself. The story is thus a human story.”¹⁴⁸ What followed was an argument relating the squalid conditions of 19th century Halifax to the rise of a charity hospital while also interrogating the ‘social gulf’ that existed between patients drawn from the margins of society and the middle-class doctors who tended to them. It is unknown if Shortt influenced Gagan as he does not cite him. However, he too rejected “the customary iconography of the history of medicine as it used to be written – heroic surgeons wise and avuncular GPs, self-less nurses, harrowing medical ordeals, scientific miracles, and assorted institutional ‘characters.’”¹⁴⁹ His subsequent analysis traced the growth of the hospital in relation to Owen Sound’s economic milieu, explored the professionalization of doctors between 1900 and 1925, and the distrust it created in patients.

Perhaps the single most important monograph for the social history of Canadian hospitals is *For Patients of Moderate Means* (2006) by David and Rosemary Gagan. Focusing on the 20th century the Gagans emphasized the shift from hospitals as the last resort of the sick poor toward the preferred space for medical treatment. “When, for the first time in history, scientific and technological progress enabled individuals to purchase health, hospitals, it may be argued, progress

¹⁴⁸ Colin D. Howell, *A Century of Care: A History of the Victoria General Hospital in Halifax, 1887-1987* (Halifax: Victoria General Hospital, 1988), 7.

¹⁴⁹ David Gagan '*A Necessity Among Us*' *The Owen Sound General and Marine Hospital 1891-1985* (Buffalo: University of Buffalo Press, 1990), xi.

from treating the poor for the sake of charity to treating the rich for the sake of revenue.”¹⁵⁰ Technological advancement and thirst for profit within medical ranks coexisted with the book’s essence and helped fit hospitals into the social fabric of Canadian cities. The Gagan’s monograph serves as a Canadian version of Moris J. Vogel’s influential *The Invention of the Modern Hospital* (1980) in which he argued that the hospital’s image was shaped by the patients that used it and the 20th century shift from the periphery of medical care to the centre.¹⁵¹

Beneath the medical and economic aspects of the book—in terms of technological progress and municipal will to build institutions—the Gagans focus on the rise of middle class patients entering general hospitals. The Gagans argue that growth in population, urbanization, and immigration during the early 20th century was insufficient to account for the ballooning size and audience of hospitals. These changes may have pushed greater numbers of more sick poor and their contagious diseases into public hospitals, but it would not have led to an increase in profit, nor would it have led to the subsequent credential bolstering provided by hospital work that spurred physicians by the hundreds into these facilities.¹⁵²

The argument poses some difficult questions for the history of Canadian hospitals before the 1920s. On one hand, it would be entirely believable that there was a lag period between the sudden benefits of ‘Listerism’—which were discussed as early as 1884 in the *Canadian Lancet*—and the broader social acceptance and embrace of the hospital. On the other hand, a great deal of energy, time and money was invested throughout Canadian cities in the late-19th century. This included cities like Winnipeg and Calgary where resources were scarce and the institutions survived only because of

¹⁵⁰ David Gagan and Rosemary Gagan, *For Patients of Moderate Means*, 16.

¹⁵¹ Morris J. Vogel, *The Invention of the Modern Hospital: Boston 1870-1930* (Chicago: University of Chicago Press, 1980), 2-3. Ultimately a class argument, much like what the Gagans make.

¹⁵² David Gagan and Rosemary Gagan, *For Patients of Moderate Means*, 4-5

the dogged determination of community leaders and organizations. The Gagan's skirt the issue by suggesting that prior to the 1920s hospitals were typically well-intentioned but ineffective charities.

Two issues arise from the Gagan's argument. If hospitals remained primarily caring centres for the poor, their social significance would not necessarily disappear. Furthermore, since these institutions remained cash-strapped well into the 20th century patients of means were important and desired, but did not make the institution profitable. Thus other forces must have kept them operating. The following case studies demonstrate how even in the early 20th century when general hospitals rarely had static locations let alone wealthy clients there was sufficient civic demand and resolve to keep them open. Further, once some degree of stability was attained, issues of debt and calls for fundraising and donations remained constant. The Gagan's correctly note the theory for hospital solvency was to operate public wards at a loss to provide medical education and make up the budgetary difference by providing premium service to paying patients. Yet institution charters contained no expectation of profit, most administrators and indeed doctors were unpaid, and the government grants they actively sought would not have been provided to a profitable business. The Gagan's trace the history of an important, new demographic of patients into the framework of the 20th century general hospital; however, they are slightly over-committed to explaining the institution through a single channel.

Among Canadian historians who combine class and gender with architecture and medicine Annmarie Adams is in a category of her own. In *Architecture in the Family Way* (1996) and *Medicine by Design* (2008) Adams explored how medicine changed within different spaces. *Architecture* explored Victorian notions and expectations of womanhood, while demonstrating that the house's shape influenced medical practice. Linking medicine and femininity revealed how birth was one of many 'women's issues' along with childcare, immunization, and milk pasteurization that

became integrated into professional medicine and public health initiatives in the early 20th century.¹⁵³

With an emphasis on midwives, Adams argued that the space and design of the home had meanings to medical practitioners different from other occupants, and the practice of domestic medicine was more than a house call. Thus, medicalising the home was part of a more complicated process that involved maintaining images of respectability, and interaction between doctors and women.¹⁵⁴

Medicine by Design forwarded an innovative argument, the spirit of which informs this dissertation. By using Montréal's Royal Victoria Hospital as a case study, Adams argued that despite the constants of physical dimensions the hospital was not the same space for all who entered, and that the experience of moving through the building or spending time in it differed sharply based on race, class, and gender.¹⁵⁵ Thus, appearance and accessibility fluctuated depending on who entered. Adams's work represents not only a full embrace of social history's tenets on a medical topic, but expanded them to include how members of society experience medicine and its institutions in different ways.

Adams's methodology has an obvious appeal to social historians of medicine, but it also related to the changes in hospital administration during the late-19th and first half of the 20th centuries. Between 1880 and 1939, Adams argues, general hospitals became highly segregated spaces.¹⁵⁶ Part of the change derived from medical technology. As hospitals became safer there arose a natural need to provide services beyond wards for the indigent ill. However, the services that developed owed to social, political, and economic influences as well as scientific ones. Realizing that hospitals could heal rather than just warehouse the sick, administrators, architects, and doctors

¹⁵³ For one of the best general overviews of public health in Southern Ontario see Heather MacDougall, *Activists and Advocates: Toronto's Health Department, 1883-1983* (Toronto: Dundurn, 1990).

¹⁵⁴ Annmarie Adams, *Architecture in the Family Way: Doctors, Houses, and Women, 1870-1900* (Montreal: McGill-Queen's University Press, 1996), 38, 73-78, 105-109.

¹⁵⁵ Adams, *Medicine by Design*, 128-130.

¹⁵⁶ *Ibid*, 34.

scrambled to build institutions that could cater to a broader public. Thus, the internal space became divided and organized and these divisions strictly enforced.

Adams is as much an authority on architecture as innovative historian. *Medicine by Design* is a model for the social history of medicine, with significant portions devoted to patient experience and to nuances separating patients of different classes and genders. At times the narrative is focused on architectural designs and the men who drew them. The quality of this study drives a new research agenda, though it could focus more on administration, municipal politics, and the expectations of doctors and patients. Adams, however, does not lionize the architect as Bliss does with physicians. An enduring aspect of her scholarship has been to resist the crusade of doctors and architects to build ‘superhospitals.’ She would prefer to see older buildings preserved or repurposed as opposed to demolished.¹⁵⁷ Architects and design are important to the story of Canadian hospitals, but too much emphasis on can lead away from the practical decisions made by administrators. As well, blueprints distract attention from the negotiation and expedient cost-cutting that directed demolition, renovation and construction.

By far the best academic institutional biography of a Canadian hospital is J. T. H. Connor’s monograph *Doing Good: The Life of Toronto’s General Hospital* (2000). Though Connor accepts, in fact suggests, the classification of his book as an institutional biography, it is highly extraverted, and not at all insular as many similar projects were. Indeed, one of his stated aims was to examine how the TGH arose alongside the community and country it served.¹⁵⁸ One of his most convincing arguments relates to the balance struck by doctors and administrators in the early 20th century between the competing hospital agendas of philanthropy and education. The true cost of public ward

¹⁵⁷ Annmarie Adams, “Borrowed Buildings: Canada’s Temporary Hospitals during World War I,” *Canadian Bulletin of Medical History/ Bulletin canadien d’histoire de la médecine*. 16 (1999): 45-46. Annmarie Adams, “Critical Care? Reusing Montreal’s Royal Victoria Hospital” (paper presented at Hospital / Hôpital IHSP 2015 Conference, Montréal, Quebec, October 1-2, 2015).

¹⁵⁸ Connor, *Doing Good: The Life of Toronto’s General Hospital*, 9,11.

care at the TGH—as elsewhere—for the patient was privacy. In exchange for free, discounted, or otherwise subsidised care the patient had to accept the presence of students, both medical and nursing, while being attended to by a physician. Connor neatly fits this argument to the Canadian environment noting that the rise of responsible government separated church and state, removing connotations of religious charity from the TGH and allowed secular university interests to fill the void.¹⁵⁹

Connor's background in the history of medical technology and education at times become a driving force. Students receive frequent mention and in fact largely comprise the second half of the monograph whereas patients are discussed less. One section relates a variety of patient examples including, a young girl with leprosy who poked needles into the dead flesh on her face, a man with a pipe stuck in his penis, a boy addicted to masturbation and other peculiar situations.¹⁶⁰ Fascinating though such anecdotes may be, they are also inconsistent, coming as a block of examples at the end of chapter that did not go into nearly as much detail examining how other aspects of hospitals life or organisation shaped the more typical patient experience. Still, Connor is not blind to the importance of patients; his monograph is among the best in the field.

There is a fourth body of literature—the sociology of space—that warrants comment. Its origins reside with Durkheim and Weber and the development of urban sociology which built upon their ideas. For hospital history one of the most important elements of this literature is the idea of space as a resource, and the idea that it is a social product that shapes the experiences of individuals and interactions between people.¹⁶¹ As noted earlier with Adams's work on hospital architecture and

¹⁵⁹ Ibid, 264. A key pillar in his argument for the shift from charity to education as the TGH's *raison d'être*.

¹⁶⁰ Ibid, 153-155.

¹⁶¹ See Derek Gregory and John Urry eds., *Social Relations and Spatial Structures* (London: Macmillan, 1985) James Moran, "Architects of Madness: Informal and Formal Spaces of Treatment and Care in Nineteenth-century New Jersey," *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*. In eds. Leslie Elizabeth Topp, James E. Moran, and Jonathan Andrews (New York: Routledge, 2007), 151-71.

experience, space must not be treated simply as a static set of dimensions. For the purpose of this dissertation space is considered foremost a sensory experience, not a set of measurable areas that exist outside the bounds of human perception. One of the resultant challenges of this approach is the pursuit of evidence or at least clues. Close attention must be paid to acoustics, smells, temperature, colours, lighting, and—most difficult of all—the ‘feel’ of a given place.

The history of hospital administration is less studied than the history of hospital administrators. Biographies of individuals who oversaw hospitals are common. The best Canadian example is Michael Bliss’s biography of Toronto business tycoon-cum-TGH chairman Joseph Flavelle.¹⁶² However, the study of administration both as a contested process that negotiated with multiple interests or as a field of professional knowledge is less well-known. Although administration and the development of a bureaucratic class professional body has been studied in other contexts, to put together a collection of this literature for medicine in general and hospitals in particular requires some cobbling.¹⁶³ The sheer complexity of administration at the end of the period studied in this thesis makes the subject intrinsically interesting; eminent to public interest yet largely out of public view.

The most important Canadian source on hospital administration is Agnew’s combination of study and memoir *Canadian Hospitals 1920-1970*. The merits of Agnew’s account are also its liabilities. He was an insider and could not avoid assigning significant influence to doctors and later

¹⁶² Michael Bliss, *A Canadian Millionaire: The Life and Business Times of Sir Joseph Bart Flavelle, 1858-1939* (Toronto: Macmillan of Canada, 1978). For a British example see: Abel-Smith, *The Hospitals 1800-1948*. For something more recent and focused on the United States see M. Arndt and B. Bigelow, “Hospital Administration in the early 1900s: visions for the future and the reality of daily practice,” *Journal of Healthcare Management* 52 (2007): 34-47.

¹⁶³ Doug Owsam, *The Government Generation: Canadian Intellectuals and the State 1900-1945* (Toronto: University of Toronto Press, 1986). Though there are many viable examples, one that fits especially well with the emphasis on rhetoric in this chapter is Jacquie L’Etang, *Public Relations in Britain: A History of Professional Practice in the 20th Century* (London: Routledge, 2004). For a more theoretical piece examining the changing world of public, private, and professional relations as well as the power dynamics between them see Jurgen Habermas, *The Structural Transformation of the Public Sphere: An Inquiry into a Category of Bourgeois Society* (Cambridge: Polity Press, 1989). For a brief Canadian introduction see Christy Simpson, “Getting Engaged: Exploring Professionalization in Canada,” *HEC Forum* 24:3 (2012) 149-151.

administrators. He excessively details the shortcomings of past hospitals relative to the standards of the 1970s. For instance he makes much of the stench of burning rubber as nurses boiled catheters, the inadequate wiring, “armies” of rats, silverfish, and cockroaches in the kitchens, and how hiding pipes within the structure represented the “height of sophisticated hospital design at the time.”¹⁶⁴ Valid complaints all, but he compared the past with the present in an unfair manner, and did so largely to accentuate how improved hospitals had become by the 1970s. Triumphalism is a hindrance throughout the book, but putting that aside it discloses a lot about the professionalization of medicine in Canada. Agnew provides an encyclopedic survey of the development of health boards and associations both at the provincial and private level in each province. Further, his section on the history of hospital administration is by far the most complete in the Canadian literature.

For Agnew, the story of administration was one, predictably, of progress. However, due to his exhaustive knowledge of Canadian hospitals, and willingness to write at length, he also makes us aware of the diversity among administrators throughout the 20th century. The position was not a profession until at least the 1930s. Thus, in smaller hospitals administrators were often nurses, whereas in other cities they came from the ranks of bankers, businessmen, retired military men or philanthropists who wanted to do some good with their time. In fact, the frequency of female administrators can hardly be overstated. A 1929 survey of 7,610 hospitals in the United States and Canada found approximately 40% of superintendents were nurses, nuns, or lay-women.¹⁶⁵

Thus, the early administrator was often untrained in either administration or medicine. The institutions were classrooms for management. For Agnew, a major development between 1920 and 1970 was the movement of administrators, along with their various titles such as executive director,

¹⁶⁴ Agnew, *Canadian Hospitals 1920 to 1970*, 7-9.

¹⁶⁵ Michael M. Davis, *Hospital Administration, A Career: The Need of Trained Executives for a Billion Dollar Business, and How They May Be Trained* (Chicago: Self Published by author 1929), 8. The survey was undertaken by the American Medical Association.

vice-president and president, away from voting members to attending members on the hospital's board of trustees.¹⁶⁶ The administrator in this sense stood astride the board of trustees. Their job was organizing the hospital on a daily basis as if atop a pyramid, while liaising with trustees on major matters such as adding new buildings, and issued reports on the state of the institution. Agnew is surely correct on this separation as a long-term trend; however, in practice for much of the 20th century there were constructive connections between trustees and administration. Committee reports flowed up and trustees often sat on executive committees.

Agnew categorized administrations according to whether they were predominately composed of medical men and women or, beginning in the 1920s and 1930s, university-educated. One of the most significant moments was the 1933 formation of the American College of Hospital Administrators, spurred by the fact lay administrators in the 1920s began attending meetings of the American Hospital Association which demonstrated an appetite for professional recognition. In 1935 Malcolm MacEachern published his *Hospital Organization and Management*, which was one of the first and most widely-read treatises for administrators.¹⁶⁷

In 1928 Marquette University offered the first graduate program for hospital administration. It lasted only one year due to lack of enrollment. The University of Chicago began a graduate programme in hospital administration in 1934; it survived and other universities followed. In Canada graduate courses in hospital management did not appear until 1946 when the University of Toronto offered one.¹⁶⁸ By 1970 hospital administrators were often trained specifically as such while trustee boards began to contain more doctors. Agnew supported this split. He encouraged administrative education to advocate for a “greater role” in managing the medical side of hospitals in addition to financial, public relations, and internal committee roles. He also hoped for an expanded vision of

¹⁶⁶ Agnew, *Canadian Hospitals 1920 to 1970: A Dramatic Half Century*, 130.

¹⁶⁷ Malcolm MacEachern, *Hospital Organization and Management* (Chicago: Physicians' Record Co, 1935)

¹⁶⁸ Agnew, *Canadian Hospitals 1920 to 1970: A Dramatic Half Century*, 132-133.

what the hospital could achieve in terms of education and research. The importance of American universities and medical organizations—and as the subsequent chapters demonstrate consulting firms—underscore that Canada was a North American country, and ideas and professionals flowed across borders.

American medical historians have a richer tradition of studying hospital administration as a profession. In 1989 American historian David Rosner argued that the field of hospital administration developed with three “intertwined and sometimes contradictory goals” in mind: to handle the business and economic issues of the hospitals including the logistics of acquiring food, laundry, cost accounting and the like, to provide basic social services for patients such as determining release protocols, securing home care and similar services, and to maintain moral and social order within the institution. In simplest terms the administrator had to act as the intermediary between patients, doctors, nurses, family members, and support staff.¹⁶⁹ Rosner argues that after the 1940s administrators shifted their focus away from providing moral and medical services to functioning as business managers. The hospital boards and administrations discussed in this thesis had no shortage of worry over both the provision of medical care and finances—or more accurately debt. Rosner makes the optimistic argument that the business impulse competed with a long history of civic-minded individuals seeking these positions, and that a business ethos is not assured to take over despite substantial inroads made by this mentality after the Second World War.

Morris Vogel provided one of the few early accounts of the context from which a professional body of hospital administrators emerged. In a 1989 essay covering the years 1895-1915 he examines lay-person led hospitals in the United States. He acknowledged that the organization of

¹⁶⁹ David Rosner, “Doing Well or Doing Good: The Ambivalent Focus of Hospital Administration,” in *The American General Hospital: Communities and Social Contexts*, ed. Diana Elizabeth Long and Janet Golden (Ithaca: Cornell University Press, 1989), 157. Though the American context is quite different, the Rosner thesis that the type of individual attracted to the role and the sense of an established ethos of service and humanitarian care is important, especially in the early part of the 20th century as this was a professional field that was truly transnational at the time.

this group also involved Canadian administrators. Vogel cites three reasons for the movement towards a professional class of administrator: the rise of middle-class patients which brought in more money to account for while increasing outlay, the architectural requirements of antiseptic and anesthetic techniques which required new, designed buildings, and the increased participation of administrators at medical gatherings.¹⁷⁰ The cost and architectural requirements of facilitating more complex surgeries challenged administrators to keep hospitals from going too far into the red. They were aware how other medical professions, notably doctors, were forming associations. These administrators followed a similar path organizing sponsoring journals, sharing information, and eventually seeking specialized university education.

The 1980s saw an outpouring of literature from sociologists, architects, and neuroscientists that sought to locate healing properties in space itself. The research of these scholars aligns in two ways with this dissertation. First it demonstrates that there is a relationship between space, healing, recovery and health. Second, it shows how the spatial concerns of administrators, doctors, and patients that are examined in the subsequent chapters were not insular reactions to the challenges of daily hospital life. These concerns endured and became a focus for professional groups. Based on this body of research the Academy of Neuroscience for Architecture was formed in 2003. The publication of behavioural geographer Roger Ulrich's research into environmental effects of surgical recovery rates in 1984 was a turning point for the field, and aspect of a broader movement in the social sciences that sought to understand how design played an active role in human experience.

Ulrich studied the recovery rates of patients in a Pennsylvania hospital who had undergone cholecystectomy—removal of the gallbladder—between 1972 and 1981. His data included the same 200 beds on the second and third floors of the building, the same nurses, excluded the very old and

¹⁷⁰ Moris J. Vogel, "Managing Medicine: Creating a Profession of Hospital Administration in the United States, 1895-1915," in *The Hospital in History*, ed. Lindsay Granshaw and Roy Porter (London: Routledge, 1989), 244-246.

young, and those with psychological disorders. The rooms contained two patients, each with a clear view of the window, as well as virtually identical furnishings and arrangements thereof. The key variable was the crop of deciduous trees one side of the wing overlooked compared to the other side which faced a brick wall. To amplify the relevance of the environment Ulrich limited the recovery periods to those within 1 May and 20 October to ensure that there were leaves on the trees.¹⁷¹ His research demonstrated that ‘tree view’ patients had shorter postoperative recovery periods, fewer complications, fewer negative review comments by nurses, and less frequent and strong doses of analgesic. Ulrich was not suggesting only natural scenes were beneficial. He argued that his research should not be interpreted as a triumph of nature over artificiality. His point was that built space could have a profound effect on recovery, and that architects, doctors, and administrators should not ignore it.

Ulrich’s ideas remain current, as demonstrated by Esther Sternburg’s *Healing Spaces: The Science of Place and Well-Being* (2009). Sternburg, a medical doctor, provides a series of chapters examining hospitals from the perspective of a patient’s senses. She examined sound, lighting, and size as key components of what a patient must take in, in order to comprehend and perceive a space.¹⁷² Her two chapters on outsiders getting lost in hospitals are especially interesting as they demonstrate the difficulty patients have in moving through medical facilities as well as exposing the sheer complexity of modern hospitals. It serves as a potent reminder that what might be most plausible in theory—medical or architectural—may not translate into something that serves the patient.

¹⁷¹ R. S. Ulrich et al, “View Through a Window may Influence Recovery from Surgery,” *Science* (1984): 420.

¹⁷² Esther M. Sternberg, *Healing Spaces: The Science of Place and Well-Being* (Cambridge: The Belknap Press of Harvard University Press, 2009), 27, 54, 98, 151. A similar, and more recent, example focused on art instead of architecture may be found in Richard Cork, *The Healing Presence of Art: A History of Western Art in Hospitals* (New Haven: Yale University Press, 2012) Though Cork does not argue literally heals, he does suggest its presence has an important influence on mood, not only for patients but also staff and visitors.

British historian of hospitals Lindsay Prior produced a historiographical essay examining the use of spatial theory for hospitals, in which she emphasised Foucaultian language arguing that buildings were mechanisms for different forms of ‘power-knowledge.’ In other words space and society are not separate. Prior went on to describe hospital plans as essentially “archeological records which encapsulate and imprison within themselves a genealogy of medical knowledge,” and thus the changing aspects of ward design, size, utilities and technology reveal much about the nature of medical care provided, the experience of patients and “disclose innumerable principles concerning the conceptualization of disease and illness.”¹⁷³ To her credit she marshalled many practical examples: the construction of children’s wards to the rise of the child as a focal element of medical practice, the pavilion with miasmic ideas of disease, the asylum with the ‘invention’ of madness.

While Prior was most likely correct in proposing that there is significant historical detail lurking in spatial organization, it is less clear that medical knowledge and focus correlate so directly with building decisions. Maternity hospitals are one example. All four case study hospitals eventually built, or acquired, a separate building exclusively for such use. In Toronto this happened in 1878, in Winnipeg 1888, 1900 in Calgary and 1929 in Vancouver. The temporal spread is not tremendous, though the difference between Vancouver and Toronto is nearly fifty years. Why did the medicalization of childbirth proceed differently? The discrepancy must then be explicable in some other way, and it is. All these buildings had very different origins. For example the Winnipeg maternity wing was funded by civic organization rather than being part of administrative plans. While Prior’s discussion on space is helpful, and her recommendation of architectural analysis vis a vis hospitals makes sense, there are drawbacks. The organisation of wards, wings, and staff areas reveal social and medical information.

¹⁷³ Lindsay Prior, “The Architecture of the Hospital: A Study of Spatial Organization,” *The British Journal of Sociology* 39:1 (1998), 93.

One of the best books discussing the history of modern hospitals, and the administration thereof, is Rosemary Stevens's *In Sickness and In Wealth* (1989, 1999). Stevens wrote one of those rare books where even offhand comments contained significant arguments. For example, her core contention was that hospitals in the United States had 'chameleon-like' qualities allowing them to assume a different "social surface" depending upon political, medical, social, and economic circumstances. Even voluntary hospitals had become expansionist, income-maximizing institutions, behaving essentially like businesses. However, they retained a symbolic and social significance as embodiments of hope, science, technology, and expertise, as well as altruism, social solidarity and community spirit.¹⁷⁴

The emphasis of American scholars on the business of hospitals highlights the similarities and differences with events in Canada. Canadian hospitals struggled with finances and took on debt, especially before the Second World War when both the provincial and federal governments were fairly aloof in terms of providing funds. However, American hospitals routinely mortgaged property and buildings in the 1980s and 1990s. This was not the case with the TGH, WGH, CGH, or VGH, nor do the records of these institutions suggest that was even under consideration. The American hospital occupied a peculiar space between the public and private sector just as its Canadian brethren did. However, the 20th century Canadian hospital strengthened its ties with the state and university as opposed to those in the United States that pursued a more independent, market-oriented approach.

Much like other Canadian topics, hospital historiography requires reaching outside national boundaries with some regularity. The work of the Gagans, Adams, Howell, and Connor provides a good foundation. Porter, Granshaw, Risse, Prior, Verderber, Rosen, and Vogel worked in a European or American framework. There is also regional historiography relating to the cities of the case study

¹⁷⁴ Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (Baltimore: Johns Hopkins University Press, 1999, xi-xii, 6.

hospitals, and is dealt with in the following chapters. The social history of medicine has been established as a field, but more is needed especially as it applies to hospitals. Indeed one of the shortcomings of meta-style histories such as Risse or the Gagens is they cannot touch on individual hospitals with great detail. These studies miss the yearly administrative struggles, and the politicking that underwrote funding and construction.

Conclusion

Canadian medical history drew inspiration from scholars in Britain and the United States, and proceeded more slowly than its counterparts in terms of incorporating new theory and methodology. Nevertheless, the current state of the field shows promise. More research is needed on the Arctic, First Nations (especially on reserves), and New France. As the country's public health-care system rounds out its first half century reflective social histories are needed.¹⁷⁵ Medical history is no longer in the thrall of medical biography and 'great man' empiricism, but the marks of these approaches are burned deeply into its lore. Scholars are becoming aware that discarding discovery or 'great man' narratives is less important than subjecting them to new scrutiny and research. Thus, the critical current of medical history may now be focused on the discipline itself. The history of the body, suicide, diet, age, sport, public health, epidemics, and mental health now command the attention of historians, integrating society and seeking to reveal a broader image than previously existed.

Hospital history can be read a touch Whiggishly, beginning with pest houses or warehouses of death, slowly changing into philanthropic if equally unhelpful institutions, and finally arriving as doctor-focused seats of technical and scientific triumphs that guide the field in research and education. Ultimately this narrative is unsatisfying. For one, it is an obsolete approach to medical

¹⁷⁵ Liza Piper and John Sandlos, "A Broken Frontier: Ecological Imperialism in the Canadian North," *Environmental History* 12 (2007): 759-95. Frank Tester and Peter Kluchynski, *Tammarniit (Mistakes): Inuit Relocation in the Eastern Arctic, 1939-1963* (Vancouver: University of British Columbia Press, 1994). While not a history of health, attention is devoted to diet, alcoholism and housing conditions.

history.¹⁷⁶ With the advent of the social turn such a tale—even if true—would not be fulfilling, for it fails to explore the role of the patient, the integration of the hospital into civic networks, the extent to which the internal organization and available services were influenced by the hand of the architect, the patient, the politician, and community organizations. An expanded scope seeks to determine how hospitals functioned, grew, what hindered their expansion, and what enabled it. There are questions about how services were offered, ultimately determined, and which departments were funded or expanded.

A more expansive approach owes inspiration to three strands of study discussed in this chapter. Institutional biographies laid a foundation, provided the raw facts of when buildings were erected, when by-laws came into place, which administrators took over, and what their vision for the institution was. Critical history upended this viewpoint. It reminded scholars to think broadly, not to trust blindly, to realize purity of motive did not automatically result in purity of action, and that medicine did not always serve the patient. Finally, the social history of medicine brought the patient into prominence. For most of the 20th century the hospital's largest constituent was the public patient. These individuals filled general wards and outpatient clinics, and received care from the honorary attending staff. Scholars must approach the institution not solely as a “temple of scientific medicine.”¹⁷⁷ The hospital was a node in a civic, professional, and social network that combined various professions, bodies of knowledge, and people interfacing with them not only on the corporeal level of mending—or attempting to mend—sick bodies, but intellectually as it created pride, offered reassurance in times of crisis, and served as an organization hub for mobilizations such as world wars or staging points for disaster response during the Cold War. An academic conception of the hospital as just a building, space, or set of dimensions is less than the sum of its parts. A more

¹⁷⁶ Guenter B. Risse, “Hospital History: New Sources and Methods,” in *Problems and Methods in the History of Medicine*, eds. Roy Porter and Andrew Wear. (London: Croom Helm, 1987), 175-177.

¹⁷⁷ David Gagan and Rosemary Gagan, *For Patients of Moderate Means*, 181.

accurate image emerges when the hospital is viewed as a societal locus where municipal politics, medical education, health, and civic pride meet.

Inspiring writers like Risse, Porter, Connor, and Vogel was the importance of hospitals to civic life, and the position of scientific authority they occupy in modern society. A surge in surgical and therapeutic success rates in the 20th century elevated the hospital to the forefront of public and medical consciousness. Administrators enjoyed an unprecedented degree of acceptance as did their institutions—despite rocky starts they became civic treasures. As American medical historian Charles Rosenberg argued in the 20th century ‘the hospital became medicalized, and medicine became hospitalized.’¹⁷⁸ It was not just the medical profession, society too became medicalized. Institutions that once struggled to entice patients through their doors began having trouble convincing them to leave. In 1968 Dr. J. D. Wallace Executive Director of the TGH quipped, “If doctors worked as hard keeping patients out of the hospital as they do to get them in, we would have a much more effective health system.”¹⁷⁹ Surgical success helped elevate hospitals in social consciousness to positions of vanguards of modernity. However, there is an older impulse behind them that deserves explanation. The impulse to maintain spaces for the ill goes back thousands of years. In this sense these buildings are a leading component of social organization. There is an enduring drive in human societies to care for one another, and especially for the ill. This theme deserves recognition, and stands astride the histories of medical achievement, patient experience, and distrust.

¹⁷⁸ Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), 189.

¹⁷⁹ “Dr. J. D. Wallace, Executive Director to Mr. T. J. Bell,” 2 April 1968, 2-3. File TG 1.4.30 Box TGH-1430-1711 TGH Fonds UHN Archives

Chapter II – In “the interests of suffering humanity;” Years of establishment, spatial acquisition, and self-justification: 1880-1910

Between 1890 and 1910 social and medical perceptions of North American hospitals began transforming from charnel houses for the poor to the treatment facility preferred by all members of society. During the decades that followed hospital trustees, administrators, politicians, doctors, and citizens became embroiled in the challenge of responding to this change. The most obvious, and expensive, response was a flurry of building that continued until the Depression years of the 1930s. The emergence of a new, costly, and popular institution carried far-reaching ramifications for municipal governments and civil societies as responsibility did not fall neatly within any single purview. By the same token, none could easily claim exemption from owning some role in its maintenance. To properly appreciate this shift in medical consumption, it is important to establish the size, scope, and administrative structure of hospital facilities already in place. The years 1880-1910 were crucial to the history of modern Canadian hospitals as these institutions moved from the periphery of medical care to the centre.

Of the four hospital case studies in this dissertation only the Winnipeg and Toronto General Hospitals (WGH, TGH) were in operation prior to 1880. The WGH was established in 1872, and the TGH in 1820 as the ‘York General.’ The Vancouver General opened in 1886, and Calgary General in 1890 (VGH, CGH). The founding of general hospitals in the last quarter of the 19th century was a trend in urban Canada.¹⁸⁰ The TGH’s earlier establishment stands out from its peers; however, it did not begin to resemble its late-19th century brethren until 1853 when it moved to a 200-bed building on Gerrard Street.

¹⁸⁰ David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950* (Montreal: McGill-Queen’s University Press, 2002), 4-5. David Gagan ‘A Necessity Among Us’ *The Owen Sound General and Marine Hospital 1891-1985* (Buffalo: University of Buffalo Press, 1990), 10-12. Morris J. Vogel, *The Invention of the Modern Hospital: Boston 1870-1930* (Chicago: University of Chicago Press, 1980), 7-9.

The economic, social, and political context of Toronto differed notably from western-Canadian cities. By the 1880s the TGH was established in its community. The TGH also benefited from and interfaced with big businesses, philanthropy, university officials, and political connections earlier than its western brethren. In the west civic boosterism, political optimism, and the unflagging efforts of civil societies had a larger role. Economic context affected the west and east alike. Building and using hospitals had an economic component, and the fortunes of patient and institution cannot be severed from that context.¹⁸¹

Hospitals had many common characteristics during this period of establishment, but that did not nullify regional differences. The most striking similarity, and one that continued throughout the 20th century, was the tendency towards near-identical administrative structures. Boards of trustees and directors, house and building committees, medical boards, and women's auxiliaries appear within the management apparatus of all the general hospitals examined.¹⁸² Power relations between these entities—internal politics—and external forces such as the provincial government, municipality, or civil societies differed. Still, there was a general convergence of a 'mentality' or mode of institutional organization. Such a model reminds historians that hospitals reflected the milieu from which they emerged, and are prime candidates for social analysis.

¹⁸¹ Specific contexts are discussed in the subsections, for broad economic overviews see J. E. Conway, *The West: The History of a Region in Confederation* (Toronto: James Lorimer & Company, Publishers, 1983), J. Arthur Lower, *Western Canada: An Outline History* (Toronto: Douglas & McIntyre, 1983) and K. J. Rea, *A Guide to Canadian Economic History* (Toronto: Canadian Scholar's Press, 1991).

¹⁸² A note on the use of the word boards. Board, the board, directors, administrators are used largely interchangeably when referring to the formal, directorship of the hospital. These individuals were often doctors as well, but not necessarily and they were not the same type of administrator as a medical administrator on a ward or a department head. In those cases distinction are made. Boards were not monolithic; personalities could and often did clash, certain voices spoke in isolation or above others. In cases where such distinction is warranted names are stated. The choice to refer to the structure or office is an attempt to appreciate what cannot be gleaned from sources. Attributing an address by the president of the board, titled 'President's Address' ignores or obscures that hours of debate, discussion, and political bartering that happened in the preceding meetings. In the interest of capturing that somewhat, when there is not specific cause to pry individual actors out, the board is used to refer to the coven of individuals through whom ideas passed and led to the form in which they were eventually presented.

An important characteristic of these 19th century hospitals is size. The TGH is an exception as it serviced a large, urban population; however, most hospitals pre-1900 rarely had more than 50 beds. The size of these hospitals was a product of more than modest population. The concept of large institutions was not well-established in the minds of doctors, builders, or the general public. Large hospitals existed in Europe and the United States, but they remained largely bent on correcting behaviour, treating the very poor, eliminating vagrants from city streets, and isolating patients during epidemics.¹⁸³ Another aspect was the risk involved in building these institutions. In the 1880s anaesthetic and antiseptic advancements began tempting the middle classes into the hospital. However effective new drugs and techniques were, there was no wholesale public acceptance of these institutions. Funding, whether it came in the form of provincial monies, municipal debentures, or citizen donations were given on a fair measure of faith. A further contributing factor to the size of these early buildings was the difficulty in finding an adequate amount of doctors, orderlies, and nurses. Training and medical schools became fixtures of 20th century hospital planning, but in the early period such programmes were in their infancy and trained personnel were scarce.¹⁸⁴ Without sufficient staffing the hospital could not function regardless of how many beds it had.

The following subsections examine the founding of the VGH, WGH, CGH, and TGH from establishment until approximately 1910. In these formative years, hospitals tended to originate as charitable, citizen-organized institutions. They did not have an independent institutional history, but were often appendages or beneficiaries of ‘pioneer’ agencies such as the Canadian Pacific Railway

¹⁸³ Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (New York: Oxford University Press, 1999), 232-235. Erwin H. Ackerknecht, *Medicine at the Paris Hospital 1794-1848* (Baltimore: Johns Hopkins Press, 1967) xiv. Vogel, *The Invention of the Modern Hospital*, 99-100. Vogel makes the intriguing argument that type of dwelling played as much a role as population changes. Namely, that as apartments became more common it became less spatially viable to care for the sick at home.

¹⁸⁴ Lynn Kirkwood, “Enough but not too Much: Nursing Education in English Language Canada 1874-2000,” in Christina Bates, Dianne Elizabeth Dodd, and Nicole Rousseau eds. *On All Frontiers: Four Centuries of Canadian Nursing* (Ottawa: University of Ottawa Press, 2005), 183. Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*. (Toronto: Oxford University Press, 1996), 26-31.

(CPR), Northwest Mounted Police (NWMP), or Hudson's Bay Company (HBC). In particular, the western hospitals gained independence as civic needs increased demand of health services. However, they all accrued enough political capital to receive acts of incorporation and some access to public funds. At the close of the 19th century these hospitals had secure footholds in the communities they served. Furthermore, they accumulated respectable capital holdings in terms of buildings and property. They were not wealthy, but held enough fixed capital to be taken seriously. At the turn of the 20th century hospitals began expanding more rapidly. Medical advancements and public outreach began to clear the stigmas of the 19th century. Other circumstances helped increase the reputation of hospitals such as more efficacy in dealing with epidemic diseases, and changes in municipal politics that became increasingly focused on public health.¹⁸⁵

Toronto 1870-1910

The TGH is the second oldest general hospital in Canada, and therefore offers a different perspective from the 'frontier' hospitals of Winnipeg, Calgary, and Vancouver. In 1812, only 25 years removed from the 'Toronto Purchase,' the area of Upper Canada that became Toronto was closer to a frontier setting. But by 1880 the TGH enjoyed an established position within its community. By then the TGH had existed for several generations of Torontonians which helped it become a facet of civic consciousness and identity. The origins and initial establishment of the TGH fall beyond the scope of this dissertation, but a brief overview provides context and reveals a unique element of the TGH; as western hospitals struggled to establish themselves the TGH had already been around long enough to have its own myths.

The TGH sprung from charitable impulses unlike many of the young hospitals in newer territories that originated as corporate or government agencies. In that sense hospital history parallels

¹⁸⁵ Esyllt W. Jones, *Influenza 1918: Disease, Death, and Struggle in Winnipeg* (Toronto: University of Toronto Press, 2007). 24-26. Gagan 'A Necessity Among Us, 28. Heather MacDougall, *Activists and Advocates: Toronto's Health Department, 1883-1983* (Toronto: Dundurn, 1990)

the history of secular social services. The first hospital facilities in the Toronto area—then York—were military. During the War of 1812 there was a surge of impermanent facilities for soldiers. The Loyal and Patriotic Society of Upper Canada (LPSUP) formed in 1813 around two principles; alleviating war-time distress and commemorating Upper-Canadian volunteers. Initially the LPSUP planned to use its resources for commemorative purposes. The LPSUP solicited approximately £13,000 in donations for commemoration by 1817; however, it spent almost £8,000 of that sum on private physician care for veterans. Caring for veteran's health was becoming a major line in the organization's budget, but it did not turn away from commemoration immediately.¹⁸⁶

In 1817 the LPSUP took a major step to pursue its second principle of commemoration by ordering gold and silver medals for veterans of the 1812 war. When the medals arrived from England there were 62 in gold for officers and 550 in silver for lower ranks.¹⁸⁷ The society was unsure to whom and on what criteria it should dispense the medals. Indecision turned to inaction, and the medals were vaulted for safe keeping. While the medals languished in a Bank of Canada vault it occurred to the LPSUP how the erection of a hospital might serve both of its guiding principles. At first the plans only considered veterans; however, the swelling population of York sensitised the society to the fact any hospital it built would come under public pressure.

The 'medal wars' as C. Clarke, superintendent of the TGH, in 1913 called them were not directly relevant to spatial decisions in the late-19th or 20th centuries, nor did they factor into the building projects after 1820. This event—or at least its myth—bears mentioning to highlight the TGH's unique social context. By 1913 the TGH had produced its first commemorative history. Western hospitals sought to justify their existence and scrape together donations. Clarke wrote in his

¹⁸⁶ W. G. Cosbie, *The Toronto General Hospital 1819-1965: A Chronicle* (Toronto: Macmillan of Canada, 1975), 6

¹⁸⁷ *Ibid*, 10.

1913 history that “the medals have become a faded memory; the hospital is a glorious reality.”¹⁸⁸ In addition to a larger population and better-integrated position as a node in the trade and social networks of the urban north-east, administrators and doctors in Toronto interfaced with a populace accustomed to the presence of a public general hospital.

The first TGH was a small wooden building. It did not occupy a permanent, purpose-built structure until 1829. Construction began on the ‘King Street Hospital’ building in 1820. The two-storey brick main building was 107 feet long by 60 feet wide with recessed galleries on the north and south sides. Later two additional small buildings were added for housing fever patients. The building was completed in 1824, but did not see its first patient until 1829. Parliament occupied the TGH upon completion, and remained in place for four years. The hospital finally began to function in 1829, and remained there in some capacity until 1855. The TGH accommodated up to 100 patients, and at 10,200 square feet averaged 102 square feet per patient. The actual space per bed was less than 102, since kitchens, operating rooms, nursing stations and other ancillary services cut into the ward space. Clarke quoted a traveller from 1850 who found the hospital “pleasant and the rooms and halls spacious and airy.”¹⁸⁹ Had patients actually had 102 square feet each it would have placed the building in good standing. Hospital regulations in the 20th century created legal minimums in terms of patient space that were usually no less than 90 square feet. In 1862 the King Street hospital was demolished.

In 1853 the board—incorporated in 1847—concluded the York General was no longer worth its maintenance costs and began planning for a new building. The board settled on a plot of land on

¹⁸⁸ C. K. Clarke, *A History of the Toronto General Hospital: Including an Account of the Medal of the Loyal and Patriotic Society of 1812* (Toronto: William Briggs, 1913), 25.

¹⁸⁹ Clarke, *A History of the Toronto General Hospital*, 38. J. Ross Robertson, *Landmarks of Toronto: A Collection of Historical Sketches of the old Town of York from 1792 until 1833; and of Toronto from 1834: 1914. Also Two Hundred and Thirty-Eight Engravings and Places and Scenes in Toronto or in Connection with the City – Sixth Series Complete* (Ottawa: Department of Agriculture, 1914), 372.

Gerrard Street. An article in the *Toronto Leader* approved the site noting “several acres secures the new building from the injurious effects of overcrowding, and give it all the advantages which are to be derived from an airy and unconfined position.”¹⁹⁰ The *Upper Canada Journal of Medical, Surgical and Physical Science* corroborated this claim by describing the King Street hospital as “extremely bad, both old and inefficient.” Further, it was “entirely without ventilation,” and “so ill-arranged that it was with difficulty anything like a proper separation of patients can be made...a perfect picture of ruin and decay.”¹⁹¹ The first portions of the ‘Gerrard Street Hospital’ were erected in 1854. William Hay was the project’s architect. He based the new building off designs he had drawn for Scottish hospitals. Total cost was around \$60,000, and was partly funded through debentures.¹⁹²

The move did not turn out well at first. Clarke described the financial state of the Gerrard Street hospital as “embarrassing,” and during an economic depression the situation became so exacerbated that from 1868-1869 the hospital temporarily closed. By the late-1870s the hospital was showing its age: floors had settled, drainage broke down, wooden fixtures rotted out, and the heating system was in disarray.¹⁹³ The closure of 1868-1869 led to a significant change in hospital administration. The city had three members on the board, but failed to offer any funding to resume operation. The province intervened on the condition that the board was reconstructed to include three government trustees, the mayor, and a member elected by subscribers. The change dovetailed with a provincial act whereby the institution could receive aid commensurate with the amount of improvement it carried out on the building. In 1875 the hospital received a windfall in the form of

¹⁹⁰ Clarke, *A History of the Toronto General Hospital*, 66.

¹⁹¹ Editorial Department, “The Toronto General Hospital,” *Upper Canada Journal of Medical, Surgical and Physical Sciences* 2:9 (1853): 280. The article added that female patients often occupied hallways and leaks were common.

¹⁹² J. T. H. Connor, *Doing Good: The Life of Toronto’s General Hospital* (Toronto: University of Toronto Press, 2000), 84-85.

¹⁹³ Clarke, *A History of the Toronto General Hospital*, 74

two bequests amounting to \$16,000. The money financed a new heating and drainage system and an ‘outdoor department’ for outpatient care.

By 1855 the hospital was a collection of six purpose-built structures that formed a medical campus. The buildings included the original central edifice, the west wing, the outpatient service, the Burnside lying in hospital, Andrew Mercer Eye and Ear Infirmary, and Women’s Pavilion. The total bed count was 400.¹⁹⁴ In the basement beneath the west-wing, built in 1877, were a nurses’s dining room, kitchen, pantries, and workshop of the maintenance staff. Under the central pavilion was an upholstery room, the general kitchen for all buildings, sleeping quarters for staff, and furnace and coal rooms. Beneath the eastern division was a carpentry shop and accommodation for servants. All facilities were connected via tunnels.¹⁹⁵ Handling tasks such as carpentry and plumbing allowed for the achievement of two ends; the work counted as ‘improvement,’ and the hospital could claim it was an important civic employer.

In 1882 the TGH added a building specialising in care for women with funds acquired from private subscriptions. The “Pavilion,” as the board referred to it, was a two-storey building of white brick located on the northern portion of the hospital grounds. In 1895 further expansion raised capacity to 40 beds. Annex buildings often addressed a specific need, but the pavilion differed in this respect by reproducing several medical and logistical services. It had operating rooms, public and private wards, kitchens, pantries, baths, a separate dispensary, and outpatient service for women.¹⁹⁶ Constructing separate kitchen and storage facilitates was a matter of convenience since the pavilion

¹⁹⁴ Connor, *Doing Good: The Life of Toronto’s General Hospital*, 123. The Mercer Eye and Ear Infirmary got its name in 1878 due to a \$10,000 bequest from the state of Andrew Mercer. Mercer died without a will and the Provincial Government funnelled some of his wealth to the TGH.

¹⁹⁵ “A Greater Hospital: Commemorating the Opening of the new Extensions including the new Private Patient’s Pavilion, Toronto General Hospital,” 21 April 1930, 6. File TG 1.6.3 Box 8 TGH Fonds, UHN Archives

¹⁹⁶ “Toronto General Hospital, 400 Gerrard Street East: Established 1819, incorporated by Act of Parliament, 1847” [Pamphlet] (Toronto: Rowsell and Hutchison, 1896), 41

was not linked by tunnel to the main building. Duplicating other services related to patient's sex as wards were designated for males and females.

The maternity hospital also added new services, and operated under some additional regulations. For instance, women in the public wards were admitted no earlier than two weeks before their expected "accouchement." In the private wards patients had to prove they could afford the services. Administrators insisted on such rules to ensure they never faced a choice between expelling a woman in labour or allowing her to stay at the institution's expense. Public patients had a different experience than their counterparts in the private rooms. They had to wear clothing assigned by the hospital, and were expected to make their own beds and provide assistance to the nurses if requested. One rule that applied to all patients was that "on no pretence whatsoever shall the mother leave the Hospital without taking the infant with her."¹⁹⁷ It presumably was a greater concern in public wards where women were less likely to have much support or resources. The hospital's fear of being left with a baby was understandable. Administration did not want the TGH to acquire a reputation as place where mothers abandoned their children.

With wards and services spread throughout the complex, and often duplicated, spatial experiences were hardly consistent. Private and public wards existed throughout the grounds. For instance, private rooms were located in the west and east wing expansions. Nursing quarters were similarly dispersed ensuring staff members also experienced the hospital differently. An important development was the use of semi-private wards on the second floor of the main building. The presence of semi-private accommodation demonstrated the broadening demographic interested in hospital services. Private rooms had long existed in hospitals, but were rarely in the majority outside isolation wings. The presence of semi-private wards catered to new class of patient that was neither destitute nor wealthy. Lighting in the hospital came from gas. It was heated by steam and hot water.

¹⁹⁷ Ibid, 29.

Administrators worried about a fire breaking out and ensured that extinguishers, hoses, and pails were spread liberally throughout the institution.¹⁹⁸

With more patients—both real and prospective—administrators sought to ensure the general public considered the TGH a safe place that was capable of healing. Part of this battle was fostering faith in the efficacy of medical care. Another was to convince citizens that the space had evolved beyond a refuge for the destitute poor. In his 1913 history of the TGH Clarke wrote “...prejudice against hospitals still lingers in the minds of certain classes of the community, who, unfairly belittle and criticize the institutions devoted to the sick poor—institutions which are monuments to the humanitarianism which animates public-spirited men and women.”¹⁹⁹ Administrators struggled to maintain a facility that depended on civic consent, but was not embraced across all levels of society.

TGH rules in 1891 strove to control the space, but were also a reaction to patient agency. Rules helped to define institutional identity. For instance, the outright ban of all chronic cases, senile people, the insane, and incurables was a way for the TGH to present itself as an active treatment institution.²⁰⁰ Ailments such as insanity provided an important foil for hospitals. These cases helped routinize the idea that there would be times medicine could not help without reducing its reputation. The TGH made no official provision for the mentally ill until 1906 when a provincial grant provided one ward for “patients in the pre-insane stage of certain brain affections.” It consisted of 12 beds that were divided evenly between males and females.²⁰¹ The ward was in operation for only four months out of the hospital year so the 1906 report does not represent a full annual sample; however, in that

¹⁹⁸ “Toronto General Hospital – Annual Report of Medical Superintendent and Registrars for Year ending September 30, 1891,” 1892, 53. File TG 1.2.1 Box 2 TGH Fonds UHN Archives

¹⁹⁹ Clarke, *A History of the Toronto General Hospital*, 78.

²⁰⁰ “Annual Report of the Toronto General Hospital for the year ending 30 September 1891,” 1892, 41. File 12.1 Box 2 TGH Fonds UHN Archives.

²⁰¹ “Annual Report of the Toronto General Hospital: For the year ending 30 September 1906,” 1907, 15. A recurring theme in later chapters is the frequency with which general hospitals reject any obligation to care for the mentally ill. Administrators insisted that it is the duty of provincial asylums. Provincial governments often tried to avoid or minimize these responsibilities. Throughout the 20th century numerous deals were struck between trustee boards and Health Ministers whereby those experiencing mental illness received ‘treatment’ in hospital.

time 35 patients were treated seven of whom were found ‘insane’ and transferred to the provincial asylum.

Rules also reveal some of the institution’s inner workings. For instance, patient fees were solely for room and board making the medical care *gratis*. The trade-off, for the patient, was that in exchange for free care they had to accept the institution’s authority. Administrator described this system with dramatic rhetoric: “[Patients] must not in any way endanger their own chances of recovery, nor the recovery of their fellow patients; and must as far as possible help maintain regulations and discipline in the Hospital.”²⁰² From the patient’s perspective the rules implied a solely negative role in their own recovery. They could worsen chances of recovery through bad behaviour, but could not improve them outside of passively allowing the treatment to proceed.

Patients were to be in their “proper place in the wards” during meal times and during the visits of physicians. By 8 o’clock in the evening all had to be in bed. Leaving the hospital without express permission from the medical superintendent was prohibited. However, there are pitfalls to the Foucauldian application in many Canadian hospitals. Consider rule two: “Patients must be quiet and exemplary in their behaviour, conform strictly to the rules of the Hospital and carry out all orders ...No indecent conduct will be tolerated. The use of tobacco in any form is strictly prohibited. Loud talking or unnecessary noise in wards or corridors is forbidden.”²⁰³ The rules read to the cadence of a didactic institution. But internal documents do not outline such a mission. With the exception of generic words such as ‘quiet’ and ‘calm’ there was no substantive moral or behavioural model outlined in board minutes. Rather than attempt to define good behaviour, the rules assumed patients knew how to act properly and implored them to do so. Rules required patients to behave deferentially toward staff. One rule did so overtly by requiring silence when physicians were present.

²⁰² “Annual Report of the Toronto General Hospital for the year ending 30 September 1891,” 1892, 41. File 12.1 Box 2 TGH Fonds UHN Archives.

²⁰³ “Toronto General Hospital, 400 Gerrard Street East” [Pamphlet], 26

Another did so subtly by banning hats on the ward. Rules could also reveal the precariousness of institutional practices. Rule three prohibited patients from touching or removing the diet card from the end of each bed. This demonstrated how routines were vulnerable to tampering. General hospitals used discipline as a tool to keep schedules and enforce routine, but not as an end in itself.

Rules represented the most formal declaration of how administrators sought to control movement within space, and are a useful indicator of the different ways patients experienced hospital grounds. The most fundamental factor to movement was gender since all wards were designated either female or male. Patients of the opposite sex were strictly prohibited from entry. Nurses—at the time near-exclusively female—and orderlies were exempted from these rules and moved freely within the wards. Close behind gender was class. Patients were situated in private or public wards, and movement between the two was not allowed at any time. Patients's experience differed in the rooms themselves as well as by the larger privileges these spaces afforded them. Patients in private wards could have friends visit “at any suitable hours in the day-time” and even have them spend the night with permission from the medical superintendent. Public ward patients were limited to set visiting hours.²⁰⁴ Similarly the open ground west of Carriage Road was off limits to males in public wards, but open to private and female patients.

Although the TGH was a discrete entity, bounded geographically by its property holdings and legally by the territory it was responsible for, it was not an entirely ‘placed’ location. In 1880 the TGH coordinated with the police department to expand the institution's reach by establishing an ambulance program. The TGH received three via donation: one each from John Ross Robertson, the Manufacturer's Life Assurance Company, and police commissioner. After relocating to Gerrard

²⁰⁴ “Annual Report of the Toronto General Hospital for the year ending 30 September 1891,” 1892, 41. File 12.1 Box 2 TGH Fonds UHN Archives.

Street, the TGH interacted more with its urban environment in part due to ambulances.²⁰⁵ The ambulance brought the hospital into the community as a bastion of disciplined medical space that forayed beyond the institution's boundaries. The inside of the ambulance was 3 feet 5 inches in width 6 feet 5 inches in length and 4 feet 3 inches in height. Internal walls were made of wood, and were polished and exposed to promote hygiene.²⁰⁶ The presence of an onboard nurse had practical merit and symbolic value. It helped conjure the image of a sanitary ambulance headed to a modern hospital under the watchful eye of a medical agent, all of which sought to present an institution freed of unwholesome stereotypes.

There was no provision for the administration of medicine during the ambulance ride—unless the physician opted to come along with his medical bag—but the advent of ambulances demonstrated some striking changes in hospital administration. True there were initially only three vehicles, but they began to medicalise the community by traveling through it. No longer was the hospital a disconnected node for receiving. It changed the scope of planning as well. Administrators began to consider city and street gridding as it affected the hospital's ability to respond. The space of the ambulance itself was institutional, and emphasised cleanliness and utilitarian design to reproduce a clinical environment.²⁰⁷ Ambulances extended the hospital's reach and accelerated response time.

In 1904 businessman and philanthropist Joseph Wesley Flavelle was elected chairman of the board of trustees. He had served on the board as a member since 1902. Flavelle felt the TGH had not delivered on recent requests by medical staff. His first initiative was to expand surgical capacity, but this was halted by the cost. In 1905 Flavelle argued for wholesale change: “the whole conception of

²⁰⁵ *An Act Respecting the Toronto General Hospital, Revised Statutes of Ontario*, 1906, c. 12, pp. 507 The move necessitated the closing of two streets.

²⁰⁶ “Toronto General Hospital, 400 Gerrard Street East” [Pamphlet], 46

²⁰⁷ For a general history of emergency medicine including the provision of ambulances see Brian J. Zink, *Anyone, Anything, Anytime: A History of Emergency Medicine* (Philadelphia: Mosby Elsevier, 2006) Ambulance history in Canada is not well-explored, one Ontario example is James A. Hanna, *A Century of Red Blankets: A History of Ambulance Service in Ontario* (Erin: Boston Mills Press, 1982).

the institution, including buildings equipment, maintenance, administration...” had to modernize. In his mind the TGH had not kept pace with the rate of medical advancement, and neglected its educational responsibilities.²⁰⁸ The board decided instead of renovating old buildings to pursue “a large plan of reorganization...providing new buildings and equipment suitable for the modern and scientific treatment of the sick poor and affording facilities of high excellence for educational work...”²⁰⁹ It was the first step toward the 1913 move to College Street, and an important affirmation of the institution’s developing identity as a place of teaching and research as well as healing.

As internal confidence in the building project grew the board contracted architects to draw a design. By 1905 the TGH had received over \$1,000,000 in subscriptions fees. Meanwhile, negotiations were ongoing with the university, province, and municipality about the prospects of receiving additional funds. One obstacle was a lack of clarity on what the endgame was for the TGH building project. Each constituent had different interests related to hospital function, but the board could make no guarantees until a firm design existed. What administrators had not fully anticipated was the possibility of moving locations. However, the College Street site proved highly attractive and held the promise of expansion.

The board decided on a site south of College Street, between University Avenue and Elizabeth Street. The grounds comprised 220 feet in length along College Street and 140 foot width on Christopher Street. With an estimated property cost of \$550,000 the committee now had one firm number to work with. A 1905 Act respecting the University of Toronto (University Act) enabled trustees of the University of Toronto to assist in reorganizing the TGH. The University Act provided

²⁰⁸ Clarke, *A History of the Toronto General Hospital*, 119. Michael Bliss, *A Canadian Millionaire: The Life and Business Times of Sir Joseph Flavelle, Bart. 1858-1939* (Toronto: Macmillan of Canada, 1978), 204-206. Michael Bliss’s biography of Flavelle devoted some attention to his time with the TGH. However, it is not considered in as much detail as other business activities. The impression Bliss offers is that Flavelle spent much of his time bickering with the university and being misled by architects Darling and Parsons. Though it has some interesting sections about the challenges of chairing such an institution and some frank comments on the extent to which the TGH made use of newspapers to increase their public standing.

²⁰⁹ Clarke, *A History of the Toronto General Hospital*, 119-120.

funds in aggregate for a large campus building project, but earmarked up to \$250,000 for hospital reorganization.²¹⁰ In 1906 the Toronto General Hospital Act, reformulated the board to 28 members. Five were appointed by the university trustees. The act also ensured that any medical student of the University of Toronto could visit the wards.²¹¹ Upon the organization of the board the city released \$200,000 in funds for construction. The provincial government provided \$250,000. Meanwhile wealthy citizens Cawthra Mulock, George Cox, Timothy Eaton, and a bequest from the late Hart A. Massey provided a further \$350,000.²¹²

Administrators had a challenge in how to approach hospital commemorations. It was fine to look back fondly—but not too fondly—and comments tended to reveal contemporary expectations. In 1913 Clarke described the operating room of 1880 as “good-sized, fairly well-lighted and equipped,” capable of accommodating most students who wished to observe. Though he also added that the table was “plain wooden, with no means of lowering or raising the patient... You can find as good a table in many of the kitchens in the country today. The operating room was kept spotlessly clean. The halls and floors of the different wards were very clean.”²¹³ He presented the hospital as benign on the major contemporary concern—sanitation—but inadequate and quaint in its outdated technology and spatial resources. Clarke used commemoration as a way to justify expansion by way of reminding citizens where the hospital had come from, and where he hoped it was headed.

From 1906-1910 the process moved slowly as the university and TGH negotiated funding arrangements. On the architectural front plans were developing. The Architectural firm Darling and

²¹⁰ Cosbie, *The Toronto General Hospital 1819-1965*, 141. *An Act Respecting the University of Toronto, Revised Statutes of Ontario* 1905, c. 5 and c. 7, pp. 97-98.

²¹¹ *An Act Respecting the Toronto General Hospital, Revised Statutes of Ontario*, 1906, c. 4, c.20 pp. 502-503, 510. The rest of the council comprised eight appointed by the Lieutenant-Governor, five by the municipality, and seven elected by subscribers. This would constitute the trustees of the TGH. A quorum was set at 9. The Act provided other benefits, for instance c. 10 exempted it from taxation on buildings and ground in use for medical purposes.

²¹² Clarke, *A History of the Toronto General Hospital*, 119. Believed to be George Albertus Cox, but the source is unclear. Cawthra Mulock became involved with the TGH in 1904 through Joseph Flavelle.

²¹³ *Ibid*, 83.

Parson was hired in 1906. The firm's resume included many large institutional buildings such as the University of Toronto Faculty of Law, Union Bank Building, and Canadian Bank of Commerce. The architects decided on a block system that would arrange buildings so that wards, laboratories, and administrative offices stood with just enough distance between them to allow airflow and sunlight.²¹⁴ By 1908 they presented a list of required buildings that included a laundry, power house, maternity building, nurses's residence, separate wings for private and semi-private wards, and an administration building.²¹⁵ Darling and Parson estimated the cost at \$1,388,000. What began in 1905 as a 400-bed facility grew into 550 beds by 1910 that included an outpatient facility with an estimated cost of \$2,900 per bed. On 1 December 1910, the university and TGH agreed to a deal that allowed construction to begin. The university would provide \$600,000 toward construction, and an additional \$100,000 for a pathology building.²¹⁶

Despite being long-established the TGH was not immune to delays and shortcomings. The new 'College Street' hospital did not open until 1913. Though the value of a hospital was not in dispute—in fact that was one of the few general areas of agreement between competing factions—the manifold options for building, funding, and organization caused delays. In Toronto, an established medical community and tradition of education within the hospital intensified debate and interest in that space. Building a new hospital was not simply a quest for relieving suffering and sickness. It represented a major investment with professional, economic, and educational ramifications for more specific interests than the 'general public.'

The TGH was the sophisticated achievement of an established city, its monied leaders, university specialists, and professionals. The nascent polities of the west had ambitious personalities, but faced brisk obstacles in acquiring capital, staff and social support. Legally there was no

²¹⁴ "Superintendent's Report," 1906, 21. File 1.2.3, Box 2. TGH Fonds UHN Archives.

²¹⁵ For an example of these buildings see Appendix II image 2.1.

²¹⁶ Clarke, *A History of the Toronto General Hospital*, 126.

uncertainty that health fell within the purview of provincial and territorial governments, but whether it was to be a large system or municipally administered remained undecided in the 19th century. Instead, civil society stepped into the breach and sought to provide health care as best it could. The strictly regional or civic hospital, at least in organizational reach, resembled much older hospitals in Europe. But their relationship with the community and government differed.

Winnipeg 1871 – 1910

The WGH's early history involves a marked lack of government involvement, including at the municipal level. In 1871 an influx of soldiers responding to the Riel Rebellion coupled with raw sewage pollution in the Red River led to a typhoid outbreak.²¹⁷ Lieutenant-Governor Adams G. Archibald constituted a board of health in response to the epidemic. Part of the health board's mandate was to establish a hospital. The first attempt was in a converted private residence. It lasted less than three months before relocating to a larger space.²¹⁸ In 1872 the board's term expired and with it the hospital's funding. Much of the citizenry responded to the closure by banding together, pooling resources, and volunteering their time in the hopes of establishing a similar institution for the good of the city.

A meeting chaired by Andrew G. B. Bannatyne—then city postmaster—met on 18 December 1872 to plan for a new general hospital. The *Manitoba Gazette* stressed the meeting's importance for it “comprised men of all classes,” including gentlemen and doctors who agreed it was “high time” the city had a permanent, public medical institution.²¹⁹ One of the group's first actions was establishing a committee to collect donations and subscriptions. One member offered a furnished

²¹⁷ Ian Carr and Robert E. Beamish, *Manitoba Medicine: A Brief History* (Winnipeg: University of Manitoba Press, 1999), 5, 226. The population in 1871 was well under 50,000. By 1910 it had grown to nearly 200,000; around one third of the Province's total population.

²¹⁸ “History of WGH: Board of Directors, 1871-1902” [1952], 1. Box 17, File 4 WGH Fonds, Health Science Centre Archives and Museum Collections (HSCAM).

²¹⁹ “A Public Meeting” *Manitoba Gazette* 25 December 1872, 2.

building on Notre Dame Street if fundraising efforts were successful. By January 1873 the temporary hospital had five patients. A meeting on 11 January 1873 confirmed that rooms capable of accommodating up to 12 beds were in operation. Fundraising efforts were going well, and raised almost \$400. On 5 February 1873, the *Manitoba Gazette* provided a balanced appraisal of the hospital's effort: "This institution is succeeding very well so far as its accommodation and means will permit."²²⁰ The article stopped short of praising the institution. Instead it presented an image of noble intentions clashing against inadequate space.

Between 1873 and 1875 the hospital moved three times in search of more space. In March 1873 it relocated to a building on HBC land that the *Winnipeg Free Press* described as "the Hospital Hut on the [west bank] of the Red River."²²¹ The main structure was a frame building, accompanied by two lean-to structures. One served as an annex for additional patients and the other as a dwelling for the caretaker and his wife. The main building had two rooms on the ground floor and one upstairs; however, they lacked any partitioning. The walls were lined with sawdust for insulation.

On 14 May 1875, the WGH Incorporation Act passed making the WGH its own legal entity. It provided a sense of legitimacy as a formal institution, and represented a victory for the citizens who had donated time and money. The Act set some parameters for how the institution would be governed, but was far from complete. For instance, it required that fifteen directors were elected by ballot annually. However, the act did not specify how the medical staff should be appointed. In 1875 the board handled this oversight by having doctors stand for election as board members. That decision created overlap between medical staff and administration until an amendment in 1879 gave administration the power to appoint. Anyone who contributed at least \$10 per year was eligible to vote or run; subscribers of at least \$5 could attend annual meetings and for an offering of \$50 or

²²⁰ "Hospital" *Manitoba Gazette* 5 February 1873, 2.

²²¹ "Hospital Hut," *Manitoba Free Press*, 15 March 1873, 4.

more one became a life member.²²² The city established a committee to assist in managing the hospital and offered a grant of \$500.²²³

With incorporation the board sought a new building but finances were limited. Mr. Bannatyne and Mr. Andrew McDermot offered a large plot of land on Nena Street.²²⁴ The donation allowed the board to allocate more funds toward construction since it would not need to purchase any land. The Nena Street site was not perfect. It was located away from the city core which presented an obstacle for patient travel. The property was surrounded by swampland and prone to flooding. This removed the possibility of nearby land being converted to gardens or used as space for convalescent recreation.²²⁵ Still, the board accepted the site despite these shortcomings because it was free. The first purpose-built WGH stood two storeys and was painted white. It faced east to catch the rising sun. The main entrance opened into a large open space with a reception and waiting area. The surgery and pharmacy occupied one side. The opposite side of the first floor contained two rooms for private patients. There was also accommodation for the steward—a post created by the Act of incorporation—a general management position atop the staff but below the board of directors. The steward was essentially a forerunner to the 20th century position of superintendent. On the second floor was a general ward capable of accommodating up to 20 patients. On 1 October 1875 the building officially began operation, and remained in service until 1883.

Overcrowding and overstaying plagued the WGH's new building. In 1881 the house surgeon reported an average occupancy of 24 patients, which was two more than the space had been designed for. An 1883 report suggested that the problem continued. It showed how the average length of a

²²² Government of Manitoba, *An Act to incorporate the Winnipeg General Hospital* 14 May 1875, 13.

²²³ Alan F. J. Artibise, *Winnipeg: A Social History of Urban Growth 1874-1914* (Montreal: McGill-Queen's University Press, 1975), 19.

²²⁴ "History of WGH: Board of Directors, 1871-1902" [1952], 8. Box 17, File 4 WGH Fonds, HSCAM.

²²⁵ "The Story of A & B Buildings" [1952], 6. Box 28 WGH Fonds, PMA

patient stay between 1878 and 1883 was 42.5 days.²²⁶ Administrators viewed typhoid cases as the most difficult to treat and the most significant contributor to long stays. It did not help matters that the wards were not well partitioned. Female patients had limited accommodation, leading to shuffling of beds to maintain segregation by sex. Such movement provided many opportunities to spread disease.²²⁷ Flooding was a problem as well. In the absence of a proper road or walkway patients traversed a path of wooden planks to reach the hospital. At times this contributed to the problem by causing or aggravating injuries.

Another aspect to patient admission was class, but in terms of medical condition rather than economic background. By-laws forbade doctors from admitting anyone deemed insane or incurable.²²⁸ In order for a patient in either situation to be admitted permission had to be granted by the board, which also had the authority to remove anyone it deemed insane. Such policies rested upon the fear that physicians could use the hospital to unload unwanted patients. Staff doctors had different reasons to be wary of such individuals. Incurables were by definition beyond a doctor's ability to aid, and their presence wasted a bed, harmed the hospital's reputation, and hurt ward morale. Cases of insanity fell within a complex set of circumstances.²²⁹ Often doctors viewed it as untreatable unless caused by illness or medication. Moreover, psychiatric doctors generally preferred to administer treatment in specialized institutions. The board structured by-laws to allow for as much control as possible over who would be admitted.

In 1880 the board established fundraising and building committees in the hopes of moving to a larger building. Administrators began the planning phase by inviting the medical staff to submit

²²⁶ "History of WGH: Board of Directors, 1871-1902" [1952], 9. Box 17, File 4 WGH Fonds, HSCAM

²²⁷ "The Story of A & B Buildings" [1952], 5. Box 28 WGH Fonds, PMA

²²⁸ Winnipeg General Hospital, *Winnipeg General Hospital: Organized December 13th, 1872 Incorporated May 14th 1875* (Winnipeg: The Standard Printing and Publishing Company, 1876), 6

²²⁹ L. Stephen Jacyna and Stephen T. Casper eds. *The Neurological Patient in History* (Rochester: University of Rochester Press, 2012). For Canadian information see Harvey G. Simmons, *from Asylum to Welfare* (Downsview: National Institute on Mental Retardation, 1982), 178. One might also consider Roy Porter, *A Social History of Madness: The World Through the Eyes of the Insane* (London: Plume, 1989).

their thoughts on what a new site required. In a letter to the board on 19 February 1881, Dr. Lynch suggested a new building needed at least 100 beds.²³⁰ The existing buildings were overcrowded, seeing 455 patients in 1883. Bed capacity, by the administrator's own admission, was not the best gauge of a hospital's capacity. The 1883 annual report stated: "The dormitory capacity does not adequately represent the extent to which relief has been extended, as many as 72 patients having been under treatment at one time."²³¹ The problem of overcrowding extended to paying patients as well, which demonstrated the increased appeal of the hospital.

The design of the new hospital emphasised private accommodation more than its predecessors. Lynch foreshadowed many of the final decisions in his suggestions. He noted: "Any plan contemplated for the new building the board should bear in mind the great necessity which exists here for a large number of private wards, which besides being much required would be a source of considerable revenue."²³² Lynch calculated that for 100 beds it would take at least eight private wards to cover costs. He also suggested that excluding the basement, private wards, pharmacy, laundry, surgeon accommodation, and other areas at least 120 square feet should be provided per bed.²³³ The final contract called for a 60-bed structure. Lynch envisioned patients as a source of revenue, and expressed an emerging belief in balancing medical and practical agendas.

Administrators presented the medical board with five different plans and a \$20,000 budget. The board's first choice was the "Kalon" plan, which it described as "a model of hospital

²³⁰ "Medical Staff" [1952], 8. Box 17, File 4 WGH Fonds, HSCAM.

²³¹ "Winnipeg General Hospital: Act of Incorporation and By-Laws" [1884], 15-16. Box 9 WGH Fonds, HSCAM. Self-identified annual reports first appeared in 1883. This 1882 printing of by-laws is largely a forerunner. The board intended the document for public consumption and the writing was not clinical or dry. It was written to emphasise details that demonstrate the board's intent for the public to see this document.

²³² "The Story of A & B Buildings" [1952], 16. Box 28 WGH Fonds, PMA

²³³ Ibid. The document states 1200 square feet per bed, but this number must have been a misprint since that would be a gigantic amount of space per bed. 100 beds with 1200 square feet would need a building far larger than could have been erected at this time. The number most likely intended is 120, which would still have been a generous allotment of space to hope for. However it made sense to ask for more rather than less in a recommendation.

architecture.”²³⁴ Upon closer examination the costs appeared too high. The board’s second choice—based on its size, ventilation, ward arrangement, and size of private rooms—was a plan titled ‘Syndicate.’ The board approved of many elements of the second plan, but feared it would not function without alterations. The ‘Syndicate’ plan afforded only four feet per bed due to 18 foot general wards, and the board wanted at least ten. The stairwells were narrow at four feet. The board interpreted this as an architect’s trick to reduce cost on paper by reducing parts of the structure in size that would require alteration during construction.

Indecision on how to proceed lasted until August 1881 when the board realized “[we] are in a position to erect a more expensive building than first contemplated...at a cost not to exceed \$25,000.”²³⁵ They returned to the Stewart and Wilmot “Kalon” plan, and had them incorporate a stone foundation and brick exterior. The delay forced the board to seek temporary accommodation for the winter. Between the conception of a new building in 1880 and completion in 1884 the WGH again took up residence in a temporary structure. In late-1881 the board purchased the “Emigrant Shed” from the Department of Agriculture for \$5,000.²³⁶ Staff took to calling it the ‘Point Douglas.’ It was a two-storey building with a capacity of 45 beds.

Conditions at the Point Douglas were abysmal. On 24 June 1882, a board of director’s report stated: “There are no nurses, the only one hitherto employed having died within the last few days. Convalescent patients act as nurses at the present.”²³⁷ The directors were doubly alarmed by the lack of nursing since all patients transferred to the Point Douglas had been male. In late-May smallpox broke out in the Point Douglas wards. All 37 patients were moved outside to tents while the space was fumigated. The tents were framed with wooden floors that leaked in wet weather. Several blew

²³⁴ Ibid, 21. ‘Kalon’ was shorthand for ideal, physical beauty used by Greek philosophers.

²³⁵ Ibid, 25, 34. In 1882 the City of Winnipeg offered a \$5,000 grant which allowed the board to increase the budget.

²³⁶ Ibid, 3.

²³⁷ Ibid, 8.

over in a July storm. Over the summer a section of flooring was removed to allow accumulated water to dry, and several stoves had to be installed to winterize the wards. During the winter snow was banked around the ground floor, and the windows packed to control drafts despite the adverse effects on ventilation.

Poor drainage and flooding bedevilled the WGH since it moved to the McDermot site, and its 1882 call for tenders failed to attract a credible bid for this reason. The city had promised to build drains and sewerage infrastructure to improve the situation, but had yet to act. The board was reluctant to dig the foundation before this was done. In July 1882 the city reaffirmed its commitment to providing drains, but could not do so until the following year. In return for promising drains the city requested the hospital supply land for a morgue. The board agreed so long as it could pick the location. The hospital received free use of the morgue's facilities in exchange.

The board called for tenders again in February 1883 and the returns were better. It selected the Gill Atkinson Company's bid at \$40,985 exclusive of heating plumbing. The contract required completion by 15 October. On 31 March 1882 subscriptions to the building fund totalled \$25,811; however, only \$5,803.15 had been collected. By August subscriptions rose to \$35,611 as money came in from private citizens, the HBC, CPR, and a further \$5,000 from the City Council of Winnipeg.²³⁸ By the end of 1883 the board had \$23,472.48 cash on hand, which left it \$12,138.52 short. In response directors took a risk in securing a mortgage with the London and Canadian Loan and Agency Company (LCLAC) on the new building. They borrowed \$25,000 at a rate of 8%. Before LCLAC approved the transaction, it insisted that all twelve directors execute bonds in their own names to be personally responsible for \$1,000 of the debt.²³⁹ The protracted financing episode and solution depicted ingenuity and personal commitment. The final cost amounted to more than

²³⁸ "Winnipeg General Hospital: Act of Incorporation and By-Laws" [1884], 15-16. Box 9 WGH Fonds, HSCAM.

²³⁹ Ibid, 16. The architect's commission came out to \$1,337.50, suggesting their fees were approximately 4% of an assumed final cost of \$37,500

double the initial estimate at \$53,000. Certain work not included in the initial estimates—steam heating that cost \$4,135, boilers costing \$1,015.60, and plumbing for \$1,871—added over \$7,000. Costs spiralled in part from estimates that proved unrealistic, but also by the contractor’s attempts to keep to the schedule. For instance, architects required a large portion of exterior brickwork replaced when the contractor installed a poor shipment to avoid delays.²⁴⁰

Through all the economic difficulties administrative morale remained high. The board was convinced that “when completed the hospital will be one, if not the, most perfect of its size on this continent. It has the necessary room for carrying on the administration of a much larger hospital in future as the increased demands may require.”²⁴¹ Such rhetoric blunted the sting of how unwieldy the project had become. The fact that new WGH facilities were impressive helped too. Its heating system could provide different temperatures to each ward, and public and private wards sizes had been enlarged without sacrificing the isolation area. When the hospital opened the actions of nurses and doctors would determine its true utility, but administrators saw value in gloating over the space and its technical qualities. Land speculation in and around Winnipeg boomed in the late 1870s until a collapse in the spring of 1882. During that time the structure count of Winnipeg trebled and population rose by over 7000. By 1884 economic recovery merged with civic boosterism and a spirit of optimism around the new hospital buildings.²⁴²

The WGH chose to celebrate the opening. The Women’s Aid Society (WAS)—primarily comprised of the wives of doctors, administrators, or nurse alumnae—organized a charity ball on 13 February 1884 prior to any transfer of patients. In coordination with donors the WAS organized a luxurious evening. The Hudson’s Bay Company sent furnishings and draperies to disguise the clinical space. Bell Telephone provided a phone for guest use. Both large wards were transformed

²⁴⁰ “The Story of A & B Buildings” [1952], 62-63, 70. Box 28 WGH Fonds, PMA

²⁴¹ Ibid.

²⁴² Artibise, *Winnipeg: A Social History of Urban Growth 1874-1914*, 74.

into ballrooms, and dancing carried on until 3:30 in the morning. The event raised \$1,600.²⁴³ Openings were unique moments, and sometimes they bordered on the bizarre and gothic as the wards cleared of beds, filled with 19th-century revellers certainly did. Nursing historian and WGH graduate Ethel Johns described the event as being “...executed in the most artistic manner...”²⁴⁴ True no patients had been housed or treated there, no one had died, suffered, or experienced the dread and uncertainty of sickness in the temporary ballroom. However, Johns’s need to reassure readers that there was nothing untoward about the ghoulish enterprise spoke to the experiential significance of space. For one night citizens could christen the hospital with levity, but from then on such an event would be in poor taste.

Administrators had economic motivations to see the new building populated. They left the upper floor private ward vacant so incoming, rather than transferred, patients would be placed there. New patients had to pay the new rates. The rates were \$2.50 per day in private wards and \$1.00 per day in public wards. The new WGH was larger than its predecessor at two storeys. It also had an infectious ward annex. Throughout the summer a new cesspool was dug, a laundry building erected, and pipes sunk. Administration expected “the removal from the close confined wards of the old building to the large, light cheery wards, with their sun galleries of the new hospital...” to have “...a most beneficial effect not only upon patients but upon administrators.”²⁴⁵ The WGH now had an isolation ward entirely detached from the main building with separate rooms therein, an accident ward, a new operating room, running warm and cold water, and steam heating.

The new building came with high expectations; however, the reality did not always meet them. A prominent feature of the new WGH was its six private wards, but only four were initially

²⁴³ Ethel Johns, *The Winnipeg General Hospital School of Nursing, 1887-1953* (Winnipeg: Winnipeg General Hospital School of Nursing Alumnae Association, 1954), 7. “The Story of A & B Buildings” [1952], 75. Box 28 WGH Fonds, PMA

²⁴⁴ Ethel Johns, *The Winnipeg General Hospital School of Nursing, 1887-1953*, 7.

²⁴⁵ “Winnipeg General Hospital: Annual Report for the year 1884,” 19. Box 9, WGH Fonds HSCAM

furnished. There was also one private room that was not especially suited to generating income. In the basement was a “padded cell,” described by Johns as an “unspeakably horrid place, fetid and airless.”²⁴⁶ It remained in use for years as the hospital’s only method of isolating patients suffering delirium. House Surgeon Dr. Mewburn had concerns about the hospital’s flooring and ventilation. There was no easy choice as to which could be more easily solved, and worse, they tended to exacerbate each other. Mewburn noted that “the only ventilation upon which we can depend is obtained from the window that is the introduction of cold air into the wards.”²⁴⁷ A ventilation shaft passed along the roof in the centre of the main wards; however, the system was not operational. Mewburn warned that should the wards fill to capacity the lack of ventilation would have dire consequences. The wards and operating rooms contained inexpensive soft woods which shrunk and began to spring. This structural malfunction presented both a tripping hazard and a void where dust and insects began to collect. These had not been anticipated problems. During the building process ambition met with reality and led to compromise.

As 1885 ended the WGH focused on sanitation and debt. The city finally connected the main building to the municipal sewer network, but not before making the WGH pay for 400 feet of pipe that crossed its property. However, wards now had water closets, and drainage was improved across the site. The total cost for construction and renovation swelled to \$66,142.93, with \$3,026.98 in 1885 from plumbing. Of the 1883 mortgage debt, only \$2,000 had been paid back which left \$23,000 outstanding. The unpaid mortgage remained a problem throughout 1887. In 1885 private ward fees raised \$802.50 and public wards \$810.25. Meanwhile subscriptions totalled \$1,152.96. Building expenses added \$3,026.98 to the deficit, eclipsing the \$2,676.71 sum from subscriptions and ward rates. Other expenses had to be accounted for as well such as salaries and the cost of

²⁴⁶ Ethel Johns, *The Winnipeg General Hospital School of Nursing, 1887-1953*, 19.

²⁴⁷ *Ibid*, 21.

medical supplies.²⁴⁸ During 1887—in in what amounted to a bailout—the province donated \$5,000, the municipality \$3,500 and the CPR and Railway Employees Labor Organization contributed \$4,000 to pay the board's debt.²⁴⁹

The new WGH—known as A and B Flats—marked a watershed for public hospitals in Winnipeg. In some ways the project confirmed the worst possibilities about large-scale public building: costs spiralled out of control, debt swelled, and alterations continued long after completion. The shape and size of the new WGH was evidence in the shift in its social positioning. It was a large, expensive and constantly expanding. The growth was a testament to the civic importance of the hospital and its appeal across the class spectrum. The establishment also signalled other shifts such as the entrenchment of clinical medicine, and the extent to which health was transforming in public consciousness into a service.

In 1888 three buildings were added to supplement A and B blocks. A brick operating theatre accommodating 60 students was attached to the main building via a corridor at a cost of \$3,646, a new nurses's home was erected at a cost of \$9,362 to increase space for new students, and at the cost of \$7,349 a maternity hospital opened. The maternity hospital was separate from the main building and accommodated 15 patients in public wards and had four private rooms. The rate at which children entered the WGH was increasing as well. A six-bed ward in the main building was designated for that purpose.²⁵⁰ Scarlet fever and typhoid continued to plague the city, and led to a new isolation hospital in 1893. Demand for private wards grew and seven were added above the administration department.²⁵¹ In 1896 a shortage of beds forced the board to turn away patients.

²⁴⁸ "Winnipeg General hospital: Annual Report for the year 1885," 6-7. Box 9, WGH Fonds HSCAM

²⁴⁹ "Board of Trustee Minutes" 16 September 1887, 5-6. Box 15, PMA

²⁵⁰ "Annual Report of the Winnipeg General Hospital for the Year 1888" 1889, 7-9. Box 9 HSCAM. See Appendix II, image 2.2 for renderings of these structures.

²⁵¹ "Annual Report of the Winnipeg General Hospital for the Year 1893" 1894, 7, 16. Box 9 HSCAM.

In 1897 the board cast about to justify further expansion and found it in the form of commemoration. Meeting with city council on 2 June a joint-decision was reached to embark on a \$50,000 fundraising campaign to increase hospital accommodation—the Victoria Jubilee Addition—and honour Her Majesty.²⁵² The Jubilee Wing was intended to stand three storeys, and be a separate building connected by tunnel to A and B flats. The board’s architect, Mr. McCowan, had plans drawn within the year, but the building did not open until 20 September 1899. It offered 54 public beds, 9 semi-private, and 12 private specializing in surgical recovery. The cost outpaced initial estimates at \$71,350.²⁵³ The Jubilee Addition did not sate Winnipeg’s demand for hospital accommodation. In 1900 administrators noted overcrowding in the new building as evidence that “the hospital was not enlarged before there was need of it,” and by 1901 referred to the addition as having “insufficient” beds.²⁵⁴ In 1903 the board took on \$30,000 against their personal credit for the erection of a new nurses’s home and wing. C Wing was based on plans used in the Jubilee Addition to allow for immediate construction. Its completion added a new kitchen, ambulance entrance, and corridors combining its second storey with the surgical building. Public ward population increased to 176, semi-private to 50, and private to 35.²⁵⁵

The fact that no major buildings were added from 1905-1910 belied the significant population growth underway. In 1871 Winnipeg had only 700 residents, and by 1884 when A and B blocks opened population was over 7,000. By 1905 it mushroomed to 79,975 and was 132,270 by 1910.²⁵⁶ Administrators began to tinker with organization and find ways to increase capacity without building. For instance, in 1905 offices in the main building were re-arranged. In 1907 the ground

²⁵² “Annual Report of the Winnipeg General Hospital for the Year 1897” 1898, 7. Box 9 HSCAM.

²⁵³ “Annual Report of the Winnipeg General Hospital for the Year 1889” 1900, 8-9. Box 9 HSCAM.

²⁵⁴ “Annual Report of the Winnipeg General Hospital for the Year 1900” 1901, 6. Box 9 HSCAM. “Annual Report of the Winnipeg General Hospital for the Year 1901” 1902, 16. Box 9 HSCAM.

²⁵⁵ “Annual Report of the Winnipeg General Hospital for the Year 1904” 1905, 13. Box 9 HSCAM.

²⁵⁶ Artibise, *Winnipeg: A Social History of Urban Growth 1874-1914*, 130-131. See Appendix II, Image 2.3 for a floorplan of the campus.

floor of the former nurses's home was converted to a children's wing. These changes demonstrated a shift in administrative thinking. The nurses's home could always have been reused, but it took administrators a year to have it made into a children's ward. Rearrangement was not a new development in 20th century hospital administration, but it became increasingly common and important as institutions grew in size and cost.

The establishment period of the WGH is best characterized by good intentions, civic growth, and compromise. An equally appropriate word may be perseverance. Its earliest backers such as Bannatyne held the institution on course during the withdrawal of federal government support. Winnipeg exemplified organic, grassroots hospital formation. Civic boosterism in other areas spilled over to hospital planning.²⁵⁷ When civic promotion faded during a recession, the realization of a hospital plan faltered and a makeshift hospital exposed the miseries of climate, and the city's poor drainage. The class dynamics of this period are important, for while it was largely middle and upper class individuals who organized, donated, and pushed for the hospital's incarnation it was initially those of lower socio-economic status who reaped the benefits. Still, the presence of health care institutions had utility for all members of society. General hospitals rose in prominence amidst a widening patient pool and increasing relevance to medical educators and researchers.²⁵⁸ 1880s Winnipeg was no different, but its frontier status led to years of drifting from repurposed homes to emigration clearing houses before establishing a permanent base of operation. Though the trajectory

²⁵⁷ Ibid, 24, 223. Artibise argues that the commercial elite of the 1870-1890s—and really until the 1905 permanent establishment of a health board—was not focused on the human environment so much as on quick profits and railroad construction. Profit was surely a guiding priority. However, the charity exercised and organized by citizens like Bannatyne suggests this interpretation should be softened. The commercial class played an important role in the establishment and maintenance of the WGH.

²⁵⁸ Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Baltimore: Johns Hopkins University Press, 1987), 346. Rosenberg's oft-cited summation of hospital and the medical profession bears reiteration: "If the hospital had been medicalized, the medical profession had been hospitalized in the years between 1800 and 1920."

may have been weaving, the vision of a purpose-built structure, with educational designs, and above all genuine capacity to heal remained constant.

Calgary 1875-1910

In 1874 the NWMP arrived at Fort Brisebois and established a base which was renamed two years later as Fort Calgary. The NWMP had a brief but important role in the early history of the CGH. First Nations practiced medicine on the plains for centuries, but NWMP doctors brought the first institutions of Western, scientific or professional medicine to the region. NWMP troops travelled with a surgeon and veterinarian, but typically lacked sufficient resources to offer aid to those outside their ranks. Between 1875 and 1883 Fort Calgary was home to a population of approximately 4,000. In 1883 the CPR line arrived and its status as an isolated outpost melted away.²⁵⁹

In 1884 Calgary incorporated as a town. With the formalization of a municipal government came establishment of civic services such as police and fire brigades, civil societies, newspapers, and religious organizations. Concern for public health followed with population growth. The NWMP hospital grudgingly provided medical care to citizens of Calgary despite it being outside its mandate and budget; however, the purpose of a hospital was not the same for the NWMP as it was for civilians. Sickness and discomfort ranging from vermin infestation to fractured bones followed NWMP units. Troops, however, often ranged and their health facilities were transient. Attending surgeon J. Kittson wrote in 1875 that at times it was “necessary to form a Crippled Camp.” For him hospital tents were useful for isolation or convalescence.²⁶⁰ For the NWMP rustic hospitals answered specific problems. They were a tool in a medical bag rather than a permanent institution. The city’s

²⁵⁹ Evelyn Hardwick Eileen Jameson and Eleanor Tregilus, *The Science, the Art and the Spirit: Hospitals, Medicine and Nursing in Calgary* (Calgary: Century Calgary Publications, 1975), 6-7.

²⁶⁰ “Report of Surgeon John Kittson,” 19 December 1875, 22. In S. W. Horall eds. *A Chronicle of the Canadian West: North-west Mounted Police Report from 1875* (Calgary: Alberta Historical Society, 1975)

arrival as a political actor signalled the end of the NWMP's unwanted responsibility. Still, the first hospital in Calgary was a three-bed log cabin opened by the NWMP.²⁶¹

Until 1905 when the province of Alberta was established Calgary was part of Canada's Northwest Territory. Territories had fewer responsibilities than provinces; however, health still fell under its aegis. For townsfolk health was a problem affecting their living space. It stood to reason that a permanent building ought to provide aid as opposed to something transient like what the NWMP relied upon. Many new residents arrived by way of Winnipeg where A and B flats had opened in 1884. It would not have taken much imagination to think such an institution could be useful in Calgary as well.

Unlike other hospitals under consideration the CGH used demolition as a means to expand instead of a last resort when a building became totally outmoded. Like other Canadian hospitals there is a small body of commemorative writing on the CGH. The convention has been to refer to each building as 'new' hospital. Thus, the hospital of 1890-1895 was the 'Calgary General I,' or 'Cottage hospital;' its successor 1895-1910 was the 'Calgary General II;' the building in place from 1910-1953 was the 'Calgary General III' or 'Old General;' and finally from 1953-1998 the 'Calgary General IV' or 'New General' was established. It is a tedious, somewhat problematic system, but is used here for consistency sake. The TGH, WGH, and VGH all moved and rebuilt during the 20th century, but Calgary alone chose to treat each building as discrete.

The first iteration of the CGH opened in the fall of 1890 in a repurposed two-storey home on the corner of 7th Avenue and 9th Street. As a former residence, the building was not architecturally well-suited for hospital use. The bulk of accommodation was on the top floor in four small rooms. Two rooms were on the ground floor as was the kitchen. After some minor renovations the hospital

²⁶¹ For a thorough collection of essays on the NWMP see William M. Baker eds. *The Mounted Police and Prairie Society, 1873-1919* (Winnipeg: Hignell Printing Limited, 1998). Hardwick, Jameson and Tregillus, *The Science, the Art and the Spirit*, 7, 21.

could accommodate 12 patients. There was only one nurse, Mrs. Nelson Hoade, who was also cook and matron. In the entrance visitors and doctors encountered a bowl of carbolic solution to wash their hands in. Mrs. Hoade's husband worked on the ground as maintenance man. There was one assistant who did laundry and helped serve meals.²⁶²

The 1890 CGH was essentially in a temporary state. It tried to provide care without adequate funds to meet public demand. Throughout the year cots appeared in the hallways and dining room—which also served as the operating theatre.²⁶³ The 1891 annual report lamented the conditions: “It was thought in the early part of the year, some progress would have been made in the way of erecting a permanent building...but owing to the fact that our application to the Federal Government was overlooked...we found it impossible to proceed.”²⁶⁴ Trustees took advantage of these reports to remind the public no funds were made available. To increase the appeal's effect they also mentioned turning patients away.

For hospital administrators and doctors seeking funds or political leverage the threat of denying service to patients was almost always the most severe. Such rhetoric conjured sympathetic images: a desperately sick individual, a woman in labour, the victim of an accident, appearing at the hospital steps in need of assistance only to be told there was no room. However, for such an image to work, indeed for the very rhetoric of service denial to occur to administrators or politicians, there had to be a social perception that the hospital *was* the proper place for treatment. The resulting image of the hospital was an institution that bettered society by its very presence. Such appeals grew in efficacy alongside the hospital's reputation.

²⁶² Hardwick, Jameson and Tregillus, *The Science, the Art and the Spirit*, 25.

²⁶³ Ibid, 26.

²⁶⁴ “Annual Report of the Calgary General Hospital for the year Ending 31 December 1891,” 1892, 4. CGH Fonds, Box 12, File 1 Alberta Health Services Archives and Historic Collections (AHSA&HC)

Between 1890 and 1895 the CGH was too small to meet demands, and lacked the design of a medical building. Nevertheless, the range of its treatment was remarkable. In 1891, 123 patients were admitted for at least one day. The bulk of these were typhoid cases (36), but there were also 19 surgical operations, 15 cases of pneumonia, six cases of rheumatism, three cases of alcoholism, and several other conditions such as mumps, bladder infections, and tonsillitis. Other conditions appeared as well that are harder to identify such as the five cases of ‘Nervous Prostration.’²⁶⁵ The exact nature cannot be known, but their presence is evidence of some treatment for mental illness. Two cases of ‘ulceration of uterus’ appear in the statistics; however, childbirth had yet to make a large-scale move from the domestic to institutional realm.

These early days of hospital care demonstrated the influence of space on medical practice. Certain factors placed hard limits on what doctors could attempt such as the availability of surgical tools, access to medications, or presence of a laboratory. However, the physical presence of so many patients was an important aspect as well. In domestic treatment doctors and nurses generally dealt with one sick person. The challenge in hospitals was the presence of patients in almost every room. The practice of ‘steam tenting,’ prescribed to remedy a host of respiratory ailments, provides an illustration of the problem. Nurses strung sheets around a bed then placed or held steaming kettles inside. The procedure required supervision in case the patients reacted badly or became too warm.²⁶⁶ It was simple enough to perform in a domestic space. But it proved a nightmare in a setting where several patients vied for the attention and assistance of a single nurse.

The 1894 city incorporation set wheels in motion for a designed hospital building. A sympatric source of financial aid had entered the arena. Before the CPR reached Calgary the four-ward ‘Cottage Hospital’ would have been insufficient for the 4,000 residents. With population on the

²⁶⁵ Ibid, 2.

²⁶⁶ Hardwick, Jameson and Tregillus, *The Science, the Art and the Spirit*, 30.

rise more space was necessary. In 1894 ratepayers approved a by-law providing the CGH with \$10,000 for the construction of a new hospital. It was designed by the local architectural firm of Child & Wilson. Trustees learned some lessons over the previous five years, and never again would the dining and operating rooms share the same walls.

The 1895 Annual Report spared no appeal to public utility in its praise for the new buildings. It was a document dripping with the civic boosterism of prairie towns and cities in the late 19th century. “The most important event of the year was the completion of our new Hospital building....[it] is satisfactory in every way... many distinguished visitors have without exception pronounced it one of the most perfect Hospitals of its size they have visited.”²⁶⁷ The new hospital was located at the corner of 12th Avenue and 6th Street East. Mr. Mayne Daly, Minister of the Interior, laid the cornerstone on 1 September 1894. It opened less than a year later on 22 May 1895. The opening ceremony was a subdued event that featured a handful of local speakers including then-lawyer R. B. Bennett. In January 1895, the board voted to accelerate construction in the hopes of seeing the building completed all at once.²⁶⁸ Most of the structural work was finished, but plastering and painting of walls and other interior finishing remained undone.²⁶⁹ The increased building speed escalated costs, but the board’s perspective was that hospital accommodation was so poorly looked after by existing facilities that there was no alternative. The sandstone building accommodated 35 beds plus an operating room. The structure was complete, but some of the interior remained unfurnished due to financial problems. In 1895 the board could only spare \$57.70 toward the

²⁶⁷ “Annual Report of the Calgary General Hospital for the year Ending 31 December 1891,” 1896, 3. CGH Fonds, Box 12, File 2 AHSA&HC

²⁶⁸ “Minutes of the Annual Meeting of the Board of Trustees” 14 January 1895, 1. CGH Fonds, Box 3, File 1 AHSA&HC

²⁶⁹ “Minutes of Board of Directors” 16 January 1895, 3. CGH Fonds, Box 3, File 1 AHSA&HC

purchase of beds. The Women's Hospital Aid Society of Calgary (WHASC) acquired other furnishings through donations and fundraising.²⁷⁰

The CGH treated 175 patients in 1895. The number was no greater than several previous years, but the types of cases shifted dramatically in the new building. Typhoid was still the commonest reason for a night or more in hospital with 29 cases; however, there were also six finger amputations, a clubbed foot operation, nine drained abscesses, and over thirty other surgeries. There were four cases of uterine cutterage, and two cases of pregnancy.²⁷¹ In a message to subscribers the board stressed the import of the new building: "Many serious surgical operations have been successfully performed in our new building...These reflect great credit on the members of our medical staff...We now possess a first-class building."²⁷² A proper operating room was the primary reason for more varying treatment, but procedures performed in Calgary after 1895 were not newly discovered. Abscesses and fractures remained frequent in the days of the old hospital. With expanded wards, and proper operating space CGH doctors were more able to attempt operations at the hospital rather than at the patient's home.

The CGH II saw the development of an on-site training school for nurses. By the end of 1895 one woman was already accepted and two others had applied. In 19th century Canada training for nurses ranged from no formal education to attending a nursing school.²⁷³ A year later the director's annual address praised "a very efficient staff of nurses..." for which "...the marked success of the institution is due very largely to their untiring faithfulness."²⁷⁴ With the increased size of wards, and larger number of patients to care for—231 in 1896—nurses became increasingly important as the

²⁷⁰ "Annual Report of the Calgary General Hospital for the year Ending 31 December 1895," 1896, 4-5. CGH Fonds, Box 12, File 2 AHSA&HC

²⁷¹ Ibid, 8-9.

²⁷² Ibid 4.

²⁷³ McPherson, *Bedside Matters: The Transformation of Canadian Nursing*, 2-9.

²⁷⁴ "Annual Report of the Calgary General Hospital for the year Ending 31 December 1896," 1897, 4. CGH Fonds, Box 12, File 2 AHSA&HC

line between the patient and doctor. The situation was an improvement over 1890 when the solitary CGH nurse was also head cook. Nurses remained responsible for meting out discipline, serving meals, and gathering laundry.

Women played a role in the operation of the hospital, but often from outside the formal management hierarchy. For instance, the WHASC raised money for surgical tools, linens, kitchen implements, and laundry equipment. These donations aided in hospital management. Other initiatives physically changed the campus. The WHASC raised the funds to furnish a maternity ward that was not in the original plans of administrators. No hospital by-law stated administrators had to be men; however, the only women involved in CGH administration were in posts designated as female such as matron, ladies's superintendent, or head of nursing. These positions put women into contact with the institution's powerbase, but in a different way than their male counterparts.

One area where women, other than nurses, could influence hospital organization and structure was through changing attitudes towards homebirth. In part the change owed to developments in antisepsis techniques. However, it also related to doctors being more accessible in the hospital. Historian of nursing Sylvia Rinker argues that doctors were frequently unwilling to sit through the labour process. Typically they would leave, and expect to be called back just before the delivery. As a result, they often missed the birth or arrived midway through. Obstetrical nurses began discouraging homebirths due to safer hospital deliveries and ready access to doctors.²⁷⁵ The first CGH maternity ward appeared in 1896. It was carved out of the female public ward; however, an expectant mother of means could pay for a private room. In 1898 the board authorized \$8,000 towards a new maternity unit and nurses's residence.²⁷⁶

²⁷⁵ Cheryl Krasnick Warch, *Prescribed Norms: Women and Health in Canada and the United States Since 1800* (Toronto: University of Toronto Press, 2010), 92. Sylvia Rinker, "To Cultivate a Feeling of Confidence: The Nursing of Obstetric Patients, 1890-1940," *Nursing History Review* 8 (2000): 119-121.

²⁷⁶ "School of Nursing, 1895-1974" 1974, 34. CGH Fonds, Box 33, File 13 AHSA&HC

The CGH was not free of financial woes, and it ran a deficit at the end of 1896 and 1897. The federal government offered a bailout of \$749, and the Northwest Government granted \$500. The grants were welcomed, but the CGH remained almost \$3,500 in debt.²⁷⁷ The community did its best to help as well by donating money, foodstuffs, equipment such as sewing machines, and furniture. In 1897 cost per patient day decreased from \$1.17 to \$0.99 yet maintenance costs rose from \$4,248 to \$4,459. The reduced per diem did not prevent patient costs from surpassing maintenance. The average stay was 19 days, and with 4508 patient days in 1897 the CGH found itself accountable for \$4,462 which was more than the cost of upkeep. Of the 230 patients admitted only 87 entered private wards. The presumed engine for revenue generation was not working. The annual report for 1887 identified the largest pool of patients at one time as 22 and never fewer than three.²⁷⁸ Patient costs would never get below maintenance costs without private wards at constant capacity and some timely public vacancy.

Between 1896 and 1899 CGH administrators expanded services such as maternity in the hopes of attracting more paying patients. Two references appeared in the 1898 report. The first noting that “the Maternity Ward in the Hospital has been more frequently used during the past year and these cases could be much better provided for in a separate building, giving increased accommodation in the Hospital for general patients,” and again in the matron’s report: “13 maternity patients were treated in the hospital, four being at one time...It would be a great boon if there was a separate building to carry on this work.”²⁷⁹ The 1889 report noted buildings were “taxed to the utmost capacity.”²⁸⁰ Administration courted public support for expansion with appeals to

²⁷⁷ “Annual Report of the Calgary General Hospital for the year Ending 31 December 1897,” 1898, 3. CGH Fonds, Box 12, File 2 AHSA&HC

²⁷⁸ Ibid, 9.

²⁷⁹ Ibid, 4, 9-11.

²⁸⁰ “Annual Report of the Calgary General Hospital for the year Ending 31 December 1898,” 1899, 4. CGH Fonds, Box 12, File 2 AHSA&HC

overcrowding. However, they also considered certain services more lucrative than others. Separate maternity facilities solved three problems: freeing general wards since maternity cases required more privacy and thus more space, brought in a potentially lucrative constituent, and grew the campus increasing its medical footprint and civic import.

In 1899 construction began on a maternity hospital and nurses's residence. The project was made possible by the WHASC which raised \$2,223.95 through donations and events. The on-site nursing school graduated roughly two students per year who typically became employed by the hospital. The presence of increasing numbers of trained nurses removed barriers to expansion by countering the argument that there was insufficient staffing. Students remained valuable as a source of free labour since the curriculum called for job shadowing and ward hours. The maternity and nursing residence opened in 1900 at a cost of \$8,000.

Like other general hospitals in Canada the CGH feared the imposition of patients from other municipalities. In 1901 a deluge of tuberculosis patients entered the institution. Trustees sent Amédée Forget, Lieutenant Governor of the North-West Territories, a resolution that the hospital could not accept these patients and that the government had to erect its own sanatorium. The incident exposed the CGH's concern about its financial stability. The missive stressed how the CGH existed to "alleviate sickness and accidents in Calgary..." but had become "a Mecca for parties afflicted [with Tuberculosis], particularly from Eastern Canada," since there was nowhere else to turn.²⁸¹ There was some hyperbole in the board's rhetoric, but their concerns were not totally unfounded since per diems were only provided for the care of local rate payers.

During the first decade of the 20th century the CGH struggled to present the image of an institution that was both valuable and obsolete. In 1901 the board called for new infectious disease

²⁸¹ "Annual Report of the Calgary General Hospital for the year Ending 31 December 1901," 1902, 5. CGH Fonds, Box 12, File 2 AHSA&HC.

building as current facilities were “entirely inadequate and unsatisfactory,” and for the addition of a verandah to the main building.²⁸² In 1902 the board, having received no funds for the infectious disease building, set loftier goals. It called for more room in the general wards, conversion of the present maternity hospital to nursing accommodation, a new maternity building, an isolation hospital, and a laundry with steam boilers. The total estimate for these additions came to \$25,000 which was a staggering sum given the hospital was \$1,490 in debt. The 1902 trustee report commented: “I desire...to thank all who have in any way assisted in the work of this worthy institution, and trust [we] will continue to retain the support and confidence of the community.”²⁸³ The board’s rhetoric elevated the hospital above the material realm. They appealed to its civic importance, and the community’s role in its creation and maintenance.

Building commenced in 1903 when contracts were awarded for the maternity hospital, isolation hospital, and steam laundry at total cost of \$27,816. The City of Calgary provided funds for the isolation building, but a shortage of \$3,353 remained. Rather than publicly addressing debt the board insisted on the need for expanded facilities: “other extensions will be required as soon as it is at all possible to undertake them. The room in the General hospital building is not nearly sufficient for the requirements and some additions should be made during the coming year.”²⁸⁴ In 1904 the maternity hospital officially opened. The isolation and laundry buildings were complete but unfurnished. The laundry required expensive mechanical equipment which the board could not afford. The board ultimately relocated the old laundry despite the new building’s purpose of being able to house apparatuses for modern steam laundering. Furnishing the isolation building required less sophisticated items, but in greater numbers since they could not be shared.

²⁸² Ibid, 6-7.

²⁸³ “Annual Report of the Calgary General Hospital for the year Ending 31 December 1902,” 1903, 5.-6 CGH Fonds, Box 12, File 2 AHSA&HC.

²⁸⁴ “Annual Report of the Calgary General Hospital for the year Ending 31 December 1903,” 1904, 5. CGH Fonds, Box 12, File 2 AHSA&HC.

At times the process of deciding what to build resembled a riddle more than an administration challenge. For example, something as basic as increasing general ward capacity faced complex logistical hurdles. The most direct way to increase general ward capacity was to add a new wing, but that required larger laundry, kitchen, and nursing facilities. Another option was to reduce risk of infectious patients in the wards by adding a larger isolation building. To pursue any of these approaches led to sub-issues. The easiest way to increase nursing quarters was to hand over the maternity hospital as it was not an ideal building for medical practice in the first place; however, returning maternity care to the general wards would not increase occupancy making a new maternity building necessary. This chain of reasoning led to the maternity, isolation hospital, and steam laundry additions (1903-1904), and demonstrated the contingent nature of space. In essence the medical campus was an ecosystem. If one area grew, shrank, or changed the effects rippled through the whole. Hospitals administrators, and by extension the patients and tax payers who funded them, discovered they were the stewards of an institution of immense logistical demands, expense, and civic expectation.

The spatial ordering of the nurses's home and main hospital building underwent significant change with the addition of the new buildings. The main no longer required its own isolation ward. The elimination of this "dangerous feature" added 32 beds.²⁸⁵ The old maternity-nurses's home converted solely to nursing accommodation. It was a boon to nurses who would no longer return from 12 hour shifts to a space that rung with the cries of newborns. However, it was also true that the CGH was providing nurses with space only after it proved unsuitable for anything else.

Inspector of Territorial Hospitals, Dr. G. A. Kennedy's 1905 report spoke glowingly of the maternity and isolation buildings. He noted: "It is a spacious and well-designed structure, with wide halls, wide doors, fine case rooms and bath rooms on each floor." The new facility initially provided

²⁸⁵ "CGH for the Year 1905," 1905, 7. File 1, Box 4-M-2457 CGH Fonds, Glenbow Archives (GA)

accommodation for 12-16 patients. The variable bed capacity evidenced administrator's growing mindfulness of the unpredictability of needs. The isolation hospital stood a "sufficient distance" from the rest of the plant and Kennedy appraised it as "well built and well adapted for the purpose, and can accommodate 16 patients."²⁸⁶ The differences in how Kennedy described the spaces spoke to their uses. He and the board wanted women to come voluntarily to the maternity hospital. The isolation building had value during undesirable circumstances, and thus Kennedy's descriptions were utilitarian rather than enticing.

The urge to expand had not abated either. In 1905 the board petitioned both the province and city for \$16,000 in grants to add a surgical wing approximately the same size as the maternity hospital.²⁸⁷ The board had long ascribed much civic importance to the CGH, but with each building added it gained a tangible asset increasing capital holdings and providing potential collateral. A 1906 appraisal found the buildings alone to be worth \$59,225; the main building valued at \$15,000, the maternity hospital at \$13,000, the isolation building at \$11,200 and nurses's home at \$11,000.²⁸⁸ For all the rhetoric about social and medical utility—which was true—expansion had a preservationist aspect as well. The board hoped that that which grew was unlikely to die.

The trustees's decision to pursue a new surgical building led to the third rebuild in the hospital's short history. Trustees had hinted at the need for a new building almost before the CGH II opened. By 1906 subtly was over: "The number of patients has increased and we feel that the hospital will have to be added to if we are going to keep abreast of the times, and it is thought by the Board of Directors that a new Surgical Wing should be built and every effort should be made to

²⁸⁶ "Annual Report of the Calgary General Hospital for the year Ending 31 December 1903," 1904, 6. CGH Fonds, Box 12, File 2 AHSA&HC. See Appendix II, Image 2.4 for an exterior view of these hospitals, and 2.5 for interior.

²⁸⁷ "Minutes: Regular Meeting of the CGH" 20 December 1905, 1. CHB Fonds, Box 1, File M-2455, GA

²⁸⁸ "Minutes: Regular Meeting of the CGH" 9 January, 1906, 3. CHB Fonds, Box 1, File M-2455, GA

obtain a grant from the Provincial Government.”²⁸⁹ The board hastened to remind Calgarians how the surgical wing was a major project and required that they take “still more interest” to see it through. On 21 March 1906 the board commissioned drawings.²⁹⁰

By 10 September 1906 \$4,785.55 was pledged in subscription, but only \$2,768.85 had actually been collected.²⁹¹ The situation had not improved by 22 October when the board ordered the use of a canvasser to chase down outstanding subscriptions. Despite the apparent difficulty in securing funds the board established a permanent building committee on 12 November. The committee’s first task was to rank potential buildings by urgent need.²⁹² Its first official action was petitioning the city for a \$50,000 grant to finance the surgical wing, extend the isolation hospital, and provide a central heating system.²⁹³ The request demonstrated how the quest for a surgical wing immediately expanded to other needs. Similar to how the 1903-1905 attempts to ease overcrowding led to the erection of two buildings.

The annual report for 1906 identified the surgical wing as an impetus for a new hospital. Administrators could not continue simply throwing up wings whenever the occupancy limit was reached. Directors noted how “the hospital must be enlarged” and recommended that a surgical wing of at least 50 beds and operating room be added, that the main general building provide more room for administration and patients, and the isolation hospital at least double its capacity.²⁹⁴ Then there were logistical concerns, the need for a larger boiler and power house to heat the new space, and electrical machinery, and better accommodation for nurses. More patients meant more laundry, more food, more garbage, more power consumption, and more staff.

²⁸⁹ “Annual Report of the Calgary General Hospital for the year Ending 31 December 1905,” 1906, 6. CGH Fonds, Box 12, File 2 AHSA&HC.

²⁹⁰ “Minutes: Regular Meeting of the CGH” 23 March 1906. 1. CHB Fonds, Box 1, File M-2455, GA

²⁹¹ “Minutes: Regular Meeting of the CGH” 10 September 1906. 2. CHB Fonds, Box 1, File M-2455, GA

²⁹² “Minutes: Regular Meeting of the CGH” 12 November 1906. 3. CHB Fonds, Box 1, File M-2455, GA

²⁹³ “Minutes: Regular Meeting of the CGH” 10 December 1906. 1. CHB Fonds, Box 1, File M-2455, GA

²⁹⁴ “Annual Report of the Calgary General Hospital for the year Ending 31 December 1906,” 1907, 5. CGH Fonds, Box 12, File 2 AHSA&HC

The CGH suffered chronic financial problems. In the 1906 annual trustees noted: “Numerous efforts have been made to raise funds for these necessary additions but with small success...”²⁹⁵ The main economic frustration was outstanding donations. The surgical wing alone had received only \$5,215.20 in donations while general donations for 1906 sat at \$1,585.53. A by-law to raise funds for hospitals construction was the logical next step for administrators and stated they would push for one. For early general hospitals the problems was not usually in finding pledged donations but in collecting them. The city came through for the hospital in 1907 and 1908 with by-laws 757, and 900 providing grants to the CGH of \$75,000 and \$95,000 respectively.²⁹⁶ The board had an easier time convincing the city of its worth than it did donors; however, that relationship included negotiation. For instance, the 1907 grants came in response to the hospital’s petition for \$125,000 in funding.²⁹⁷ The board settled on a site north of the Bow River for the CGH III building. The area was proposed and unanimously accepted on 26 March 1907.²⁹⁸

With a site chosen and funding secured—at least enough to begin—the final hurdle for the board was to decide what to build, find architects and hire contractors. On 27 June 1907, the board empowered secretary treasurer to order plans for a ‘modern’ red-brick hospital consisting of a main, maternity, isolation, and nursing residence in separate buildings or wings. The budget was set at \$140,000.²⁹⁹ The surgical wing project began as a reaction to insufficient space, but the planning revealed that a new wing alone would not slake long-term demand. The board was convinced that the CGH could not serve the public until it expanded substantially. In late-November 1907 four plans, each scrutinized by an independent architect, were chosen for final consideration. The

²⁹⁵ Ibid. 6.

²⁹⁶ “Calgary General hospital” 18 April 1950, 2. CHB Fonds, Box 4, File M-2457, GA

²⁹⁷ “Minutes: Regular Meeting of the CGH” 21 March 1907. 1. CHB Fonds, Box 1, File M-2455, GA

²⁹⁸ “Minutes: Regular Meeting of the CGH” 26 March 1907. 1. CHB Fonds, Box 1, File M-2455, GA. For good measure the board also advised upping their funding request to \$140,000 in large part so that adjoining lots to the proposed building site could be purchased for future expansion or general hospital use.

²⁹⁹ “Minutes: Regular Meeting of the CGH” 27 June 1907, 1. CHB Fonds, Box 1, File M-2455, GA

building committee and city council would each have until 1 February 1908 for examination purposes. The window was intended to allow for a spring start to construction.

The CGH III officially opened on 1 February 1910; just less than two years after the board selected its design. The brick building was a substantial improvement over its predecessor, with a large central unit and two adjoining wings running east and west. The main floor of the east wing was for maternity cases and the east held 14 private wards and one general ward. Living quarters for nurses and administration officers were in the West wing. In the main building there were 18 private rooms and three general wards, two operating rooms, and a children's unit. A central lift connected all five floors to the kitchen on the top level to allow meals and dishes to move quickly throughout the building without creating bottlenecks during mealtimes.³⁰⁰ The CGH's capacity rose to 160 beds. It added modern amenities including an elevator, telephones, call bells, running water, and electric lighting. The size of the hospital also caused ripples in the organization of staff as the board commissioned three new departments: laundry, diet, and maintenance. The ambitious programme of expansion expressed the exuberance of a prairie boom; Calgary rode a wave of economic speculation and political progressivism.³⁰¹

The CGH struggled more than other hospitals under examination with organization and funding due to recalcitrant donors, internal divisions, and a cautious city government. The CGH lacked a strong core of civic and business leaders as the WGH or TGH enjoyed. One of the foremost

³⁰⁰ D. Scollard *hospital: A Portrait of Calgary General* (Winnipeg: Hignell Printing, 1981), 22. The ideal location for a kitchen was one of the great unknowns in hospital design during the early 20th century. Of the General hospitals explored in this dissertation they all experimented with different locations; top floors, basements, middle floors and so on. In Toronto and Vancouver hospital employed elaborate conveyor systems—'trayveyors'—to carry trays through the buildings.

³⁰¹ Alan F. J. Artibise, "Boosterism and the Development of Prairie Cities, 1871-1913," in R. Douglas Francis and Howard Palmer eds., *The Prairie West: Historical Readings* (Edmonton: Pica Pica Press, 1985) 410-421. Artibise described the booster mentality as being something 'more complex' than simple salesmanship for the idea of expansion or mindless rhetoric. However, he argues it did not approach anything resembling a complete or fully coherent ideology; though at its core he conceded an organizing principle around the notion that for a city to become better it had to become bigger. For a shorter version focused on Calgary see Max Foran, "The Boosters in Boosterism: Some Calgary Examples," *Urban History Review / Revue d'histoire urbaine* 8:2 (1979): 77-82. Though useful to the city more generally, it does not feed into anything relating to the hospital or medicine.

strengths of the CGH was the WHASC which bankrolled much of its early expansion. From 1890-1910 the CGH resided in buildings that were not modern, but the CGH II moved in that direction. The addition of new wings to increase bed capacity by around 30 would never keep up with demand; however, administrators pursued that tack until the planning stages of the CGH III. By 1910 hospitalization in Calgary had a foothold. It grew from a converted residence to a series of cramped wings, and finally to a building incorporating the successes and failures of the previous projects. As the hospital moved into the 20th century its future became bound more tightly to the municipality than the interaction during its establishment would suggest.

Vancouver – 1886-1910

The VGH, like much of built Vancouver in the 19th century, owed its genesis to the CPR.³⁰² Commemorative histories evoked images of rail labourers stopping at the medical tent, the first hospital servicing the area, to have work injuries stitched up.³⁰³ As the city grew so did demand for health care. Vancouverites soon began to stretch the CPR's medical resources. On 13 June 1886 fire destroyed much of the city. Following this crisis, the board of health negotiated a deal with the CPR whereby it would take over running the hospital in exchange for providing CPR employees with care at a reduced rate.³⁰⁴ Popular historian Clare Marcus wrote in an official VGH history "...growth in building alone did not satisfy the people of Vancouver, who were determined to obtain improved hospital management free of any profit motive."³⁰⁵ The reduced rates were public knowledge.³⁰⁶

³⁰² Robert McDonald, *Making Vancouver 1863-1913* (Vancouver: University of British Columbia Press, 1996), 67.

³⁰³ Peter Walton, *The VGH Story: A History of the Vancouver General Hospital, A Century of Caring* (Vancouver: Vancouver General Hospital Public Relations Department, 1988), 1-3.

³⁰⁴ Margaret W. Andrews, "The Best Advertisement a City Can Have: Public Health Services in Vancouver 1886-1888," *Urban History Review/Revue d'histoire urbaine* 12:3 (1984): 19-21. For a somewhat popular though serious history of the fire in more detail see Lisa Anne Smith, *Vancouver Is Ashes: The Great Fire of 1886* (Vancouver: Ronsdale Press, 2014)

³⁰⁵ Clare Marcus, *History of Vancouver General Hospital* (Vancouver: Vancouver General Hospital Public Relations Department, 1977), 3.

³⁰⁶ "The City Council," *The Vancouver News Advertiser*, 9 November 1886, 1. The reduced rate deal also applied to the Hastings Mill Company.

The modest size of the VGH's first incarnation demonstrated financial uncertainty and the tentative nature of the city's foray into health care. On 23 May 1888 Vancouver passed a by-law to raise \$150,000 through debentures for general improvements to the city. The law earmarked \$10,000 for the purchase of land, equipment, and material to build and operate a general hospital. The city made further comment on 22 June stating: "For some time past it has been apparent that the present hospital accommodation of the city were extremely inadequate to its rapidly increasing wants and the attention of the...City Council has been directed towards supplying the required accommodation."³⁰⁷ The city took over hospital services in a moment of crisis where demand was naturally high. As normalcy returned elected officials realized they had come into the operation of a crucial civic institution.

Medical and architectural actors spurred the actions of city council as well as civilians demand. In the summer of 1887 a London physician, Dr. Edmunds, visited Vancouver. At the council's request, he inspected hospital facilities and addressed a meeting where he appraised the current conditions. He suggested a new building with more beds was the most pressing need. Soon after the city opened bidding to architects interested in designing a new hospital. The winner, A. S. McCartney, was empowered by city council to make further modifications to the design as he saw fit. The city publicized the involvement of these professionals and promised the citizenry a building to feel proud of. Investing tax-payer funds required as much attention to rhetoric as it did to architectural drawings and financial planning. On 22 September 1888 the hospital opened. However, it represented only one third of the edifice depicted in McCartney's drawings. The full plan involved three wings connected by enclosed galleries. Erecting one wing alone cost \$8,000 which put full realization out of the question. The council saw the upside in a partial implementation. A small

³⁰⁷ "Excerpts from the pages of the 'News Advertiser,' Vancouver British Columbia: May-June-July-August-September 1888" 23 May 1945, 1. Box 535-D-1, file 1, Vancouver General Hospital Fonds, City of Vancouver Archives (VGH Fonds, CVA)

project meant less risk and expansion was still possible.³⁰⁸ The remaining \$2,000 from the initial grant was used to procure medication, equipment, and furniture necessary for the operation of the hospital.

The VGH was a two-storey frame building that rested on a dressed stone basement. It extended 27 by 75 feet inclusive of an annex for bathing that took up 12 by 20 feet. Inside the walls were extra layers of rough boards and tarpaper. The exteriors were plastered and the floors deadened in an effort to diminish noise and increase structural stability. Dampening sound made practical sense in a hospital. Other decisions, such as placing an entire flight of stairs at the front door, emphasised aesthetics over utility. The operating room was on the first floor near the entrance. Across from it was a dispensary, and nurses's room with a window for observation. The main ward was a "spacious" area of 27 by 50 feet and a ceiling height of 14 feet with an intended capacity of 16. Four, three by seven foot French windows encircled the ward which opened onto wide verandahs. Other amenities included ventilators, multiple stoves for heat, and electrical lightning. With total square footage of 1,350, patient beds had approximately nine by nine foot plots, less what floor space was needed for furniture and equipment. The upstairs contained a similar open ward of 16 beds for women, a balcony, nurses's room and three private wards. There was also a full basement, containing a kitchen, store rooms, laundry, and administrative offices.³⁰⁹

The council had political motives in describing wards as spacious, the building as sturdy, and the materials and workmanship as being of the best quality. When providing the *Vancouver News-Advertiser* with information pertaining to the new building administrators emphasised the five-foot-wide staircase that connected the first and second floor. The ability of space to influence the mood of patients underpinned much of the description. Readers learned of the "magnificent view of the city

³⁰⁸ Donald Luxton, *Vancouver General Hospital 100 Years of Care and Service* (Vancouver: Vancouver Coastal Health Unit, 2006), 4.

³⁰⁹ "The New Civic Hospital," 22 June 1888, 4. Box 535-D-1, file 1, VGH Fonds, CVA

and Inlet” from the balcony or the French windows.³¹⁰ These descriptions marshalled the promise of comfort, wholesomeness, and relaxation to present prospective patients with the image of a healthy space worth visiting.

The VGH opened without ceremony; however, a low-key beginning did not avoid mishaps. The stairway leading to the front door concerned the medical staff. Dr. C. F. Dodington wrote in the *News Advertiser* that 17 uneven steps frustrated entrance for the able-bodied let alone the injured or ill. He asked hypothetically: “Fancy a patient with fractured ribs or a broken thigh, or any other agonizing injury, jerked and jolted up these 20 steps in a torturing Jacob’s ladder before entering the haven of rest and recovery above.”³¹¹ Dodington only criticised the architecture. He was confident the treatment dispensed—his purview—was not in doubt.

Dobbington had broader aims than architectural change. His comments spoke to a feud between the hospital and board of health. The letter continued: “The hospital entrance and sidewalk ought to have been on the same level. This error will have to be rectified at considerable cost. I cannot conceive that such a mistake as this would have been perpetrated had there been a Medical Board in office during construction...”³¹² Dobbington’s reaction to architectural elements demonstrated that doctors were interested in physical design and aware their position had political leverage. The call for a medical board revealed that some doctors wished to integrate directly into the administrative structure.

Administrators sought to justify the new building’s expense by regaling the public with grand descriptions of space, patient experience, and civic utility. They promised the new hospital would prove: “one of the best investments... Vancouver has made,” subtly restating the novelty of a public

³¹⁰ Ibid.

³¹¹ “City Hospital to Editor,” *Vancouver News Advertiser*, 7 September, 1888,” 4. Box 535-D-1, file 1, VGH Fonds, CVA

³¹² “City Council,” *Vancouver News Advertiser*, 22 September 1888, 8.

building specifically for health care. Though there was no opening ceremony, administrators dramatized the transfer of patients from the old building by suggesting the “poor sufferers already looked better for the change.” They described the main ward—the only one actually fully operational on 22 September—as “cheerful and homelike” in appearance, mentioning the bright fires and beds with “snowy” coverlets as the very “embodiment of rest.” The space was not defined solely by its furniture. There were human props as well. Miss Cricknay, in a high, white linen cap and regulation nurses’s uniform “looked the personification of Sir Walter Scott’s ideal.”³¹³ The description revealed the uncertain position of the hospital in the public imagination. Unlike mid-20th century portrayals that stressed medical services and modern technology these emphasised domestic virtues of cleanliness, quiet, and calm.

The new VGH was at once a response to shortcomings in public health, an architectural triumph, a medical shrine, and a domestic pastiche. In isolation any of these descriptions rung true, but comparison brought conflict. For the grand vision of the architect and his three-winged hospital only one was built, and it won the ire of the medical staff. For every effort made to mimic the idealised domestic setting there was the bustle of visitors, the cries of patients, and the relentless crusade of doctors and nurses enforcing hospital standards.³¹⁴ The administrative structure blurred the lines between medical practice and politics. A medical board—not established until construction was completed—consisting of five doctors oversaw the hospital; however only sitting members of city council had votes. In effect any decision made by the medical board was a suggestion to the city.

VGH doctors found both city council and its organ, the board of public health, difficult to deal with, and formed the Vancouver Medical Society (VMS) in response. In the ensuing squabble three distinct factions emerged: the medical profession and its representation the VMS, the broad

³¹³ Ibid, 9. Surely referring to Scott’s quote: “Chivalry! --- why, maiden, she is the nurse of pure and high affection --- the stay of the oppressed, the redressed of grievances, the curb of the tyranny...” Above quotes from this page too.

³¹⁴ “The VGH as a major medical centre,” 1954, 1. File 1, Box 535-D-7 VGH Fonds CVA

membership of city council, and the board of public health. The VMS perceived the board of public health as its principle adversary. During the summer of 1888 doctors from the medical society wrote city council to voice displeasure over the fact they had been kept out of the recent drafting of hospital rules. The city ignored these initial communications, and dismissed a VMS delegation. The board of public health provided input instead. In July 1888 city council assigned a physician—Dr. Robertson—to the hospital staff against a VMS recommendation. In response, the medical society wrote city council claiming that through “influence over the Board of Health,” and “wire-pulling” Dr. Robertson had been effectively “appointed” to the Medical Board of the hospital.³¹⁵ The VMS sought to present the situation as the city and board of health making a decision at the public’s expense. The society stressed how the position came with a \$1,000 salary to ensure it looked even more nefarious.

The city acknowledged in the fall of 1888 that it had made a mistake, but stopped short of admitting to the more serious implications about corruption. The municipality conceded that “several medical men in the city, besides a large majority of its citizens...” felt the appointment unjust and since “it is the patient’s interests [that] should be considered the public should have a voice in the matter.”³¹⁶ The incident revealed the growing civic and social significance of the VGH. The council could not administer the hospital. It relied on the expertise and skills of the medical profession and VMS. The council needed society's goodwill in order to work.

The VMS took city council’s admission as a blessing to proceed with more drastic actions. On the evening that the aforementioned remarks became public it held a meeting and resolved that the last medical staff election was “informal, irregular and void,” and demanded that city council

³¹⁵ “Action of the Medical Society” *Vancouver Daily World* 12 October 1888, 1.

³¹⁶ *Ibid.*

restart the process.³¹⁷ One much-contested issue was the size of the medical board. The committee attempted to address that issue as well. Dr. Dodington drafted a management scheme calling for all nine qualified physicians at the VGH to be nominated for the position given to Dr. Robertson, and the board size itself should never be fewer than six. At a public meeting on 12 October Dr. Dodington courted public approval stating: “The Chairman of the Board of Health, however, wanted merely five medical men and appointed whom he had chosen...the Council should be ashamed...The whole thing was arranged beforehand...No clique or rings should be allowed in this body.”³¹⁸ Interestingly, Dodington chose to leverage public abhorrence of corruption and waste rather than his medical qualifications.

The general public interfaced with the hospital in more than ways than electing municipal officials. The most direct and intimate way was as a patient in either the free wards or private rooms. Injury, sickness, and pain are experienced foremost at the sensory level of the individual; however, the presence of a person suffering invariably affected those around them. Visitation was another cause for private citizens to venture inside the VGH. Visitation presented a host of problems for medical staff, especially nurses, as it broke routines, excited patients, risked infection, and induced sadness.³¹⁹ Nevertheless, administrators knew the VGH could not be a closed institution. It set a visiting hour between three and four o’clock on Wednesdays and Sundays. Special permission could be obtained for other hours, but required approval from the medical board. Other factors limited entrance as well. Religious services were banned in public wards, and a clergyman could only visit upon patient request and physician approval.³²⁰

³¹⁷ “The Hospital Board” *Vancouver Daily World* 13 October 1888, 1. This article contains reprints of the meeting minutes from which the remarks are gathered.

³¹⁸ *Ibid.*

³¹⁹ Bruce Lindsay, “Pariahs or Partners? Welcome and Unwelcome Visitors in the Jenny Lind Hospital for Sick Children, Norwich, 1900-50,” 111-113. in Graham Mooney and Jonathan Reinartz eds., *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (New York: Editions Rodopi B. V., 2009)

³²⁰ “Report of the Health Committee” *Vancouver Daily World* 16 October 1888, 1.

Patient experiences in the VGH revealed the conflict between administrative attempts to control space and human agency. Hospital rules provide a useful vista from which to glimpse the lived experience of patients. Granted rules were only as relevant as the thoroughness of enforcement. Doctors and orderlies patrolled the wards making rounds and attending various matters. However, nurses were the primary supervisors of these spaces. The most marginalized of all medical agents was the most visual, and present symbol of authority. Controlling access to space was a central component of designing rules, especially given how wards were segregated between paying and non-paying. To maintain this division a patient could only leave the ward with the matron's permission.

Other rules focused patients at an individual level by policing the body or mind. Patients were to "keep themselves clean and respectably dressed," while "rendering willing obedience to all orders" given by the hospital staff.³²¹ All patients so able were to be out of bed for breakfast, and then vacate the ward to allow for cleaning prior to the physician's rounds. Rules prohibited many forms of socialization and entertainment including playing cards, gambling, noisy conversation, loitering in halls and washrooms, or smoking. Other rules implied the tediousness of a stay in hospital and the proclivity of patients to find diversions. These included prohibitions against lighting matches, defacing the walls, using bathroom sinks for laundry, profane language, ungentlemanly or unladylike behaviour at the table, and emptying of waste baskets into the sinks. Patients were naturally forbidden to bring alcoholic beverages or have such drinks delivered by visitors. Any patient who was able had to assist in the care of fellow patients as directed by the ward Matron. By 9 o'clock all had to be in bed with the lights off.

Rules revealed patient tendencies that frustrated the ability of nurses and doctors to carry out their tasks. They also showed the drudgery of being bedridden or confined to a ward. Some rules were practical, such as preventing the wearing of boots in bed or emptying of waste bins into the

³²¹ "Untitled list of rules" 1890, 17. Box 535-D-1, file 1, VGH Fonds, CVA

sinks risked damage to equipment. Others made medical sense, for instance imbibing alcohol or smoking—even before the full health concerns of these products were understood—could aggravate symptoms. However, the regiments of time, the policing of language, the insistence on ‘ladylike’ behaviour, and bans on cards and gambling spoke to administrative concern about the social atmosphere. The hospital had to conform to an image of domesticity, of order, and of upstanding behaviour that if ignored would hobble the institution and undermine its reputation. Rules also addressed the actions of the staff. Nurses were barred, under threat of dismissal, from interfering with the religious opinions of a patient. They had to convey an image of religious neutrality. Nursing duties extended beyond the palliative care to ensuring sanitation throughout the ward, and that floors and walls were kept “scrupulously clean and in order.”³²² Nurses had a different experience than patient, but their conduct and non-medical duties, played an important role in maintaining the hospital as ordered, clean, wholesome, and secular.

Between 1890 and 1902 two red-brick additions were added, but were not enough to satisfy demand for beds. The board reported in late-September 1902 that the present accommodation was “wholly inadequate.” In January 1903 a by-law allotted the VGH two city blocks for the erection a new facility. The board was concerned about finances and turned to the public for aid. Directors positioned the hospital as a civic necessity: “The erection of a modern hospital will so much add to the pride of the City...The hospital is for all and should appeal to all and nothing will help it as forcibly as prompt, bold action.”³²³ In 1902 the VGH was incorporated which marked the beginning of its time as a ‘general hospital,’ and ending its brief history as the ‘Vancouver City Hospital.’ The Act called for the City of Vancouver to provide \$50,000 in debentures to the hospital for erection of buildings and upkeep.

³²² Ibid.

³²³ “Report of adjourned meeting of Board of Directors” 30 September 1902, 1. Box 535-D-5, file 2-3, VGH Fonds, CVA. Also source of above quote.

The 1902 project consisted of a main building with east and west wings designed by the architectural firm Grant & Henderson. Completed in 1905 it added new operating rooms and an administration building. A nurses's home was also part of the project albeit badly behind schedule. In the interim nurses received temporary quarters in the administration building which was initially intended for private ward use. In 1903 the city transferred \$50,000 to the VGH which accounted for 60% of the cost. A provincial grant of \$20,000 came soon after. The board accepted the building committee recommendation for 300 beds, nurses's home, laundry, isolation building, mortuary, and power plant for electric lighting and heating. The main building was three storeys while the wings had two, each containing four public wards of 16 beds, four semi-private, and 20 private to allow for 100 patients in each.³²⁴ The balance of the decade saw two minor extensions. A wooden isolation building was added in 1906 and a southeast wing constructed in 1907.

The municipal-level bickering over hospital management, visitation hours, and religious practice speaks to the larger change in social organization as it related to health services. City council did not have experience administering a hospital, just as many of the doctors practicing within the freshly-erected VGH walls had not previously considered managing an institution. The religious diversity of Canadian society, outside Quebec and several predominately Francophone regions in other provinces, precluded a community wide service under church direction.³²⁵ Civil, secular society had to work out arrangements among political, medical and donor groups. In Vancouver between 1888 and 1910 the medical profession did a better job recognizing the shift in how medicine would be experienced and leveraging public support to elevate their standing and achieve their goals.

³²⁴ "Minutes of Monthly Meeting of the Board" 12 March 1903, 1-2. 320 Series A Vol. I VGH Fonds ,CVA. The Provincial grant was 14 May 1903.

³²⁵ Gagan and Gagan, *For Patients of Moderate Means*, 2-9. Risse, *Mending Bodies, Saving Souls: A History of Hospitals*. 8, 216.

Conclusion

The historiography of the hospital in Canada and elsewhere has made much of how ‘Listerism’ made surgery and convalescence much safer.³²⁶ What it has not considered in great depth is the extent to which that was understood by doctors at the time. Doctors applied recent discoveries, and were active agents in the entrenchment of hospitals in a position of public prominence. The first pages of hospital history—like much of medical history—were written by doctors. The history of hospital growth in the late-19th century must be seen not solely in the glow of medical advancements. Clarke’s 1913 history of the TGH commented that even before “the blessings of Pasteur’s and Lister’s discoveries” since the 1870s the hospital had become truly formidable, and medicine had advanced substantially.³²⁷ The medical community saw potential in research, education, and specialization that required a hospital rather than domestic setting.

Building hospitals in the 1880s was a risky venture for all involved. For architects they were grand projects with no guarantee of being realized. Municipal politicians saw in hospitals the opportunity to etch their mark upon the city’s landscape, and provide a tangible bit of good. However, they also risked serious debt, scandal, and ridicule. By the early 1900s it was the general public that had that greatest variety of interest at stake. Individuals faced the prospect—but not guarantee—of healing, better care for their families, and safer births. The hospital was a major economic boon, not only through those it employed directly, but also through its consumption of food, materials, and medicines. Meanwhile, doctors risked reputation and health to operate a new, class-diverse space.³²⁸

³²⁶ Though this was not without internal debates. See J. T. H. Connor, “Listerism Unmasked: Antisepsis and Asepsis in Victorian Anglo-Canada,” *Journal of the History of Medicine and Allied Sciences* 49 (1994): 207-239.

³²⁷ Clarke, *A History of the Toronto General Hospital*, 79.

³²⁸ Robert Woods, “Physician, heal thyself: the health and mortality of Victorian Doctors,” *Social History of Medicine: The Journal of the Society for the Social History of Medicine/SSHM* 9:1 (1996):1-4. The social history of medicine has a ways to go in applying its focus on experience and perception of sickness to doctors. Woods is one of the few to do so.

Architects played a smaller role in hospital development than they would in the 20th century. In large part because many hospitals took up residence in existing spaces such as homes or abandoned buildings. In such cases there was neither cause nor resources to hire an architect. As the hospital became a more entrenched institution, the prospect of new buildings increased, and professionals became involved. These architects did not always specialize in hospital design. Instead they experimented on how to develop medical space, working closely with doctors and administrators. Each province granted administrators the authority to “erect, equip and maintain all buildings.”³²⁹ However, doing so required the knowledge of professionals like architects and doctors. The architectural profession developed many hospital specialists in the 20th century. Even during periods of little or no expansion architects sat on hospital building committees to provide guidance on maintenance and planning.

The arc of nursing professionalization that bound these workers to the hospital was crucial to the institution’s entrenchment in civic life. Initially not all nurses were formally trained, even still their presence was crucial to daily operation. Yet, they reinforced some of the basic ordering of the hospital. In the 19th century it was common for private nurses to follow patients into the hospital. A nurse could specialize in private ward nursing, and would attend a particular patient who paid for her services. Though private nurses were still subordinate to the authority of staff doctors.³³⁰ Nursing had to overcome a less than flattering image that developed in tandem with ineffectual healthcare facilities. In Toronto, Clarke reminisced that “nursing was not a profession, not even a vocation, but, ordinarily, a makeshift adopted by the Sairy Gamps and Betsy Prigs of the bygone days. Few, if any, had the vision of Florence Nightingale, that angel of mercy, whose doings...awakened the

³²⁹ *An Act Respecting the Toronto General Hospital, Revised Statutes of Ontario*, 1906, c. 15, pp. 509 The TGH is cited here, though the same language appears in all Provincial General Hospital Acts in this time period for the hospitals under discussion.

³³⁰ McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*, 2-4.

world to the possibilities of nursing as a profession.”³³¹ Administrators needed nurses to function, but they also needed the public and medical communities to trust and accept them. The type of work also contributed to the importance of nursing and the establishment of the profession as the hospital’s supporting pillar. Patient stays were generally quite long. People who entered a hospital often stayed for several weeks with much of that time spent in convalescence. Some of that could have taken place in the home if not for concern for infection or relapse. Nurses did not perform surgery, diagnose, or prescribe. However, they could administer medication, change dressings, and as the main authority on a ward when doctors were not present, frequently occupied the role of most *useful* medical agent.

It seems unfair to condemn hospitals in the 19th century for overcrowding or incurring debts. While neither was a good state for a health care facility, the presence of these problems obscures more significant aspects of late-19th and early 20th century hospital projects. The expectation of donors and patients were important. An 1897 traveller to the CGH was “pleased with the institution and surprised that such a complete building for the purpose should be found in the west.”³³² The general hospitals discussed in this chapter had no sole impetus. The territorial, provincial, and municipal levels of government dispensed resources. But hospitals were far from state projects. Religious groups, women’s organizations, wealthy philanthropists, doctors, nurses, and average citizens were just as important. They donated funds, materials, time, labour and professional services that ensured their hospitals approached a measure of success.

The period 1880-1910 was one of relatively limited communication between the four case study hospitals. By the end of the period professional networks of doctors and architects were

³³¹ Clarke, *A History of the Toronto General Hospital*, 91

³³² “Annual Report of the Calgary General Hospital for the year Ending 31 December 1897,” 1898, 5. CGH Fonds, Box 12, File 2 AHSA&HC

beginning to forge links in western Canada.³³³ The TGH was in regular contact with hospitals in New York and Montréal. Its western counterparts were focused primarily on establishment and survival rather than fine-tuning. These hospitals were not isolated; VGH administrators sought the aid of a British doctor to survey their institution. In 1912 the WGH requested a \$30,000 grant on the basis what the TGH and Montreal General was receiving.³³⁴ Travellers and settlers brought information about hospitals in the east. The hospitals were connected by other, non-medical processes such as the developing state and its arm the CPR. In 1881 the CPR bridged the Red River bringing a flood of settlers to Winnipeg. It did the same for Calgary's population in 1883, and in 1886 passed the medical facility that became the VGH to Vancouver's city council.³³⁵ The CPR's expansion consistently demonstrated how urban populations needed hospitals. The late-19th century hospitals being founded in Canada's west were components of a boom in urban development and population growth. These institutions had the advantage of appearing in a time when hospitals and medicine became necessary to each other as never before. General hospitals of this vintage were as much a part of civic identity and history as they were necessities to the provision of medical care, research, and education.

The west-bound traveller who remarked on the state of the CGH demonstrated the sheer enormity of the task these cities faced. The accountant's ledger rarely balanced and the patients's stays were long; however, the quintessential purpose of the hospital to care for the ill and heal the injured, advanced during the period of 1880-1910. The efforts of volunteer administrators, nurses, and doctors rehabilitated the image of the hospitals. They shielded their fledgling institutions from grotesque imagery of 'gateways of death,' and shepherded them towards professionalization,

³³³ Carr and Beamish, *Manitoba Medicine: A Brief History*,

³³⁴ "WGH Requires \$30,000 to meet outstanding Liabilities and Maintenance Account for 1912," 1912, 1. Folder 1, Box 7 WGH Fonds PMA. The WGH received \$1.25 per day (\$1.00 from city, \$0.25 from the province) when patients cost was \$1.92. The board noted how in Montreal the per diem was \$2.15, and \$1.50 in Toronto.

³³⁵ "Beatrice Fines Manuscript – A Hundred Years of Health," 1972, 33. Folder1, Box P498 WGH Fonds PMA

scientific medicine, education, and clinical sanitation. Expectation cut both ways. As these institutions endured into the 20th century the great achievements of yesteryear became reminders of a barbaric age, primitivism, and best efforts. What administrators gained during the years 1880-1910 was legitimacy as a useful institution. What followed in the 20th century was a quest to produce and maintain ‘modern’ spaces.

Chapter III – “a private enterprise performing a public service” War, Depression, Stagnation and Growth, 1911-1945

By 1911 general hospitals in Toronto, Winnipeg, Calgary, and Vancouver were established community institutions that had struggled, survived, and completed large-scale building projects. 1911-1930 was a settling-in period for management as they moved toward larger, better-funded campuses. Hospital professionals, in the form of architects, consultants, and administrators became more common. The apparent permanence and civic presence of general hospitals contributed to growing patient demand. Local factors remained at the forefront of building praxis, but administrators made design and organizational decisions on the advice of more voices. Influence from American and Canadian hospitals began to affect administrative decisions more often; however, they never eclipsed regional needs. In the 1930s financial catastrophe tightened the purse strings of governments and private donor, halting expansion and forcing doctors, administrators, and nurses to find new ways of stretching space and resources.

For patients 1911-1945 was a transitory phase where large public wards began falling out of favour and semi-private rooms started shifting to standard accommodation. Though this period—evidenced by the 1919 ‘Spanish’ influenza pandemic—was not free from urban sickness and contagion, public health improvements had a salutary influence. Accordingly, hospitals were less battered by waves of unassailable diseases.³³⁶ The alliances forged with universities in the first decade of the 20th century began to bear fruit, and patients became an increasingly valuable resource for education and research. Patients were acquiring a voice in how they expected to be treated, what

³³⁶ Christopher Rutt and Sue C. Sullivan, *This is Public Health: A Canadian History* (Ottawa: Canadian Public Health Association, 2010), 58-60. Outbreaks of controllable disease still occurred. In 1923 an outbreak of typhoid due to contaminated water in Cochrane killed 50. In 1927 milk contamination killed 533 in Montreal. For contrasting examples from the 19th century see Geoffrey Bilson, *A Darkened House: Cholera in Nineteenth-Century Canada* (Toronto: University of Toronto Press, 1980) or Michael Bliss, *Plague: A Story of Smallpox in Montreal* (Montreal: HarperCollins Canada, 1991) Bliss in particular makes much of the public health failure given the disease could have been completely halted by vaccination. Bilson focused more on social and political aspects of public health, namely quarantine.

services ought to be offered, and how institutions should expand. The public exerted influence by voting for funding by-laws.

Hospitals were not immune to more general changes in social organization. As municipal, provincial, and federal governments modernized hospitals followed suite.³³⁷ On a micro level this meant a swelling of committees, increases in the size of governing boards, and numerous tedious reports. In a macro sense increasingly sophisticated governing systems, coupled with the importance of hospitals to public health, led to intermingling with government officials. Hospitals—except the CGH—sought to maintain independence while entering into alliances that could provide funds. The peculiar legal and social position of hospitals discussed in chapter two carried on with a slightly different flair. Hospital value was less debatable, but these institutions remained expensive and technically demanding to operate. Trustees generally maintained autonomy despite an approaching vanishing point where the state and hospital combined.

By the 1920s hospital reputations had improved dramatically in the public imagination—it was no longer the charnel house—but this was largely on grounds of medical efficacy rather than administrative competence. Doctors were better at healing, curing disease, setting bones, and conducting surgeries in the hospital; that much was clear to the average citizen. What was unclear was why costs were high, debt crippling, and the need to build new facilities constant. In the following decades the idea of professionalization became crucial to administrative staff seeking public respect and trust.³³⁸

If 1880-1910 were decades of establishment, 1911-1945 were decades of entrenchment and formalization. Consultation and architectural firms specialized in hospitals, the medical profession

³³⁷ Doug Oram, *The Government Generation: Canadian Intellectuals and the State 1900-1945* (Toronto: University of Toronto Press, 1986), 47. Oram examines the growing influence by social scientists and intellectuals on government bureaucracy.

³³⁸ G. Harvey Agnew, *Canadian Hospitals 1920 to 1970: A Dramatic Half Century* (Toronto: University of Toronto Press, 1974), 59-65.

embraced the institution as central to research and healing, and citizens came to regard it as a community pillar.³³⁹ Building and internal arrangement remained central to the daily work of administration; however, their agendas now included juggling a host of political and legal interests as well. Hospitals experienced a growth in politicization, especially after the Second World War when the politics of health became a major voting issue.³⁴⁰ Administrators became more aware that they oversaw an institution of practical import and political utility; the voters listened when it came to their health. These decades, especially the 1930s, were also times of struggle during which costs spiralled and campuses stagnated. Scrimping could only go so far before it became counter-productive—functionality could only outweigh aesthetics to a certain point—and solutions came in the form of fluid design and mechanization.

Toronto 1911-1945

In March 1911 Toronto's political nobility gathered to lay the corner stone of the 'New General.' The honour party included Governor General of Canada Earl Gray, Bishop James Sweeney, Lieutenant Governor of Ontario John Gibson, and Mayor George Geary.³⁴¹ The presence of such illustrious guests demonstrated growing institutional prestige. Men of power perceived political and social value in attending. When the building opened in 1913, it became known as the 'New General' or College Street Hospital. The Old General was scheduled for demolition, but this was not carried out until after the First World War. On the day prior to opening trustees released a statement hoping to seize political capital and remind the community of the hospital's value. "As might be supposed, with the prospect of entering the New Hospital at such an early date a great deal has to be done in the

³³⁹ David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950* (Montreal: McGill-Queen's University Press, 2002), 66-68.

³⁴⁰ Alvin Finkel, *Social Policy and Practice in Canada: A History* (Waterloo: Wilfred Laurier University Press, 2006), 169-174.

³⁴¹ "Laying the Corner Stone," March 1911. File 1430-1711, Box 8. TGH Fonds UHN Archives

way of perfecting an organization designed to meet changed conditions.”³⁴² The rhetoric laid the groundwork for an organizational agenda predicated on amplifying the research and teaching relationship with the university. In a case where patients paid the price of administrative ambition, ‘nervous wards’ were removed in order to accommodate a larger number of nursing students.

The 1912 annual report took a hard line defending the decision about ‘nervous wards.’ It stated, “The public does not understand, apparently, that the institution is not equipped to deal with these people satisfactorily or with safety to patients and nurses...if we must open our doors to patients suffering psychosis we do so at very great risk, especially when patients are either homicidal or suicidal.” The rhetorical scope was sweeping. It appealed to potential patients on issues of safety, employee experience, and medical limitations. However, it also marshalled an architectural argument: “No amount of foresight in a building not specifically equipped will provide against a tragedy occurring in some of these instances, and that we have escaped during the past year has been largely a matter of good luck.”³⁴³ The board’s claim was fair in so far as it was true that contemporary convention ascribed specific needs to psychiatric care facilities.³⁴⁴

The 1913 opening of the ‘New General’ followed a formal celebration and several days of public inspection. Administrators speculated that at least 150,000 Torontonians—approximately 40% of the city—came to see it. The building opened to patients on 10 July 1913, many of whom were transferred from the Gerrard Street building by ambulance.³⁴⁵ The new hospital consisted of several interconnected wings which included an administration building, medical wing, surgical

³⁴² “TGH Annual Report for the year ending 31 December 1912,” 1913, 17. File 1.2.10, Box 8. TGH Fonds UHN Archives. See Appendix III, 3.1 for a drawing of proposed pathology building that was part of the new hospital expansion.

³⁴³ Ibid, 17. Source of above quote as well.

³⁴⁴ Edna Hudson, *The Provincial Asylum in Toronto: Reflections on Social and Architectural History* (Toronto: Toronto Region Architectural Conservancy, 2000), 14-17.

³⁴⁵ “TGH Annual Report for the year ending 31 December 1913,” 1914, 15. File 1.2.10, Box 8. TGH Fonds UHN Archives

wing, emergency building, out-patient building, power house, nurses's home, servants building, private patient wards, obstetrics service, workshop, and garage.

The building's design took patients into consideration. The height and depth of examination cubicles was chosen to ensure that "...during examination or treatment [the patient] is hidden from the curious eye of his neighbour."³⁴⁶ Areas such as hallways were policed. Patients had to remain seated in the hall until called by a nurse. Forced seating was a situation where the curve of power bent in two directions. The act was not invasive, but it harkened to the discipline of the factory or school where movement was regulated.³⁴⁷ It also ignored medical considerations. A patient could have sought relief through movement or reprieve from a congested space. No repeal of the rule appears in surviving documents; however, future reports do not refer to it which suggests it was relaxed or abandoned. For the hospital, every rule was a responsibility, another issue to manage or track. Rules likely to be broken or require significant effort to keep in place took time away from medical practice. Loosening rules was sometimes the best way to maintain order.

Administrators began deploying staff inside the institution toward the pursuit of nonmedical, but still important tasks. In 1915 social workers were posted at exits to the general wards and outpatient clinic. Their job was to solicit information from discharged individuals, remain in contact, and follow up during recovery. It was not strange for the social service department to enter the discharge process, but it revealed how recovery was not just a patient concern. The 1915 annual report suggested "The efficiency of the hospital plant should be tested as the business man tests the efficiency of his business."³⁴⁸ The TGH's goal was to reduce relapses due to ineffective treatment.

³⁴⁶ Ibid, 29.

³⁴⁷ See Susan E. Houston and Alison Prentice, *Schooling and Scholars in Nineteenth Century Ontario* (Toronto: University of Toronto Press, 1988), 108. The conventional sources for this observation reside with scholars like Foucault. However, Prentice and Houston focus on the presence of 'discipline' in Canadian education. Though their analysis ends in 1900, many patients of this period would have experienced that system.

³⁴⁸ "TGH Annual Report for the year ending 31 December 1915," 1916, 31. File 1.2.13, Box 8. TGH Fonds UHN Archives

Ensuring effective treatment was closely related to patient selection. A large section of the 1915 annual report railed against incurables—wartime austerity likely forced many elderly people from their or their children’s homes—employing some especially colourful rhetoric. “The aged left in our hands have to be fitted into the institution like marble in a piece of mosaic work.” The wards were so filled with ‘legitimate’ patients that the influx of the elderly who were more aged than ill caused much strain. The report noted: “legally children are not responsible for parents and when senility approaches the hospital is the convenient dumping ground for the useless members of a family.”³⁴⁹ The harsh wording spoke to the severity of what administration viewed as ‘improper’ patients entering the hospital. Besides draining resources and slowing operation doctors gained virtually no research value or technical knowledge from incurables.

Administrators were not above exploiting ethnic stereotypes to promote TGH facilities. Nurses assigned to the outpatient clinic received “wonderful education going to the home [of to-be mothers] and study the racial characteristic and home environment.” The expectations that followed were not surprising: “The Italian with little conception of home comforts, used in Italy to out-door life, settling in our poorer districts had to be told everything needed for a Canadian Baby...the poorly kept Jewish home where the baby is nearly always welcome...” compared to the “...English or Scotch home where the mother perhaps is struggling or alone, for very often at this time the worthless father is away...In the midst of these darker visions is the happy though poor home of the industrious working man whose thrifty wife has everything clean and prepared. The latter keep the

³⁴⁹ “TGH Annual Report for the year ending 31 December 1915,” 1916, 32. File 1.2.13, Box 8. TGH Fonds UHN Archives. David Halpern, *Mental Health and the Built Environment: More Than Bricks And Mortar?* (London: Routledge, 1995), 8, 31-36. Halpern examines how weather patterns and poverty can affect mood. He argues that these increase likelihood of death, mental illness, and overall health complaints makes it possible that during harsh climactic or economic periods institutions such as hospitals would be subject to heavier patient loads. Also see James G. Snell, *The Citizen’s Wage: The State and the Elderly in Canada, 1900-1951* (Toronto: University of Toronto Press, 1996), 103-105. Snell emphasizes the active role played by the elderly between 1900 and 1940 that led to major changes in the ‘Old Age Pension’ but mainly the idea of a ‘citizen’s wage’ becoming universal. For this reason it is important not to imagine the elderly as merely cast off into institutions, but families still had to make difficult decision given the weakness of social programs between 1900 and 1940.

nurses' faith in a better balance."³⁵⁰ Administrators used negative characterizations of space outside the hospital to bolster its reputation as safe, clean, and healthy.

The extent to which TGH administrators lambasted orphaned children, the mentally unwell, aged, immigrant groups, and the poor was more than simple bigotry. Much of the rhetoric related to a broader fear about the future of the institution and social stability. One administrator noted, "The mentally defective is one of the most serious social economic problems. From everywhere comes the same story that feeble-mindedness is a chief cause of vice, misery and delinquency and present public provision for the defective is utterly inadequate."³⁵¹ The undertone spoke not only to people who they felt were undesirable to a society, but also to a ward. The other aspect was financial. These categories did not—or at least were presented by administrators as unable to—provide economic value to their community.

Administrators stressed the influence of environment and space over behaviour. Referring to cases of juvenile delinquency the report noted: "About two-thirds of our delinquent children come from homes where dirty and poorly ventilated rooms predominate. How can there be a thought of beauty in the mind of a child whose vision is bounded by bare walls, ash heaps, garbage piles, filth and grime?" Administrators linked squalor to crime, "This type of child is shut in among surroundings which sear the mind by suggestions of evil whose ideals of truth and purity are warped. As a result of this environment our reformatories are filled and criminals produced."³⁵² Medicalizing crime expanded the TGH's disciplinary space, and helped define a 'worthy patient.'³⁵³

³⁵⁰ "TGH Annual Report for the year ending 31 December 1915," 1916, 33. File 1.2.13, Box 8. TGH Fonds UHN Archives.

³⁵¹ Ibid, 34.

³⁵² Ibid.

³⁵³ Stephen Bocking, "Science and Space in the Northern Environment," *Environmental History* 12 (2007): 868-871. Bocking's conception of 'disciplinary space' as the intellectual territory in which concepts and methods particular to a discipline are considered authoritative and relevant is extremely helpful in understanding the goals of hospital administration in the first half of the 20th century.

The First World War was a defining event of the early 20th century that pushed the TGH to its limits. A major problem was the increase in commodity prices. Medical supplies were always expensive, but during wartime the hospital had to scrimp and ration more than ever. Early in the war trustees passed a resolution extending overdraft to \$100,000, but the sum was soon dwarfed by expenses. The hospital could use as much as seven tons of coal per day. By 1917 this amounted to around \$50,000 annually could only be reduced through the purchase of new, expensive machinery. Historian J. T. H. Connor noted administrators feared a coal shortage so much that they stockpiled when possible. At one point 800 tons were piled on the tennis courts.³⁵⁴

During the First World War military contracts became a way to bring in some much-needed revenue. In 1917 Sydney Chilton Mewburn, Minister of Militia and Defence, signed a seven-year lease on the old Gerrard Street Hospital for use by convalescing soldiers. The lease demonstrated how medically unprepared the federal government was.³⁵⁵ The building was slated for demolition due to severe wiring problems and a rat infestation in the basement. Fortunately for Mewburn, the lease had a clause allowing him to sever the contract within a year of the war ending.³⁵⁶ The Gerrard lease was one of many episodes during the First World War that revealed the country's reliance on minimal state apparatuses.³⁵⁷ There were other lucrative contracts too. The military took out a standing lease on 140 hospital beds. These were billed at the daily rate regardless of occupation. The deal yielded \$144,000 per year for the TGH.³⁵⁸

An influx of medical students after the First World War helped the TGH strengthen its relationship with the University of Toronto. TGH doctor and historian W. G. Cosbie argued that a

³⁵⁴ J. T. H. Connor, *Doing Good: The Life of Toronto's General Hospital* (Toronto: University of Toronto Press, 2000), 201.

³⁵⁵ Annmarie Adams, "Borrowed Buildings: Canada's Temporary Hospitals during World War I," *Canadian Bulletin of Medical History/ Bulletin canadien d'histoire de la médecine*. 16 (1999): 29-31.

³⁵⁶ "Colonel Bickford to Trustees TGH," 13 September 1919, 1-2. File 1.4.2, Box 5. TGH Fonds UHN Archives

³⁵⁷ Kellen Kurschinski, "State, Service, and Survival: Canada's Great War Disabled" 1914-44 (PhD diss., McMaster University, 2014), 4-6.

³⁵⁸ Connor, *Doing Good: The Life of Toronto's General Hospital*, 203.

closer relationship renewed emphasis on clinical education and research.³⁵⁹ However, overtaxed buildings presented a problem. The 1913 population which the ‘new general’ had been built for was around 375,000. By 1925 it was closer to 556,000, and the TGH’s reputation attracted patients from across the country and border. The hospital needed more space to capitalize on an influx of students. More ward space meant more patients and more opportunities for students, but buildings were not immediately forthcoming. Procedure became increasingly difficult to maintain in older buildings, and the staff felt stretched.

Administrative procedure can reveal much about patient experience, but the inverse is also true. On 19 March 1928, Philip Howard underwent a routine tonsillectomy at the TGH. His case underscored the importance of electronic communications and inter-staff organization. Howard rested throughout the morning and afternoon. He was in pain, but not so badly that he did not play with his toys in bed. That afternoon his doctor prescribed ice-cream for supper. Unbeknownst to the prescribing doctor the kitchen was out of stock. Around 5 o’clock someone in Howard’s room, 412, turned on the call light. The light for room 436 came on around the same time. Ward nurse Ruth McMath, knowing room 412 had a designated nurse, went to room 436. After attending to her patient, McMath returned to the hallway where a frantic nurse—Ms. Lindsay—asked about the location of the nurse assigned to room 412. At that moment, the missing nurse appeared along with trustee Mark Irish. Together they went to room 412 and discovered a distraught Mrs. Howard whose son had vomited up a “considerable amount of old blood and mucus.”³⁶⁰ The nurses set to work changing soiled linens, washing the boy’s face, and remaking the bed. Howard recovered, took his ice-cream at six o’clock, and felt ‘much better.’

³⁵⁹ W. G. Cosbie, *The Toronto General Hospital 1819-1965: A Chronicle* (Toronto: Macmillan of Canada, 1975), 164.

³⁶⁰ “C. J. Decker to Mark H. Irish,” 23 March 1928, 1. File 2.2.12, Box 13. TGH Fonds UHN Archives. Note the patient’s name has been anonymized.

Howard's experience was merely one in a sea of similar dramas—not all of which had such agreeable outcomes. A formal investigation and much administrative handwringing unfolded in the days that followed. The main controversy, at least for Irish and Superintendent Chester Decker, pertained to the whereabouts of the nurses and why nursing superintendent, Mrs. Gunn, was in the diet kitchen rather than on the ward. Based on the investigation records, the specialist for 412 approached Gunn shortly before dinner hour about the ice-cream. It was late for a special request, so Gunn went directly to the dietician. There was none in stock, and a rush order was placed. By Gunn's account she was off the floor "maybe ten minutes." However, in that time the patient had become ill, vomited, and other patients came to witness a trustee yelling "who the hell is running this floor – what the hell are these [call] lights for?"³⁶¹ The nurses assigned to that floor Gunn, Agnes Neill, Mary Robinson, Ruth McMath H. A. Foord, and Ms. Lindsay submitted statements explaining their whereabouts. The confusion began with the prescription of ice-cream by a doctor who did not inform the kitchen, but nurses took the blame.

The internal investigation relating to the Howard case was serious. Systems ranging from call lights to supply requisition—all forms of discipline—failed to outmanoeuvre human miscommunication. Sexism caused the situation and directed blame. The reaction of male administrators revealed the precariousness with which hospital space was organized, its reliance on technology and communication systems, and how there were vulnerabilities. Decker stated, "under the present system of nursing service in the Private Patient's Pavilion it is quite possible, in fact not uncommon, to hear of a patient's light having gone unattended for ten of fifteen minutes although their lights were on."³⁶² Organizational practices exacerbated these issues. During the day, the private floors averaged 15 nurses for 25 patients, but by evening time this dropped to five. Beyond

³⁶¹ Ibid, 1-2.

³⁶² "C. J. Decker to Mark H. Irish," 24 March 1928 1. File TG 2.2.12, Box 13 TGH Fonds UHN Archives

that, nurses were required to assist in preparing meal trays during supper hour which took them away from medical obligations.

In March 1926 trustees advanced a tentative building program including a large private patient wing. They planned to finance it by collecting 50% of the cost through subscriptions and 25% from the university and city each. At an April meeting the board estimated its budget at \$2,000,000.³⁶³ In December an invitation was sent to hospital consultant Dr. S. S. Goldwater of New York. He accepted, and offered a cautious appraisal: “As a scheme for a general hospital dedicated to teaching medicine as well as treatment of the sick, the expanded scheme is probably not one that it would be wise to advocate today if ground were being broken for an entirely new group of buildings...” however, he added “...viewed as a step in the development of a hospital which is already functioning, the plan seems to me sound and defensible.”³⁶⁴ He did not believe the plan would produce an ideal arrangement for staff, but it would “...distinctly improve the conditions for accommodation and treatment of both ward and private patients.” The board accepted the inconvenience, and hired architectural firm Darling and Pearson to draft the plans.

Architectural drawings were completed in April 1928 and in June the contract was awarded to the W. H. Yates Construction Company. Estimates exceeded \$3,750,000 when a mere \$2,500,000 was pledged. The additions extended the east and west wings as well as the south medical wing to increase public ward accommodation. A new Private Patient’s Pavilion facing University Avenue with capacity for 280 patients was also getting underway. The existing pavilion from 1913 converted to a nurse’s residence. When the new pavilion was finished in April 1930 it stood nine storeys with 320 beds. It had fifteen operating rooms on the surgical—ninth—floor, and two floors for obstetrical

³⁶³ “Except from Minutes of the Board of Trustees,” 24 March 1926, 1. File 1.3.6, Box 4 TGH Fonds UHN Archives, “Except from Minutes of the Board of Trustees,” 28 April 1926, 1. . File 1.3.6, Box 4 TGH Fonds UHN Archives.

³⁶⁴ “S. S. Goldwater to Dr. Decker,” 12 January 1927, 1. File 1.3.6, Box 4 TGH Fonds UHN Archives Goldwater remained in contact with the TGH through 1928 by serving as a visiting member of the building committee.

patients, with nurseries, private dining rooms, and kitchens. On the operating floor there were furnished lounges for surgeons and physicians as well as for obstetricians who often stayed overnight. Trustees passed a by-law in October 1929 to borrow up to \$1,500,000 for construction. The city offered a grant of \$1,400,000, and the university secured \$1,100,000 from the province. Expenditure swelled to \$4,500,000 but with a large portion of the cost covered and donations rolling in the economic side of expansion was largely covered.³⁶⁵ The spread of funding sources—city, university, province, and general public—spoke to the small, federated nature of the Canadian state. No single apparatus existed to fund a general hospital so administrators went about it piecemeal.

Administrators embraced publicity when the pavilion opened. A 1930 pamphlet gushed:

Perhaps the most outstanding impression to be gained is one of colour, the liberal but discreet use of which makes the pavilion resemble a palatial modern hotel specially equipped to heal all sickness and manner of disease. One finds color everywhere from the sumptuous dark-panelled rotunda to the vast interconnected suits of operating rooms which occupy the entire 9th floor. In all of the 15 operating rooms and their adjacent anaesthetic rooms the walls are furnished in a special tile with a soft, gray mother-of-pearl finish, which is confidently expected to sooth patients and present the nervous tautness which the old batten white produced in many sufferers. Science wedded to comfort: Gleaming nickelled Monel metal replaces white enamel in practical all fixtures. A subdued but pleasing tone of buff has been used in the walls of corridors and rooms. Beds and bedside accessories are metal finished with grained wood effect. Cherry chintz covered armchairs and lounging chairs, curtains that are quiet but illuminated with deft touches of bright color. Persian rugs on the floor, the electric wall brackets lights with tinted shades all will combine for the well-being and early recovery of the patient.³⁶⁶

The pamphlet described comfort, cleanliness, and safety to the cadence of the ‘roaring twenties.’³⁶⁷

Some features that were not advertised to the public drew the interest of other constituents. In 1929 Matthew O’Foley, editor of the journal *Hospital Management*, wrote to the TGH asking for more information on the conveyor belt system it would be using to move meals and dishes throughout the

³⁶⁵ Cosbie, *The Toronto General Hospital 1819-1965: A Chronicle*, 181.

³⁶⁶ “A Greater Hospital: Commemorating the opening of the new Extensions including the new Private Patients Pavilion, TGH,” 21-26 April 1930, 15. File 1.6.3, Box 8 TGH Fonds UHN Archives

³⁶⁷ Matthew T. Downey et al *The Roaring Twenties and an Unsettled Peace, 1919-1929* Vol. 2 (Toronto: Maxwell Macmillan Canada, 1992), 19-21, 63-67. After the First World War consumers desired opulence, and manufacturers when possible delivered luxury and comfort to patch over the trauma of war. Granted the economy of the 1920s did not entirely live up to the title of ‘roaring.’

building.³⁶⁸ Still, the main focus was public marketability. Fundraising had gone well, but construction costs were high and the bulk of new beds were for private patients. The pamphlet, then, was as much advertisement as press release. By emphasising comfort, medical efficacy, and luxury—even likening the hospital to a hotel—administrators courted a wealthier clientele.

The choreographed opening demonstrated the importance of space and movement. The opening committee planned everything from where guests would enter to which floors they reached by stairs and which by elevators. On 25 and 26 April the buildings were opened to the public. On most floors only a few rooms were available. Guides were stationed on each floor to give directions. Flowers and ferns were placed throughout the building to add a feeling of calm, beauty, and sophistication.³⁶⁹ It was a performance worthy of a great stage. The regulation of space, the guidance of movement, and the preferential treatment to certain guests aligned with the building's purpose of providing high-level care to those with means.

Sometimes agency comes from the least likely of sources, and in the case of patients could take the form of fear and sickness. Release material for the new pavilion noted the relationship between space and emotions. “Under the best of circumstances the average operating room can scarcely claim to have a cheerful memory with the patient. Ghostly-white walls, steaming sterilizers, smell of ether, and other unpleasant features combine to create a frightening atmosphere.” The operating room was a powerful space. It affected the patient across many senses: sight, sound, smell, and feel. The operating room was the core of medicine's exclusivity; it was the holiest chamber and symbol of the profession's efficacy. It is significant that designs reflected patient expectation and emotion. In the new pavilion “most of these terror[s] have been eliminated. In place thereof, English

³⁶⁸ “Matthew O’Foley to C. J. Decker,” 2 July 1929, 1 File TG 2.2.35 Box TG15 TGH 210-2370 TGH Fonds UHN Archives

³⁶⁹ “Formal Opening, Procedure for Opening,” 1930, 1. File 1.6.3, Box 8 TGH Fonds UHN Archives For a pioneering work employing analysis to how medical space was experienced through movement see Annmarie Adams, *Medicine by Design: The Architect and the Modern Hospital, 1893-1943* (Minneapolis: University of Minnesota Press, 2008).

tile of a restful blue-gray shade easy on the eye and nerves. The artistic tiling cost three times the amount of the white variety.”³⁷⁰ The blue tile would not have fit into the budget, but an anonymous board member donated funds to bridge the gap.

The next few years saw several small projects and events, but nothing to rival the Private Patient’s Pavilion. In 1931 the American Hospital Association held its annual meeting in Toronto from 28 September to 2 October. It was an indication that American administrators were aware of the TGH, and spoke to how transnational the industry was. In 1933 administrators used a bequest from the Dunlap family to purchase a building from the University of Toronto located across from the hospital. It was renamed the Dunlap Building, and put to use as a pathology laboratory. In 1934 an out-patient annex was erected which added approximately 80 beds to the overall capacity. However, economic slowdown halted building plans in the late 1930s. The TGH returned to an era of austerity, shortages, and over-crowding as it tried to cope with the community needs during economic stagnation.

In a 1938 memorandum TGH administrators sought to shame the province and municipality over inadequate funding. The gist of the argument was that per diems had fallen too far behind costs. As it stood, the city paid \$1.75 per patient day and the province added \$0.60. During the 1930s per diem loss per indigent patient was approximately \$0.17. In 1936 patient days amounted to 254,348, which equated to a loss of \$43,239. The board likened the hospital to a “large plant whose raw materials are sick human beings and they are more entitled to the use of up-to-date equipment than inanimate raw materials” to remind the public that equipment upkeep and replacement suffered from operational losses.³⁷¹ Medicines, food, and wages were expenses that could not be ignored. The

³⁷⁰ “Operating Floor of the General Hospital’s New Wing Marvel of Medicine and Science,” 1930, 1. File TG 2.4.75 Box 17 TGH Fonds UHN Archives. Also source of above quote.

³⁷¹ “Memorandum on Hospital Situation,” 1938, 3. File TG 2.13.32 Box TG 0009, TG 25 TGH Fonds UHN Archives

mood had changed a lot in eight years. Descriptions of Persian rugs had been replaced by the austere, efficient image of a factory.

The Second World War was especially hard on the TGH due to the preceding economic downturn. Medical professionals were difficult to retain during wartime, because nurses, surgeons, and doctors left for overseas service. However, the TGH struggled to keep non-medical staff as well. A mixture of military work and industrial opportunity bled away much of its existing labour and left replacements in short supply. In 1942 teenagers were given voluntary positions to perform basic tasks such as maintenance, serving meals, and organizing supplies. By the end of the war staff shortages were so acute that medical students had to double as orderlies. The Depression had done nothing to soften the blow of a sudden surge in demand coupled with a shrinking labour pool. Throughout the 1930s revenue decreased to the point that only 16% of patients were covering the cost of their services.³⁷² City council had been unwilling to raise taxes so per diem contribution did not increase. The TGH's act of incorporation limited the extent to which it could increase ward rates so it could not simply raise fees to cover costs.

Financial relief did not come to the TGH until 1944 when an amendment to the General Hospitals Act—the first in 17 years relating to payment—raised municipal grants to \$2.25 per day and provincial ones to \$0.75. The cost per day hovered around \$3.98. It was a welcome improvement, but not a solution. The TGH found itself trying to wait out the war with the expectation that federal funds would be available for construction. In 1945 the Chairman wrote, “Many social post-war measures will be passed to keep mankind healthy, wealthy, and wise and free from care from swaddling clothes...”³⁷³ Administrators strove for optimism, and made plans.

³⁷² Cosbie, *The Toronto General Hospital 1819-1965: A Chronicle*, 224-225.

³⁷³ “Chairman’s Remarks, 1945,” quoted in Cosbie, *The Toronto General Hospital 1819-1965: A Chronicle*, 227.

By the end of the Second World War the TGH had moved to a new location, solved its disputes with the university, and grown into a world-class institution for medical education and research. By leaving Gerrard Street it was physically and intellectually closer to the university. Increasingly, expansion had a bent toward laboratories and specialized clinics that were bankrolled as much by ward fees as by provincial grants awarded to the medical school. The strain of two world wars and the Depression slowed development. But they also strengthened public acceptance of the TGH as an important civic and medical institution.

Winnipeg 1911-1945

The WGH was expanding in 1911. A \$550,000 project to construct an east and a central wing was underway. The price was high, but administrators placed their faith in local architects stating: “the plans for the new hospital building were carefully thought out and redrawn time and time again until [we] were satisfied they were as nearly perfect as possible and lend them to future extension when this becomes necessary.”³⁷⁴ Administrators now discussed expansion without any hint of completion in the building programme. Acceptance of ceaseless building was an important development in administrative thinking during the war years and Depression. Trustees were cognisant of their buildings’ age, and always looked to expand.

Between 1912 and 1918 bed capacity increased to 650. The central and east wings were officially opened on 1 November 1913, known as east B and west E. The WGH ran a deficit in 1912 due to buildings costs and loss of revenue during construction. Total revenue for the year 1912 was \$209,466 of which \$168,449 came from patient fees paid at the point of service or through municipal grants, and \$41,016 from voluntary contributions. Operating expenses, before building costs, came in at \$235,930. While the new wing was built, other areas were demolished, causing a temporary

³⁷⁴ “Winnipeg General Hospital: Annual Report for the year 1911,” 1912, 10. Box 9 WGH Fonds, HSCAM. See Appendix III, Images 3.2 for construction photos.

reduction in availability of private wards.³⁷⁵ Administrators had prepared for reduced income, but delays in construction threw off the calculation.

As the WGH grew, its financial situation deteriorated. In 1913 it ran a deficit of \$51,519. Worse, a by-law to provide building funds was defeated at the polls. Trustees borrowed money to keep the building project moving; however, creditors did so upon the personal guarantee of board members. Lack of revenue plagued the institution. Of the 382 patients treated in 1913 only 33 were private, compared to 94 semi-private and 255 public. The WGH's next move was to request a \$400,000 grant from the province by arguing it deserved public funds as an educational entity. On 19 February 1914, the province provided \$60,000 to clear mortgage payments. Administrators believed that without its mortgage debt it could return to operating as a "voluntary and teaching institution as it was in the past, believing that through voluntary assistance the public will take a much greater interest, thereby increasing its efficiency in the care and welfare of the patients."³⁷⁶ The statement was an olive branch to the voting public who had not seen fit to finance expansion. Administrators learned two lessons: that monies could be attained in large quantities from sources besides rate-payers and private subscription, and despite the local context of a problem the province could side with the hospital.

Until the beginning of the First World War the WGH devoted large sections of its annual reports to justifying expenses. The wording of these reports revealed the development of a professional language and philosophy of hospital management. Educating the public and convincing them to accept taxes was a difficult task. One administrator wrote, "The question of cost per patient day is not very generally understood by the lay mind, and it might be stated that the comparison of

³⁷⁵ "Winnipeg General Hospital: Annual Report for the year 1912," 1913, 11. Box 9 WGH Fonds, HSCAM.

³⁷⁶ *Ibid.*, 13-14.

costs between hospitals depends entirely on services given...and there are no two hospitals alike.”³⁷⁷

Such factors ranging from services, variety of food consumed, numbers of graduate nurses, types of doctors, to the very size of the facility, and the cost of maintenance combined to make budgetary projection more an art than a science. The challenge for administrators was convincing the public to trust them even while its debt and expenses rose dramatically.

In 1913 when the new wings opened they added 250 beds to the overall capacity. It also marked the last major construction until 1919. The board reported, “The WGH is a hospital with a plain exterior the principal expenditure being incurred in the interior, as the Trustees were desirous of having a complete modern hospital...the general opinion of authorities on hospitals is that this has been accomplished.”³⁷⁸ Administrators had found rhetorical value in the word modern for its ability to sound both promising and mysterious. The emphasis on the opinion of authorities distanced the hospital’s internal workings from the public. Citizens were not expected to understand the subtleties or complexities of its organisation.

The outbreak of the First World War thrust the WGH into unfamiliar territory; suddenly the insular general hospital had to help its country in the broadest sense. Winnipeg served as something of a clearing house for western troops. It also had a large population of single men who were recent British immigrants and eager to enlist. In addition to the WGH, the military hospital commission oversaw health facilities such as the Tuxedo Military Hospital. By April 1917 the commission reported that 3,545 soldiers had received care in Winnipeg.³⁷⁹ Other duties included typhoid inoculations, of which the WGH performed 12,000 in 1914. Superintendent G. W. Sinclair noted:

³⁷⁷ Ibid, 14.

³⁷⁸ “Winnipeg General Hospital: Annual Report for the year 1913,” 1914, 13. Box 9 WGH Fonds, HSCAM.

³⁷⁹ Jim Blanchard, *Winnipeg’s Great War: A City Comes of Age* (Winnipeg: University of Manitoba Press, 2010), 5-6, 194-196. Blanchard mentioned plans for a proposed 600-bed, \$1 million dollar soldier’s hospital that was approved but never realized.

“The war has also resulted in a more or less disturbing influence on our various staffs...”³⁸⁰ He referred to nurses and doctors who enlisted, which was a problem for hospitals across the country.

Minor—and costly—alterations and renovations continued during the war. In 1915, 30 rooms on J flat were renovated and repainted. After the renovation two, two-bed wards on J flat were sponsored by the International Order of Odd Fellows. Outside, the fence enclosing the property was replaced.³⁸¹ The Jubilee Wing received a minor extension in the form of an additional storey in 1916 which provided space for seven beds in less crowded conditions. Trustees called for further semi-private and private accommodation noting that “the needs of a large modern hospital such as the WGH which occupies a leading place among institutions of its kind in Canada are never ending...”³⁸² The WGH had not met demand since the war began.

Renovation in the annex building during 1917 produced “two large airy public wards, and rendered the building thoroughly serviceable and as modern and attractive as any other part of the hospital.” As a result D flat shifted from public to semi-private accommodation. A power house was added but not opened until late-1918 because the board could not afford the cost of boilers for it. The province provided \$50,000 for a ‘psychopathic’ building under the condition that the WGH run it. Trustees noted “There is great urgency for providing proper accommodation for the care of patients suffering mental derangement and nerve shock, among whom are a number of returned soldiers...”³⁸³ The reference to military personnel helped justify expenditure. It revealed the tendency of provincial governments to downplay care for mental illness, and the war exposed medical problems that were ignored during peace time.

³⁸⁰ “Winnipeg General Hospital: Annual Report for the year 1914,” 1915, 29. Box 9 WGH Fonds, HSCAM.

³⁸¹ “Minutes of a Meeting of the House Committee,” 5 August 1918, 1. Box 18 WGH Fonds, HSCAM.

³⁸² “Winnipeg General Hospital: Annual Report for the year 1916,” 1917, 14. Box 9 WGH Fonds, HSCAM.

³⁸³ “Winnipeg General Hospital: Annual Report for the year 1917,” 1918, 15. Box 9 WGH Fonds, HSCAM. Also source of above quote.

The war reshaped the hospital campus, leading to additions such as a building for mental health. In 1916 and 1917 large wards—A and D flat—of roughly 90 beds were set aside for the care of soldiers. Most of the work carried on at the WGH in the second half of the war was on returning veterans whose: “bones have been shattered, muscles torn away, nerves and blood vessels severed and joints ankylosed as the result of injury and infection.”³⁸⁴ Such gruesome rhetoric presented the institution as serving both a practical and noble purpose. Outpatient services were squeezed by the fact that so many wards had converted to military use. The decision to build a psychiatric facility alluded to the fact that wards rung with the cries of traumatised soldiers. The Invalid Soldiers’s Commission provided payments toward any hospital service required by a veteran for rehabilitation.

For patients ward-life was not pleasant, but the presence of soldiers had some upside. In 1920 there were still sixty soldiers under continual care at the WGH. The general wards were at capacity during all but the summer months.³⁸⁵ In 1921 visiting restrictions on private wards were relaxed to allow easier access for organizations that entertained soldiers.³⁸⁶ The wider effect of their efforts was stimulating administrative thought about the doldrums of a hospital stay. Soldiers had a privileged position in social discourse, and stringent adherence to rules did not mesh with that image. The growing leniency trickled down to civilian patient. It also coincided with a general broadening of the types of patients entering the wards. A fundraising request from 1919 noted the hospital was “holding open the door of healing to rich and poor alike, to the leading citizen or the newest unsettled immigrant.”³⁸⁷ Soldiers did not choose where they were treated; however, civilians did and increasingly diverse demographics turned to the WGH.

³⁸⁴ Ibid, 30.

³⁸⁵ “Winnipeg General Hospital: Annual Report for the year 1920,” 1921, 18. Box 10 WGH Fonds, HSCAM.

³⁸⁶ “Minutes of a Meeting of the House Committee,” 13 April 1921, 1. Box 18 WGH Fonds, PMA.

³⁸⁷ “The Hospital Appeal - \$200,000,” 1919, 2. File 1, Box 7 WGH Fonds PMA

The influenza pandemic stifled the WGH's immediate post-war building plans. Some renovations and financial aid came to the hospital, but in reality it had traded one health crisis for another.³⁸⁸ The two large wards set aside for solid treatment were turned over to cases of influenza. Meanwhile the passing of the Charity Aid Act increased provincial payments for general ward patients by \$0.25. More money was helpful, but the increase was marginal compared to operating expenses. The total payment per patient was just under \$2.00 when the actual cost was between \$3.00 and \$4.00. Parsimony by the province was matched by that of the federal government. Both entities preferred to view the hospital as a municipal responsibility.³⁸⁹ Some renovations occurred during 1919. J ward was renovated to provide a 'thoroughly modern and convenient' space for the care of eye, ear, nose, and throat cases. K ward was improved to care for orthopedic patients. The south annex building was converted to an internes residence, and H flat became a ward for sick nurses.³⁹⁰ The post-war model of gradual modernization was one way to maintain older buildings.

The 1920s were a decade of reorganization and renovation. Private and semi-private accommodation brought in enough money to break even, but public wards operated at a deficit. In 1921 the city issued a \$50,000 grant to pay down the debt. The board continued lamenting its financial position stating, "an analysis of cost distribution shows the deficit is entirely due to losses sustained in maintaining general wards and the out-patient department. Present costs of hospital operation cannot be made self-sustaining on the per diem allowed under the Hospital Act."³⁹¹ The nineteenth-century financing framework that treated hospitals as charities was ill-suited for what the

³⁸⁸ Esyllt W. Jones, *Influenza 1918: Disease, Death, and Struggle in Winnipeg* (Toronto: University of Toronto Press, 2007), 99.

³⁸⁹ James Struthers, *No Fault of Their Own: Unemployment and the Canadian Welfare State 1914-1941* (Toronto: University of Toronto Press, 1983), ix, 208. For pre 20th century see Richard B. Splane, *Social Welfare in Ontario 1791-1893: A Study of Public Welfare Administration* (Toronto: University of Toronto Press, 1965). For a discussion on provincial parsimony for the late 19th century that echoed into the 20th see Peter Oliver, *'Terror to Evil-Doers' Prisons and Punishment in Nineteenth-Century Ontario* (Toronto: University of Toronto Press, 1998), 502-505.

³⁹⁰ "The Hospital Appeal - \$200,000," November 1919, 2-6. Box 7 WGH Fonds, HSCAM.

³⁹¹ "Winnipeg General Hospital: Annual Report for the year 1921," 1922, 14. Box 10 WGH Fonds, HSCAM.

institution was becoming. The board proposed a new facility, despite the cost of construction. It hoped to reduce expenses by removing duplicate services through centralization. Each dollar saved in upkeep was one that general ward fees did not have to provide.

In 1923 WGH solvency improved by partnering with the Federated Budget Board of Winnipeg (FBBW)—a precursor to the United Way.³⁹² Previously it relied on voluntary contributions, personal subscriptions, and meagre municipal per diems. The WGH ran a surplus of \$8,176 the first year; however, that meant the FBBW would award them a smaller sum for 1924. The FBBW's intention was to avoid debt not subsidise a surplus. Monies from the FBBW were not retroactive, so the city had to pay \$15,000 for 1922. An amendment to the WGH Act allowed the hospital to issue bonds up to \$150,000. The province guaranteed the bonds to help sales.

At the close of the 1920s WGH administrators expressed a pressing need for new buildings. The articulation revealed the complexities of what was becoming a modern era of hospital architecture and logistics. No longer were hospitals mere dormitories. They were kitchens, labs, homes, laundries, workshops, storage spaces, morgues, classrooms, social services, and data banks. For the hospital to expand in one area was to expand in all. Capacity remained high—never dropping below 90% in the 1920s—so administrators called for more beds and for spaces to provide a growing array of services. A further problem was fireproofing, which required costly auxiliary services such as sprinklers.

The WGH had sought federal funds as early as 1931, and initially there was traction. Trustee C. S. Riley led a WGH deputation to see Premier John Bracken in 1931. Riley hoped to convince

³⁹² Gene Walz “Shaky-Wacky Animations: The Case of Manitoba” in William Beard and Jerry White eds. *North of Everything: English-Canadian Cinema Since 1880* (Calgary: University of Alberta Press, 2002), 73. The Walz article was one of the only sources connecting the Federated Budget Board with the United Way, and interestingly points out that prior to its formal relationship with the WGH had commissioned an advertising silent film depicting a miser who would not donate to charities. The imagery used to convey the suffering caused by his frugality was none other than the children's wards of the WGH at the time ravaged by tuberculosis and influenza.

him that the hospital qualified for federal relief funds which Bracken could dispense. The sticking point was the nature of WGH management. Bracken feared taxpayers would view the hospital as part of the municipality. Riley countered that the WGH made no profit from private wards, statutory grants did not cover costs of general wards, and patients came from the whole province. Thus it *was* a public institution and deserved federal monies.³⁹³

The board sought money to build as well as maintain existing operations. No major construction had taken place since the 1919 psychopathic building. Bracken admitted the decision had not been formalized, and offered to recommend the hospital be included on the list for relief measures. City representatives informed the board in September that the funds were all appropriated and the hospital was receiving none. Worse, the legalities of funding the hospital were again disputed. City alderman felt the province could ultimately overcome the questions about legality; however, the idea that funding the hospital was a backdoor for providing further money to the city would endure.³⁹⁴ The FBBW increased its funding, but was not an inexhaustible source. The financial crisis forced administrators to embrace more drastic, internal options.

Administrative artifice came into play during the Depression, especially with finances and statistical reports to the public. The 1932 annual report posted daily rates for the upcoming year: \$4.00-6.50 for private rooms, \$2.75-3.50 for 2-5 bed semi-private wards, \$2.50 for semi-private children's ward, and \$1.75-2.50 for public wards. In 1928 rates were \$5.50-8.00 for private rooms, \$3.00-4.00 for 2-5 bed semi-private wards, while public and children's ward rates remained the same.³⁹⁵ With rising costs for fuel, food, and medical supplies how did the WGH reduce its fees? The answer lay in presentation. In 1928 the ward rates were truly flat; however, in 1933 the decrease

³⁹³ "A Conference between Mr. Bracken and a Deputation from the Hospital Board at the Premier's Office" 17 August 1931, 1-2. Folder 8, Box 19 WGH Fonds PMA The use of the wording 'Federal' appears to refer to Federal money granted to the Province for dispersion.

³⁹⁴ "Minutes of a Meeting of the House Committee WGH" 22 September 1931, 1. Folder 8, Box 19 WGH Fonds PMA

³⁹⁵ "Winnipeg General Hospital: Annual Report for the year 1928," 1929, 3. Box 10 WGH Fonds, HSCAM.

accompanied a corresponding reduction in services covered. No longer was the operating room, anaesthetist, X-ray, lab, surgical supplies, or ambulance included. Development in the fee schedule captured the transition from a charitable service where patients were assessed by need, to one more financially-minded and focused on providing services.

Time was so crucial a resource that its management justified expenditure when food and medical supplies were scarce. Meal times, surgeries, medicine, ward rounds, cleaning, visiting hours, and so forth were contingent upon schedules. In July 1933 the WGH house committee approved the expenditure of \$95 on a ‘master clock,’ capable of controlling all 23 of the institution’s clocks. The previous unit was of “antiquated design and worn out.”³⁹⁶ How did the board find money to buy a clock at the same time it was planting rooftop gardens out of want for supplies? For the WGH—and its counterparts—time functioned somewhat differently than in other institutions such as prisons, workshops, and schools.³⁹⁷ The existence of a schedule unavoidably exerted some degree of discipline over staff and patients alike. However, administrators also had no choice but to try and maximize efficient use of time due to the hospital’s complex function. Properly managed time was one of the few reliable tools administrators had to stave off disorder.

Another tool administrators possessed was ward arrangement. Semi-public care had been used before, but it was not a common practice for the WGH until 1935. It was first tried in 1914, under the condition that use be “strictly limited.”³⁹⁸ By 1938, semi-public care brought an important change in hospital organization by extending the honourary attending staff title to all physicians. The

³⁹⁶ “Minutes of a Meeting of the House Committee WGH” 4 July 1933, 2. Folder 8, Box 18 WGH Fonds PMA

³⁹⁷ Though the literature in this field is voluminous consider: Michael Ignatieff, *A Just Measure of Pain: The Penitentiary in the Industrial Revolution 1750-1850* (London: Puffin Publishing, 1989) Houston and Prentice, *Schooling and Scholars in Nineteenth Century Ontario*, Andrew T. Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (London: Penguin Books, 1979), Harvery G. Simmons, *From Asylum to Welfare* (Downsview: National Institute on Mental Retardation, 1982).

³⁹⁸ “Minutes of a Meeting of the House Committee WGH” 26 March 1914, 1. Folder 2, Box 18 WGH Fonds PMA At the meeting the committee suggested they be treated as “a cheap form of semi-private.” At the time such practices harmed the institution by removing patients from the education pool and discounting a service for no reason.

WGH had approximately 600 beds, 200 private and semi-private, 400 public and semi-public. In certain cases wards converted to semi-public use had a nicer setting than public wards; however, the primary difference was semi-public patients could be visited by their own doctor. A general ward patient could only be seen by a member of the honorary attending staff.

In 1936 the WGH was faced with the reality its oldest buildings A and B blocks would have to be demolished. In some areas wooden floors were in direct contact with risers from the steam lines and had begun to smoulder. The problem was exacerbated by dust and sweepings collecting under the floorboards. In the newer wards builders positioned metal flanges between the riser and floor to prevent this, and the older wards had to be renovated.³⁹⁹ In 1935 plumbing failures caused maintenance costs to spike necessitating significant expenditure in terms of painting and repairing water damage. Costs of older buildings were beginning to catch up with the administration, but there was no realistic chance of construction.

Administrators were worried about other aspects of patient safety as well. The way patients interacted with space and the furniture therein can reveal aspects of daily experience. In 1936 the house committee debated what—and they determined none—responsibility the hospital had for patients who sustained an injury from falling or climbing out of bed. Accidents were bound to happen, and a patient falling from bed does not sound strange. However, the committee called it a “daily occurrence.”⁴⁰⁰ Patients falling from bed so frequently could only mean they were trying to get out of them. Of course that does not mean patients sought escape rather it suggests that boredom, impatience, inattention, or some combination thereof spurred frequent attempts to move about. Children posed a similar problem, and their beds were equipped with bars and rails. The house

³⁹⁹ “Minutes of a Meeting of the House Committee WGH” 22 May 1934, 2. Folder 9, Box 18 WGH Fonds PMA

⁴⁰⁰ “Minutes of a Meeting of the House Committee WGH” 7 February 1936, 1. Folder 9, Box 18 WGH Fonds PMA. See Appendix III, Images 3.3. Though the image is from 1929, the lack of building during the Depression maintains its accuracy.

committee's verdict was that the hospital would not assume liability for injuries on site, since its general liability coverage would not apply.

As the austerity of the Second World War settled over Winnipeg the board entered difficult rhetorical territory. As in the previous war, patriotism and solidarity were factors that checked overreaching criticism or complaint; the plight of the home front could not compare to what those in uniform faced. Still, administrators preached as best they could from the gospel of destitution. The 1939 annual report read, "Efforts to have sorely needed new buildings included in some unemployment relief works plans which would enable the hospital to participate in government funds were continued throughout the year."⁴⁰¹ By 1941 there had been no progress in acquiring funds and the board offered one of its most honest and insightful appraisals of its position. "The Hospital is a private enterprise performing a public service which is a very different proposition."⁴⁰² The board argued it deserved consideration through unemployment relief because it shouldered an increased workload since mobilization.

With no unemployment relief in sight, the board hoped for postwar rebuilding. An executive committee meeting in 1943 agreed to "lay plans for future development, primarily as a post-war building project, realizing some months ago that the dominion department was setting in motion plans for a nation-wide construction program."⁴⁰³ The board wanted plans to include a 300 bed teaching—public ward—unit so remaining accommodation could shift to private and semi-private use. In turn services would be centralized allowing for east and west wing renovations to add 500-800 pay beds. Other changes included moving operating rooms, merging the children's hospital, and relocating X-ray services.

⁴⁰¹ "Winnipeg General Hospital: Annual Report for the year 1939," 1940, 13. Box 10 WGH Fonds, HSCAM.

⁴⁰² "Winnipeg General Hospital: Annual Report for the year 1941," 1942, 12. Box 10 WGH Fonds, HSCAM.

⁴⁰³ "Executive Committee Meeting, WGH" 5 May 1943, 1. Folder 2, Box 14 WGH Fonds PMA.

In preparation for post-war building the executive committee sought to end the use of semi-public wards. The Chairman reiterated the initial intent of such accommodation, as “established in the days of city relief for the patients of doctors who wished to keep such patients through difficult times,” and felt this practice should be curtailed or abolished.⁴⁰⁴ Semi-public care had become a nuisance for both administrative and medical staff because it interfered with medical education. Public patients had to accept the presence of medical students observing during the doctor’s rounds. However, semi-public was a different category and patients could refuse observation. Clinical experience, central to the training of nurses and doctors, cemented the hospital as crucial to medical education. Improved economic conditions were at the root of the problem. Semi-public had largely been a type of state support for physicians. Once patients could again afford semi-private or private wards, it left some of the poorer patients in semi-public and fewer in general wards. One administrator noted: “[a] lack of patients and not lack of beds was the main difficulty.”⁴⁰⁵ The final decision was to repurpose the largest semi-public ward, west 3, to semi-private immediately, and phase out remaining beds.

Demand for semi-private care during the 1940s increased, inspiring administrative confidence for reorganization. In 1942 C flat converted to semi-private accommodation, adding 75 beds. Meanwhile administrators looked past the war noting, “We must start now to plan for conditions after the war insofar as it relates to Hospital service. We must think carefully about size, type of construction and equipment and of the kind of service needed.”⁴⁰⁶ The board expected post-war building and wanted to be ready with blueprints and estimates.

Education was as important a factor as economic improvement. As early as 1943 hospital Superintendent Dr. Harry Coppinger contacted prominent doctors in the United States and Canada

⁴⁰⁴ “Executive Committee Meeting, WGH” 16 April 1944, 1. Folder 2, Box 14 WGH Fonds PMA.

⁴⁰⁵ “Executive Committee Meeting, WGH” 18 June 1944, 1. Folder 2, Box 14 WGH Fonds PMA.

⁴⁰⁶ “Winnipeg General Hospital: Annual Report for the year 1942,” 1943, 14. Box 10 WGH Fonds, HSCAM.

about the idea of becoming a medical centre—linked with the university and other local healthcare providers—rather than remaining a general hospital. In 1943 Dr. Warfield M. Firor, secretary of the American Surgical Association, forwarded Coppinger a letter from a Cincinnati professor of surgery and Surgeon General stressing the importance of closeness between veteran's hospitals and teaching spaces. The letter contained a pamphlet for New York's Columbia-Presbyterian which highlighted its mission to "heal the sick and teach new doctors."⁴⁰⁷ Knowledge of American medical centres focused on education became central to Coppinger's post-war reorganization.

In 1944 Dr. Paul Thorlaksen reported on the hospital's intentions for post-war building to the Civic Bureau Board of Trade. The scheme called for the demolition of A and B blocks, and suggested ongoing renovation until the older parts became as "completely modern in convenience and arrangement," as those planned.⁴⁰⁸ Thorlaksen sought out the bureau hoping for its blessing and that it might help the WGH secure financial support from citizens of Winnipeg. Thorlaksen made an appeal by presenting the hospital as a common necessity rather than a charity. "The necessity for this medical centre has become obvious with the increasing demand by the public for hospital accommodation and specialised treatment." He noted that demand would only increase and since "the public has become convinced that the safest place to be sick is in a hospital. This is in marked contrast to the attitude of thirty years ago when patients went to hospitals only as a last resort."⁴⁰⁹ Thus he leveraged practicality and universality—the hospital was the best source of medical care—to justify post-war funds citizen support. On 7 April 1945, the provincial legislature incorporated the Manitoba Medical Centre.⁴¹⁰ The Children's Hospital became integrated with the WGH, and

⁴⁰⁷ "Dr. Warfield M. Firor, Secretary American Surgical Association to Dr. Coppinger" 8 June 1943, 1. File 3, Box 12 WGH Fonds, PMA

⁴⁰⁸ "Report to Civic Bureau, Board of Trade – Dr. Thorlaksen" 14 April 1944, 3. File 3, Box 12 WGH Fonds, PMA

⁴⁰⁹ Ibid, 2.

⁴¹⁰ WGH is still used throughout the dissertation since it remains an autonomous entity until 1972.

formalized its relationship with the University of Manitoba. The institutions within the medical centre remained autonomous.

From a material perspective the 1911-1945 period was a challenge for the WGH. Lack of funding curtailed expansion for the better part of two decades. The board failed in several attempts to acquire new funding from the provincial and federal governments. Monies from the FBBW largely kept the institution solvent in the 1920s. However, the general public never fully lost faith in the hospital. The fact citizens did not wish the hospital to fail showed that medical care and hospitals had become fused. There was also a marked difference in the ways patients consumed hospital services, evidenced by demand for semi-private and private accommodation. During the Depression and early war years the compromise of semi-public wards demonstrated administrative compromise in the face of patient demand of care.

The World Wars strained the hospital to its limits but also cemented its reputation. Both society and government leaned on the WGH during those years and it withstood, kept its doors open, and continued to function. Perhaps what was most significant was in the final years of the Second World War administrators found a new source of funds. For an institution haggard by hectic day-to-day operation to find architects and have drawings and plans prepared is remarkable. The caveat that organization is not only proactive it can also be reactive remains. Administrators became beholden to public expectation. It was this demand that translated into fees and votes, built the hospital's reputation, and justified its expansion.

Calgary – 1911-1945

In Calgary voters played a central rather than oblique role in hospital organization because the city became directly involved in hospital management. Municipal involvement was an element in other cities as well, but two facts set Calgary apart: its early-1913-amalgamation of city and hospital

administrations, and municipal ownership of its property. Ownership of property and equipment did not make the city any better prepared to manage a hospital. In fact the hospital administration remained separated from civic government. The CGH's civic connection had notably different results during the First and Second World Wars and Depression.

On 28 April 1913, the City of Calgary passed by-law 1472 which allocated \$10,000 towards the erection of a smallpox hospital. By October it agreed to transfer property and amalgamate with the CGH to form the Calgary Hospitals Board (CHB). Management authority, in addition to property, was part of the transfer. The new board consisted of 14 members: three elected by subscribers, four appointed or elected by medical professionals, and six from the city either placed by council or chosen by ratepayers.⁴¹¹ Perhaps the most significant factor for the CGH was passing a \$200,000 by-law which set aside \$20,000 for hospital buildings. The agreement specified that all land used in the process remained the property of the city. On 5 March 1914, an act of incorporation passed provincially, officially empowering the CHB.⁴¹²

A meeting of the CGH building committee in April 1914 was unable to agree if it should pursue a new structure or expand existing facilities. If the committee added new wings the main unit would become a central administration building. Converting that building would limit design freedom because any lost beds required immediate replacement. Unable to decide, the committee sent a letter to all Calgary architects seeking their counsel.⁴¹³ With Canada entering the war four months later construction efforts halted. Enlistment among CGH staff was high; its first interne program came into effect between 1915 and 1920 to cope with shortages. In 1915, a haggard CHB

⁴¹¹ "Memorandum of Agreement between City Council and CGH" 15 October 1915, 1. Folder 1, Box 1, CGH Fonds AHS Archives. See Appendix III, Image 3.4 for image of the 'Old General.'

⁴¹² The CHB performed essentially the role played by trustees at other general hospitals. The day-to-day management staff was affiliated more with the CGH as the institution.

⁴¹³ "Minutes of the Building Committee," 20 April 1914, 1. File 3, Box 1 CGH Fonds, Glenbow Archive. (GA)

wrote to several hospitals—WGH, TGH, VGH, and facilities in Chicago, New York, Seattle, and Boston—asking about their management, standing committees, and nursing curriculum.⁴¹⁴

It is unsurprising that one of the CHB's first actions was to solicit advice from other hospitals. Before its mass outreach in September 1915, the board contacted Geo Haddon Business Manager of the VGH hoping seeking guidance on how to find an architect versed in hospital buildings, and what structures should have priority. D. A. McKillop, General Secretary of the CHB wrote, "Owing to the crowded conditions of the Hospitals in Calgary it has been thought necessary to enlarge the buildings. We have twenty-one acres and the present building covers two. Our chief difficulty seems to be to get an architect who has had sufficient experience to warrant as large a proposition as this is likely to be."⁴¹⁵ Haddon's response encapsulated the uncertainty of hospital design in the early 20th century. He had suggestions for McKillop but no firm answers. One option was to add a privation patients pavilion—as Toronto did in 1930—and convert the main building to public and semi-public wards. On the other hand, some VGH administrators felt that the hospital should split into several cells to serve different portions of the city rather than to centralize.⁴¹⁶ Haddon also suggested two Vancouver-based architects that he believed were up to the task. He concluded on the nebulous note that everything he had said was merely a suggestion, and the VGH's plans were no more mapped out than those of the CGH.

In June 1917 the building committee voted unanimously to petition city council for \$200,000 to erect a new wing. The committee's tone was urgent, "It is our opinion that in delaying this matter further the city is running great risks which may seriously endanger the health and well-being of the

⁴¹⁴ "Minutes of the Building Committee," 18 January 1915, 1. File 3, Box 1 CGH Fonds, GA

⁴¹⁵ "D. A. McKillop, General Superintendent, CGH to Geo Haddon VGH," 22 July 1914, 1. Reel 1, File 30 VGH Fonds CVA

⁴¹⁶ "Geo Haddon to D. A. McKillop," 29 July 1914, 1. Reel 1, File 30, VGH Fonds CVA

whole city.”⁴¹⁷ A month later the committee posited a plan to expand nursing accommodation. It suggested a two-storey wooden pavilion approximately 35 by 50 feet in size with a basement. The interior portions were intended to be about 7’6 feet from floor to ceiling with two bathrooms per floor, each accommodating 14 nurses in single rooms 8 by 10 feet.⁴¹⁸ On 14 August the architectural firm Lawson and Fordyce began drawing plans.

In 1919 the city dissolved the CHB and became the final authority on all matters. The internal CGH board remained as a functionary appendage. In so doing the city assumed all debt. Changes came quickly, such as the council’s adoption of clause nine of the City Commissioner’s Report which specified care for ‘mentally deranged,’ currently held by police before transfer to the provincial asylum, would become a CGH responsibility. City council did not just suggest this change they also provided specific, spatial instructions. “We consider that re-arrangement of the room for this class of patients at the hospital should be made, whereby the wards for such patients would be segregated on the ground floor, isolated from other patients.”⁴¹⁹ Aldermen were the arbiters of hospital management, and in addition to changing the types of patients, provided economic input divorced from medical considerations. They decided ward rates should increase since “the present rate prevailing at the CGH will not cover expenses consequently a deficit is entertained. In view of this fact your Committee is of the opinion that this deficit should be avoided”⁴²⁰ The city government imposed protocols focused on balancing ledgers rather than healing.

In 1919 a wooden-frame annex for emergency cases was completed with 55 beds for adults and 20 for children. The budget was \$20,000 with \$5,853 for furnishing and equipment.⁴²¹ The main building underwent reorganization to increase accommodation. Maternity cases occupied space on

⁴¹⁷ “Minutes of the Building Committee,” 15 June 1917, 1. File 3, Box 1 CGH Fonds, GA

⁴¹⁸ “Minutes of the Building Committee,” 4 July 1917, 1. File 3, Box 1 CGH Fonds, GA

⁴¹⁹ “City Clerk to Dr. Fisher,” 17 September 1919, 1. File 1, Box 19 CGH Fonds, AHS Archives

⁴²⁰ “Excerpt from Special Hospital Policy Committee” 25 September 1919, 1. File 1, Box 19, CGH Fonds AHS Archives

⁴²¹ “Dr. Fish to Mayor Marshal,” 16 February 1919, 1. File 1, Box 19. CGH Fonds AHS Archives

the first floor, and a children's ward opened. The west end of the main building's first floor underwent renovation to accommodate mentally ill patients and provide "ample daylight."⁴²² There was some accordance to medical practice as sun rooms were still in some degree of use. However, it implied there was a time—or at least a possibility—when such patients were confined with little or no light. The "cell" in the WGH basement comes to mind. Human experience was a consideration even for a city council concerned chiefly with solvency.

City council threw its weight around on small projects and day-to-day decisions, but stopped short of settling larger issues. In late-1919 it asked superintendent, Dr. Frank Fish, to prepare plans for a major expansion. Fish's response demonstrated that the medical profession began to see design as both practically and professionally important. "Before undertaking any further hospital expansion we should of course decide upon complete permanent hospital plans. These plans should be developed with the greatest care and no plan should be adopted until it has been given the most thorough study." The first step was to decide whether the current buildings should be incorporated into a new design or demolished. Dr. Fish presented the situation in bleak terms: "[The main] building although not planned at all on the most modern lines is never-the-less constructed of the most substantial permanent brick walls and we can scarcely afford to abandon them."⁴²³ He favoured demolition and rebuilding, but the cost was prohibitive.

For patients in the early 1920s one imprint of city council's role in management was strict rules. Some were medical such as segregation of patients into surgical and convalescent groups, or the requirement of a doctor's consent before a patient transfer. These produced different experiences for patients such as boredom and discomfort. Other rules were more tedious and expressed civic parsimony. A notice posted in the staff area in 1920 summed up the pressure felt by administrators:

⁴²² "City Clerk to Dr. Fisher," 11 November 1919, 1. File 1, Box 19. CGH Fonds AHS Archives

⁴²³ "Dr. Fish to Mayor and Council," 1 December 1919, 1-2. File 1, Box 19. CGH Fonds AHS Archives

“All lights are to be turned off when not required. Every effort should be made to economise in the use of all supplies. Water taps are to be turned off. Remember you are wasting money that might be used to improve our hospital.”⁴²⁴ If patients were admitted through the Workmen’s Compensation Board they were entitled only to general ward accommodation. A patient could pay the difference, but had to do so in advance.⁴²⁵

The relationship between hospital and council was punctuated by flashpoints of tension and complaint that rarely saw resolution. The department of public health operated a clinic for sick children until 1920 when it downloaded the responsibility onto the CGH. After three years of unsatisfactory conditions superintendent, L. E. W. Irving, wrote the mayor stating, “The facilities for holding these clinics has not been favourable owing to lack of space both with respect to proper waiting rooms accommodation and a room for the holding of the clinic itself.”⁴²⁶ Taking on a new responsibility meant cuts elsewhere. The disruption caused by adding a new department demonstrated the importance of design, and the zero-sum nature of space. Space was a finite resource; if one department gained, another lost. Between 1920 and 1923 three different rooms were trialed as a children’s clinic but none proved satisfactory. One of the rooms was needed for patient transfers and the other for the switchboard operator. Irving ultimately resorted to technicalities. He argued children and infants counted as neither inpatients nor outpatients, and therefore they fell within the responsibility of the public health department.

Patients had some influence on ward changes. In 1922 complaints about the sounds of car engines parked along the west and east wings of the hospital spurred new regulations.⁴²⁷ Complaints came from both wings, so they represented different ward types. The cars largely belonged to

⁴²⁴ “Notice” 24 November 1920, 1. File 1, Box 2 CGH Fonds AHS Archives.

⁴²⁵ “Notice to admission and discharge clerks” 30 May 1921, 1. File 1, Box 2. CGH Fonds AHS Archives

⁴²⁶ “L. E. W. Irving, Superintendent WGH to His Worship the Mayor, City of Calgary,” 28 September 1923, 1. File 3 Box 19. CGH Fonds AHS Archives

⁴²⁷ “Parking Cars” 3 April 1922, 1. File 1 Box 2 CGH Fonds AHS Archives

hospital staff. In response to these complaints administration required staff members park their cars opposite the main entrance. It is true that parking happened outside the ward, but sound travelled in and affected experience. The fact patients were able to force administration to side with their preferences against the staff is evidence that they were not voiceless.

The actions of doctors, too, forced administrative action. In 1923 city council ordered a report on the use of emergency services due to claims that doctors were overstating their patient's needs. On 12 June 1922 Dr. Aikenhead phoned the CGH to reserve a private room. When informed none were available, he added that it was an emergency case. Around 5 pm a nurse called to say there was still no bed. Dr. Aikenhead replied "you'll have to put him someplace, this is an emergency and suppose the man should die?"⁴²⁸ In desperation the nurse put the patient in an east wing private room whose occupant slept on the balcony. At 7 pm the patient shocked nurses by walking into the admitting office. The next day an X-ray revealed a bruised shoulder and he was discharged. The event created confusion, compromised private wards, caused tension between staff, and led to an unnecessary X-ray. On 1 October new rules were enacted. The superintendent would issue a warning for a non-exigent case, and after a third offence all future requests would be denied. Administration would not tolerate doctors 'crying wolf' to have patients admitted quickly or into private wards.⁴²⁹

The 1930s were such a dark period for CGH that many of the unpublished institutional histories or alumnae reminiscences completely ignore it. The situation was exacerbated by the 1935 Alberta Health Insurance Act. It was a piece of legislation that could have helped, but the United Farmers of Alberta Party was defeated soon after passing it. Their Social Credit successors did not

⁴²⁸ "Report Regarding Dr. Aikenhead Emergency Reservation," 17 June 1922, 1-2. File 2, Box 19 CGH Fonds AHS Archives

⁴²⁹ "Commissioners' Report: To His Worship the Mayor and Council, City of Calgary," 1 October 1923, 1. File 3, Box 19. CGH Fonds AHS Archives. The same principles applied to women in labour, and those with typhoid

enforce the legislation, and new laws were not passed until 1948.⁴³⁰ Staff shortages hurt the CGH as well. In 1933 W. H. McGuffin, CGH superintendent, wrote to the mayor warning about Calgary's situation. One of his techniques was comparison, which would have been difficult without the increasing correspondence between hospitals. He noted how at the Regina General Hospital (RGH) ten ward supervisors were employed whereas the CGH had only five. The result was the maternity ward, fourth floor men's surgical ward, third floor women's floor, second ward east wing, children's ward and women's surgical floors lacked consistent supervision.⁴³¹

Previously the city had suggested that if the hospital lacked supervisory staff that it should put senior nursing students on night shifts. In a series of rhetorical questions McGuffin attacked the idea, "Is this fair and proper having regard to the rights and welfare of the patient? In the event of an accident or error resulting in harm to the patient is the Hospital safe from an action for damage?" McGuffin saved the most pressing concern to end on. "What effect would it have upon our pay business if it became known that graduate nursing supervision was not available on some floors?"⁴³² It was a thinly-veiled warning that the city exposed itself to liability and thus financial danger. From McGuffin's perspective more employees made the hospital a weightier interest in municipal politics as more people's livelihood was linked to it. With the economy slowing health and charitable institutions moved increasingly into public focus.

The peculiar relationship and administration of the CGH had not escaped public attention, and in November 1933 a plebiscite was held on the subject. Mayor Andrew Davison argued city council should continue as an oversight body. Doctor and Alderman W. A. Lincoln countered that typically hospital boards oversaw administration and voters had a say. To encourage a vote the CGH

⁴³⁰ Robert Lampard, "The Hoadley Commission (1932-1934) and Health Insurance in Alberta," in Marchildon ed. *Making Medicare*, 183-187.

⁴³¹ "W. H. McGuffin, Medical Health Office, and Medical Superintendent to Mayor Davison, Calgary," 3 May 1933, 2-3. File 2, Box 9 CGH Fonds AHS Archives

⁴³² Ibid, 3.

wrote an open letter: “The hospitals were under the control of the city council and alderman neither have the time nor the inclination to give consideration to hospital management routine.”⁴³³ Administrators knew how other hospitals were managed and resented their anomalous situation. As a compromise the board was reformed to consist of nine members, the mayor as an ex-officio member, two Alderman, and six adult citizens of Calgary.⁴³⁴ The CHB was a corporation separate from the city but it was not governed by an autonomous body.

Between 1923 and 1940 the CGH added no structures. Even in the context of economic stagnation and total war it was remarkable for a major hospital to go 17 years without any additions; and not for lack of trying. A 1929 by-law to provide \$1,275,000 for a new wing failed to pass as did one in 1930 to provide \$60,000 for a nurse’s home.⁴³⁵ The hospital was not static, administrators rearranged wards, and new equipment trickled in altering technique and patient experience. The board also met with architects and consultants. Harvey Agnew, overseeing the Canadian Medical Association’s (CMA) Department of Hospital Service (DHS) was contacted in 1936.

From his post at the CMA Dr. Agnew had followed the “operation of the Calgary Hospitals” for some time, and believed they needed a survey to catalogue all services, property and equipment to locate inefficiency. The CMA created the DHS in 1928. Dr. Agnew left a teaching position at the University of Toronto to work there because he preferred to ‘treat sick hospitals.’ Dr. Agnew’s vision for the DHS was to create a resource for hospital administration. “To maintain a clearing house for hospital; information, establish a library service, making personal visits of consultation and advice, and to help establish provincial and regional hospital associations.”⁴³⁶ The DHS did not charge Canadian hospitals for surveys, but also could not guarantee timely completion. Agnew

⁴³³ “Plebiscite on City Hospitals Will be held,” 7. *The Albertan* 3 October 1933

⁴³⁴ “Calgary Hospitals Board,” 1-3, 1935. File 4 Box 9 CGH Fonds AHS Archives

⁴³⁵ “Calgary General Hospital,” 18 April 1950, 3. File 17, Box 2 CGH Fonds, GA.

⁴³⁶ Agnew, *Canadian Hospitals 1920 to 1970: A Dramatic Half Century*, 66.

suggested Dr. William H. Walsh of Chicago, Dr. MacEacehrn of the ACS, or Dr. Haywood of the VGH as qualified, quicker options.⁴³⁷ The CHB met on 12 May 1936 and agreed to enlist the services of Dr. Agnew despite the possibility of a long wait.

Facilities were in such bad shape that the report arrived in June of the same year. It offered stark news. “It soon became apparent in this study that owing to the present financial stringency there would be a tremendous gap between what is obviously needed, particularly with respect of the physical plant,” and thus what was recommended had to be “less Utopian but more immediately practicable.”⁴³⁸ For Agnew the most pressing concern was overcrowding. The official capacity was rated at 191 beds plus 24 bassinets. However, the average occupancy over the last year had been 200 patients, with spikes as high 233. Here Agnew appealed to the existing ‘laws’ of the industry; namely that once a hospital eclipsed 80% of its capacity proper organization and function began breaking down as segregation became impossible.

The overcrowding problem was further exacerbated by underlying patient systems that became exposed when the hospital operated near capacity. For example, patients experienced the hospital as several spaces. Agnew noted that instead of moving from admission to ward they shuffled from one temporary room to the next. In an overcrowded institution spaces used for short-term rest quickly filled which led to delay and confusion. Further, he felt existing spatial organization was lopsided. “So difficult is it to provide space for patients that extra beds have been set up elsewhere, many of the two-bed wards are obviously big enough for but one bed.”⁴³⁹ Such arrangements violated provincial regulations which required a certain square footage and amount of

⁴³⁷ “Agnew to Barnes,” 12 May 1936, 1. File 6, Box 9 CGH Fonds AHS Archives

⁴³⁸ “A Survey of the CGH and CIH: By Dr. Harvey Agnew, Secretary, Department of Hospital Service, Canadian Medical Association,” June 1936, 1. File 16 Box 2 CGH Fonds, GA.

⁴³⁹ Ibid, 5.

window ventilation per patient. He was especially concerned for some of the upper floor rooms where windows opened onto a glassed-in porch.

Agnew made three primary recommendations: to clear cases that could not be helped, divorce hospital administration from municipal politics, and build. His frankest comments came about the state of the building: “The hospital is so obsolete that no remodelling or extension can be considered as anything but a temporary and only partially satisfactory palliative.” He continued reporting that “In the light of modern medical knowledge of hospital administration the hospital was so badly designed that the only real solution is the erection of an entirely new plant.”⁴⁴⁰ For Agnew the building could not be salvaged and was a hazard to patients.

Other complaints shone a light on patient experience in a decrepit building. The pediatric ward was one such area that Dr. Agnew found impossible to improve: “Eight or nine cots in a room and four in another, adequate segregation of children is impossible. The washroom is very dark. Ventilation is bad.” The nurse’s home was sub-standard, and included rooms designed for two students having to accommodate as many as six. Further, one hospital wing was in use for nurses’s accommodation which was “wasteful of potential space for patients and is not considered desirable for the nurses who should in their off-duty hours be away from the hospital environment.”⁴⁴¹ That ward space could be liberated by housing nurses elsewhere was self-explanatory. The idea that nurses needed free time was a unique comment not previously observed in organizational discourse. There was ever-present discussion as to where and how to house nurses, but the building of these residences was almost exclusively done on the cheap. Agnew’s comment that nurses needed space from their work was a rare moment acknowledging their crucial role in hospital’s operation. It was also an indication that the hospital environment was stressful to the staff. The spatial organization of

⁴⁴⁰ Ibid, 16.

⁴⁴¹ Ibid, 9, 13-14.

the hospital was not solely a patient or doctor matter but one that required complex balance across a broad spectrum of employees.

Agnew recommended a building with bed capacity for 300. Therein he stressed particular spatial uses, namely enhanced private rooms describing existing ones as “few, and not particularly desirable as a whole.”⁴⁴² New private rooms with modern furnishing and equipment would increase patronage as well as revenue. Agnew was pragmatic, stating “as new hospitals always receive added public and professional support one could safely predict that even 300 beds would soon be found inadequate during peak periods.”⁴⁴³ The more broadly-perceived the scope of health care became the more likely it was for individuals to think they required treatment. This was a social process where doctors and patients were both responsible. With each wave of hospital building there was an intake of patients who previously had not necessarily considered that their needs could be met. Conversely, with a flurry of interest and excitement about building public donations would increase. Agnew believed it was these superfluous operational costs that drained hospital resources over time. He suggested a serious reconsideration of bed fees as an up-to-date hospital would cost \$3000 per bed.

In 1937 the CGH offered a mere 215 beds and had not acquired any new structures since 1919. Internally doctors and administrators were aware of problems but had very little power to act. Patients saw problems too. A meeting of the standardization committee in 1937 noted there were a large number of complaints about unnecessary noise on the wards coming from radios, raised voices, and heavy footsteps from visitors and staff. These issues were as architectural as behavioural. The design of the hallways, the thickness of walls, doors, and even the type of insulation and paint all

⁴⁴² Ibid, 17.

⁴⁴³ “A Survey of the CGH and CIH: By Dr. Harvey Agnew, Secretary, Department of Hospital Service, Canadian Medical Association,” June 1936, 17. File 16 Box 2 CGH Fonds, GA. For more discussion on the social perception of medial service expansion see Roy Porter, *Blood and Guts: A Short History of Medicine* (New York: W. W. Norton & Company, 2002), 44.

affected acoustics. For instance, swinging doors on the operating rooms were permanently shut as the hinges had worn out and flapped open during procedures.⁴⁴⁴

At a staff meeting on 23 June 1938 doctors vented publically about the condition of the hospital. Drs. Lincoln and Mackid remarked on the “rotting wood and exposed wire.” Dr. Danks pointed to lack of reserve bed accommodation which was “a grave danger in case of a major accident or epidemic,” and that the site was inconvenient. Dr. Hughes commented on “the deplorable state of crowding in the hospital,” and that there was great need for accommodation for the mentally ill. Only Mr. Adams, the hospital chairman, resisted the naysaying. He did not deny the need for new buildings, but noted that estimates put the cost in excess of 1.5 million dollars and “found the present propaganda re obsolete state of the hospital as pernicious.”⁴⁴⁵ He saw neither hope of raising such funds nor value in deriding the institution.

Some support gathered for the building of a new hospital in the 1930s but the beginning of the Second World War delayed plans. In 1939 a small annex known as B block was added to the nurses’s residence for the purposes of easing congestion inside the home. In the 1940 the board approved an internes residence that was never built. A breakthrough came in 1941 when construction began on two storey building named after a 1934 bequest of \$147,000 from the Perley family. The Perley wing was the only large project attempted during the war and Depression; however, it did not open until 1944.

When the Perley Wing opened in 1944, it added 49 beds and 60 bassinets plus a 20-bed surgical ward and 26-crib pediatric unit.⁴⁴⁶ There were also delivery rooms, offices, and nursing areas. The building did not have lab or incubation facilities, nor did it have spaces for families to wait. The Perley wing addressed the overcrowding issue by providing some relief but was not a

⁴⁴⁴ “Standardization Committee” 18 January 1937, 1. File 4, Box 22 CGH Fonds AHS Archives

⁴⁴⁵ “Staff Meeting,” 23 June 1938, 1. File 4, Box 22 CGH Fonds AHS Archives. Source of above quotes.

⁴⁴⁶ “CGH Historical Dates,” 1989, 8. File 15, Box 33. CGH Fonds AHS Archives

major solution. In the early 1950s the board converted the Perley solely to a maternity hospital. The decision demonstrated how administrative thought grew more pragmatic. A common complaint was lack of ward space for female patients and as the Agnew report showed the practice of ward segregation exacerbated overcrowding. Adding an all-female wing partially addressed the lack of ward space, provided a place for overflow, and eased congestion in the children's ward.

The Second World War had less dramatic an influence on the CGH than the depression; in part due to how bad the situation already was. When doctors and nurses left for overseas service the patient paid the price. However, the prospect of federal money provided optimism. Learning from the First World War there were more military health facilities set up and far less responsibility downloaded onto municipal and civic institutions.⁴⁴⁷ Civilian demand remained strong and the CGH continued struggling after the war. The CGH campus that emerged from the Second World War was unsatisfyingly similar to the one that existed in 1918.

During the Depression and war years Calgary expanded its health facilities in a minimalist manner. Funding was the basic concern of administrators, which was exacerbated by the anomaly of direct city involvement. Administrators and doctors pushed for more autonomy, and found a compromise in 1933 when the CHB was reinstated. The hospital was no longer a branch of the city government, nor was it run by doctors or charities. No reformation of governance could solve the money problems. Citizens still controlled the purse strings, and the CGH faced rising expectations and aging facilities. The promise or hope of remedies kept up morale to a degree, but Calgary's post-1918 period was lean. As the hospital moved into the mid-1940s it needed new buildings to provide health care and contribute to medical education and research.

⁴⁴⁷ Desmond Morton and Glenn T. Wright, *Winning the Second Battle: Canadian Veterans and the Return to Civilian Life, 1915-1930* (Toronto: University of Toronto Press, 1987), 8-9.

Vancouver 1911-1945

In 1911 the VGH was overcrowded and lacked the capital for a major expansion. The same year it began construction on a south-west wing which was finished and partly occupied in 1912. The main building accommodated 375 beds once fully operational, and represented completion of the original 1888 plan. Overcrowding was so bad that a central wing was planned on the site of the present power house. It dispersed patients but did not add any beds. The central wing also added surgical, kitchen, and scullery space. A new power plant and laundry were planned, as was a permanent isolation building. With the removal of these buildings a large area south of the hospital was freed for future expansion. A nurses's home was planned to free up space in the main building. Tax-payers supported expansion by voting in favour of a by-law to provide \$325,000.⁴⁴⁸

Such a large public grant coupled with major facility expansion ought to conjure the image of a secure and well-supported facility. But the 1912 annual report told a different story. Directors noted that “the past year has been marked by a Government investigation into the affairs of the hospitals,” and devoted a section to ‘self-defence.’ The chairman’s address summed up the problem of hospitals in the 1910s. They had been established as useful in the minds of the public, but lagged behind in infrastructure. “The directors have been struggling with an institution growing in importance with great rapidity, without adequate provision being at their command to meet the requirements, and as a consequence compelling by force of circumstance undue economies.”⁴⁴⁹ In addition to the by-law city council provided a grant of \$15,000 on top of the \$0.45 per diem. The chairman ended his address by reminding citizens that patients who could not pay were the true reason resources were scarce. It was a stark reminder how the fragility of health could be a potent political weapon.

⁴⁴⁸ “VGH: Annual Report for the year 1912,” 1913, 5. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

⁴⁴⁹ Ibid, 6.

Between 1913 and 1918 the VGH added at least one major building per year. In 1913 the south-west wing was fully occupied, and the power house and laundry completed. In 1914 the service wing—called the centre wing through 1912—was completed, and a nurse's home on nearby Heather Street opened. The new service wing was remarkable in its experimentation with semi-public wards. In the 1910s, ward choice was more often binary—private or public—but the expansion of different approaches demonstrated the growing acceptance, and thus use, of hospital facilities more generally. Semi-public differed mainly in how the doctor received compensation but could also include slight improvements such as portable curtains.

A number of projects were completed in 1915: a pathology building, ward X for the chronically ill, and an enlarged operating suite. The wooden isolation cottages—erected in 1906—were removed in 1916. In their place a citizen-funded building was added for use as a military hospital. The operating suite offered state of the art equipment, “equal to the best on the continent.” Administrators reached out to several Canadian and American hospitals to inquire about design and equipment. Ward X, a response to long-term patients cluttering the wards, was “large, well-lighted and airy, and at the same time gave direct access to the grounds,” though administrators were quick to add that “the need for a home for incurables of this class is a matter which has been up on several occasion with the government and with the City.”⁴⁵⁰ Incurables remained a category hospitals did not wish to handle; recovery and healing not maintenance and care were the VGH's prime directives. Still, establishing an incurable ward was evidence that a broader vision was developing.

The 1915-1916 annual reports stressed the challenge of total war. In 1916 the VGH was responsible for approximately 300 sick soldiers on top of its usual duties. The rhetorical power of caring for soldiers was not lost on the board: “The obligation to provide the very best treatment

⁴⁵⁰ “VGH: Annual Report for the year 1915,” 1916, 10-11. Box WX 2 DC 2.2 V2, VGH Fonds, CVA. Source of above quote as well.

available to men who had been broken by war, falls just as strongly on institutions of this kind as on the government....Patriotic and civic pride left no room for hesitation that accommodation be secured.”⁴⁵¹ A new building was erected next to the main complex, funded jointly by the province, municipality, citizens, and local businesses. The VGH found itself responsible for a medical emergency which put administrators on edge. However, it was also an opportunity to showcase its worth as an institution, insert itself into an important social process, provide an image of assisting in the war effort, and acquire capital.

Of all war buildings the most important to the VGH was the 1917 Marpole facility which added 300 beds. For two years the board discussed the possibility of purchasing a struggling hotel on Marpole Street and converting it to hospital use. Early in 1917 it leased the building. In 1916, 8,718 patients were treated at VGH facilities, in 1917 that rose 25% to 11,671. By the First World War doctors and administrators shared a preference for purpose-built structures rather than retrofitting other buildings. However, faced with unprecedented demand there was little choice.⁴⁵² The building was designated as a home for convalescent and intensive treatment cases, with one wing for chronic disease patients. The Marpole Annex was inadequate but the board did not wish to admit that, “The fine new building, formerly an up-to-date hotel...is very admirably adapted to such cases, affording lots of space, good air, all possible comforts and opportunities for work and entertainment.”⁴⁵³ The Marpole Annex relieved the main building of a large number of convalescent cases. One initiative that grew from the new facility was re-education and reoccupation for soldiers. Such efforts redefined convalescence, and broadening the scope of medical care and hospital function.

⁴⁵¹ “VGH: Annual Report for the year 1916,” 1917, 11. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

⁴⁵² “Military Hospital Annex, Notes by Mrs. B. T. Rogers,” 1917, 1. File 1 Box 535-D-2 VGH Fonds CVA. See Appendix III, Images 3.5 and 3.6.

⁴⁵³ “VGH: Annual Report for the year 1917,” 1918, 40. Box WX 2 DC 2.2 V2, VGH Fonds, CVA. Above statistics on pg. 10.

The influence of the First World War on the VGH was profound. In addition to the Marpole Annex a military annex on 12th Street was built and equipped through donations and fundraising. Together these two military hospitals accounted for 600 beds—half total VGH’s capacity. For this hospital war was, in a sense, big business. The institution swelled in size and was brought into frequent contact with political actors. From the perspectives of returning soldiers it became something of mixed symbol. On one hand a place of hope where a return to normalcy might be attainable as well one of dread where debilities had to be confronted.

Isolation buildings to treat influenza patients marked a pause in building activities. For the next seven years the VGH coped first with financial austerity and, as prosperity returned, financial caution. The VGH was taxed to capacity by military obligations. Administrators resorted to temporary accommodation in the isolation buildings. Finances were stretched so tightly that in June 1917 administrators agreed to segregate paying from non-paying patients inside the general wards. Their hope was that by carving out ‘charity wards’ the hospital could focus its efforts on extracting payment from patients who could actually afford it.⁴⁵⁴ The board made small improvements in 1917 and 1918, notably adding balconies to ward T in the main building and sun rooms to the military annex. Coping with returning soldiers required more wards and different facilities, but it had subtler, longer-lasting changes. For instance, the board renamed ward T the Pringle Ward in honour of Eden Pringle a graduate of the nursing school, who died in the bombing of a Red Cross hospital in France.

The 1920s started bitterly for the VGH. A by-law to provide funding for the erection of a nurses’s home and maternity hospital was defeated. The VGH then consisted of the main building, 12th Street military, Haro Street infant, Marpole military-civilian, and Heather Street isolation annexes. The board appealed that accommodation was “urgently required to keep pace with demands of the city,” and that “a large deficit resulted in the operation of the institution during the year, in

⁴⁵⁴ “Special Meeting of the Board of Directors,” 18 June 1917, 1. Box 4 VGH Fonds CVA

spite of the fact that the directors exerted every effort at economy consistent with efficiency.”⁴⁵⁵ Though the war and epidemic were over, costs and responsibility lingered. The military annex still held a larger number of ‘civilian re-establishment’ patients; however, administrators felt the number was low enough to restrict their treatment to the lower floor and place civilian patients in the rest of the building. The maternity ward was crowded. Its intended capacity was 25, but coped with closer to 60. A floor previously used as a dormitory for nurses was converted to cubicles for infants. Facilities for observation and isolation continued to be a consistent source of worry and were “inadequate in every sense of the word” for their task.⁴⁵⁶ Observation rooms were so limited in number that it was difficult to find time to clean them. Administrators noted observation rooms were especially battered because they saw alcoholics, drug addicts, and the mentally ill. The VGH’s circumstances mirrored what many general hospitals in Canada faced, an almost perpetual state of spatial adjustment without expansion.

Lack of funds forced VGH administrators to renovate rather than rebuild for most of the 1920s. The 1921 annual report commented that, “Lack of funds continued to be the main obstacle preventing the board from providing extensions or improving facilities to keep pace with the advances of the day.”⁴⁵⁷ In 1922 the province turned over \$156,491 collected from taxes on liquor sales to erase an operating deficit of \$77,792. Some of the balance went to acquiring an X-ray machine and renovating private wards. However, administrators lamented the annex system. They argued the hospital’s “extended sphere of operation” as the cause of recurring deficits.⁴⁵⁸ In 1923 the province took responsibility for the Marpole annex. The addition of an X-ray machine necessitated

⁴⁵⁵ “VGH: Annual Report for the year 1920,” 1921, 9, 11.. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

⁴⁵⁶ *Ibid*, 45.

⁴⁵⁷ “VGH: Annual Report for the year 1921,” 1922, 9, 10. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

⁴⁵⁸ “VGH: Annual Report for the year 1922,” 1923, 9, 15-16. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

new quarters in the basement of the south-west wing. Administrators deemed it unfeasible to add a new building and instead reorganized, creating wards I and G.⁴⁵⁹

In 1923 the board aspired to resume building. “It is the history of the institution that additional accommodation has only been acquired after, and not in advance, of very pressing needs. The immediate requirements seem to point to a separate pavilion for the Maternity Department.”⁴⁶⁰ The impulse was sensible in light of the preceding decade’s events. The hospital had been caught off-guard and resorted to a tedious network of annex buildings that were almost always overcrowded. Administrators in big cities aspired to build and manage a medical campus of purpose-built structures. Lack of finances blocked the board from achieving its modern vision. Most of its resources were spent simply keeping pace with developments, such as an X-ray.

In 1924 rate payers voted in favour of a bill to fund replacements for the 1906 infectious disease buildings. There was some debate as to whether the city or hospital should be responsible for operation. The final decision was to have the board operate it in exchange for remuneration. Administrators still beat the drum for a new maternity hospital, but added that a pavilion for private wards, an extension to the general wards of the main building, and a children’s hospital were necessary too.⁴⁶¹ Demand and strain fueled these suggestions, but the increased use of the word ‘modern’ in administrative rhetoric pointed to other factors. Trustees sought a way to articulate and justify the alterations necessitated by new technology and techniques. The word modern captured this idea, and administrators used it to convey an image of scientific, current, efficient, and effective healthcare practice, design and procedure. Unlike struggling prairie cities Vancouver had a robust, wealthy medical community.⁴⁶²

⁴⁵⁹“Minutes of a Meeting of the Board of Directors,” 11 October 1923, 2. Box 5 VGH Fonds CVA

⁴⁶⁰ “VGH: Annual Report for the year 1923,” 1924, 32. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

⁴⁶¹ “Report of Special Extension Committee,” 2 April 1926, 1. Box 535-A-6 VGH Fonds CVA.

⁴⁶² Margaret W. Andrews, “Medical Attendance in Vancouver, 1886-1920,” *BC Studies* 40 (1979): 32-34.

Provincial grants and funding by-laws came again in 1927. A building previously occupied by the university passed to the VGH for use as a tuberculosis hospital. It was a concrete structure that required significant internal renovation. Once finished it added 70 beds and was renamed the Fairview Pavilion. In 1928 building commenced on new maternity and private ward blocks, both of which administrators expected to be complete within a year. Once the new ward blocks opened extensive renovations began in the main building. It has been receiving excess patients due to the 12th Street annex closing. Nursing accommodation was a problem as well. Administrators noted current housing comprised “several wood structures which are far from satisfactory. A woman’s building and children’s hospital are also necessary, as are buildings for special department such as X-ray, physiotherapy, and labs.”⁴⁶³ The nursing profession expanded with patient population and educational opportunities.

By 1929 the VGH had grown to comprise a main building, private ward building, maternity building, an infant’s hospital, infectious disease hospital, tuberculosis clinic, and Heather Street annex. The maternity and private ward buildings just opened, and extensive renovations were ongoing in the main building in anticipation of closing the 12th Street annex. The board was close to realizing its goal of a modern medical campus. At the end of 1929 the VGH ran a deficit of \$347,752; \$265,643 had been expended that year alone and \$80,132 came from construction costs. A commission formed consisting of Dr. A. K. Haywood, then of Montreal, and Drs. M. T. MacEachern and W. H. Walsh of Chicago to investigate the VGH’s role in the overall medical picture for greater Vancouver. The board supported this action, but its impetus came from municipal and provincial politicians concerned about cost and accountability.⁴⁶⁴

⁴⁶³ “VGH: Annual Report for the year 1928,” 1929, 9. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

⁴⁶⁴ “Minutes of the Board of Directors,” 20 February 1936, 1. Box 7 VGH Fonds CVA.

The years 1930-1935 were spartan for the VGH. It added no buildings and even renovation was limited to little more than an enlarging of X-ray facilities in 1932. In 1930 the 12th Street annex was demolished, and ward rates rose from \$2.00 per day to \$2.50. The commission recommended an extension programme over ten years, but it would solve only the most urgent problems of nursing accommodation and overcrowding. Significantly, the report suggested, “that immediate future consideration be given to the engaging of a specialist in hospital planning and architecture to study the whole question of expansion and that your Board secure a plan which will take care of the community needs for years to come....”⁴⁶⁵ Such a suggestion spoke to the emergence of professional consultants and architects, but also the entrenchment of the hospital as an institution deserving the attention of fields outside medicine. The board received the recommendation well, but took no action due to lack of funds.

During the period of stagnation minor alterations and reorganization continued. Materials were difficult to acquire, but labour was cheap. The parks board came to the VGH in 1931 as part of its involvement in the ‘Millions Days Work Campaign,’ and went about levelling and seeding the ground adjacent to the private ward pavilion and maternity building. The work was not critical to medical practice, but addressed some of the board’s concerns such as the area being an “eyesore.” Poorly-kept grounds detracted from the overall image the board wanted to project of a well-ordered and clean space. The X-ray addition of 1932 cost \$30,000 and was financed directly by city council after an inspection and vote that confirmed the “urgency of the situation.”⁴⁶⁶ By 1934 fears of overcrowding weighed on administrators. Despite juggling beds and converting storage areas into rooms, accommodation levels were 90-98%. Administrators and the nascent field of hospital professionals concurred that it was never advisable to crest 75% capacity.

⁴⁶⁵ “VGH: Annual Report for the year 1930,” 1931, 10-11, 14. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

⁴⁶⁶ “VGH: Annual Report for the year 1931,” 1932, 15-16, 18. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

Fear of litigation brought the CGH into contact with the VGH. In 1933 Barnes wrote to Dr. Haywood, who had become Medical Superintendent of the VGH, about reports he had read about a potential lawsuit. In January the VGH had placed a child with diphtheria in its isolation building who then contracted smallpox. Barnes wrote “All hospital are interested in protecting themselves against possible claims of damages...it seems hardly possible for a jury to find against the Hospital. However it was apparently done...As this judgement will likely constitute a precedent in law...”⁴⁶⁷ Barnes also asked several technical questions about the approach taken by VGH attorneys. The judge had determined the hospital erred by not maintaining separate facilities for smallpox and diphtheria patients. As a result, meals were prepared in the same kitchen, and the same nurses saw both types of patient. Haywood noted, “We are appealing this case as we realize that it will have a very serious bearing on Hospital practice in Canada if the precedent is allowed to stand. Unfortunately, these cases of co-called cross infection all occurred in unvaccinated patients.”⁴⁶⁸ His comment on vaccinations intimated that medicine was growing too complicated for politicians or lay people to understand, and that distrusting doctors would only cause harm. What better example than unvaccinated patients getting sick then suing the hospital?

A tuberculosis wing funded by the province to centralize care opened in 1936. The ‘Chest Clinic’ located at the VGH was expanded to add a further 70 beds. The wing also brought a new hand into the design of the VGH campus. Provincial architect—Henry Whittaker—whom the board lauded for his “knowledge of hospital construction” designed the new wing and consulted on design and expansion. The board had to come up with \$830 to cover roofing repairs to the private ward wing and maternity building. In 1935 the issue of public health insurance was before the provincial legislature, and the VGH saw an opportunity to tap into further funds. The 1935 annual report was

⁴⁶⁷ “J. Barnes Manager CGH to Dr. A. K. Haywood, Medical Superintendent VGH,” 28 January 1933, 1. File 2, Box 9 CGH Fonds AHS Archives.

⁴⁶⁸ “Haywood to Barnes,” 30 January 1933, 1. File 2, Box 9 CGH Fonds HAS Archives

cautious about endorsing the idea, stating that: “any plan toward health insurance should provide adequate funding for the VGH. Provision for the financing of new buildings should aspects of the proposed act call for a greater accommodation of patients....and provision for financing chronic cases in subsidiary hospitals.”⁴⁶⁹ The board was eager for legislation that elevated its social importance, and integration into a major program was one way to do so. However, some board members feared it could offload responsibility and cost.

The act passed on 31 March 1936, but was less ambitious than planned, promising to provide only \$50,000 toward the scheme compared to the \$1,200,000 threshold recommended in committee. The periodical *Medical Economics* described it as: “pruned and shorn...till the Bill emerged a sorry enough spectacle. For it is a pale shadow of its former self, anaemic, and paralyzed in its lower limbs or lower income-levels...”⁴⁷⁰ The VGH board was nonplussed: “...time alone will tell what the actual effect on the operation of the hospital will be.”⁴⁷¹ Doctors resisted over concern that their income would drop substantially. They already were providing a significant amount of unpaid care. Of 700 doctors queried in 1936 only 13 replied they would work under the bill.⁴⁷² It was postponed indefinitely after a 1937 referendum, and never enacted.

In February 1935 the board engaged the Chicago-based hospital consulting firm of Dr. W. H. Walsh and received his report in April 1936. Walsh had been on the earlier VGH commission but his Canadian roots went even deeper. In 1929 he was a member of the British Columbia Hospital Commission analyzing health care facilities. Walsh provided extensive uncompensated consultation to the VGH. In 1936 he participated in a board meeting where he confirmed the administrative belief

⁴⁶⁹ “VGH: Annual Report for the year 1935,” 1936, 12, 15. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

⁴⁷⁰ “The Health Insurance Bill of British Columbia: An Editorial in the Bulletin of the Vancouver Medical Association, May 1936” *Medical Economics* (1936): 685.

⁴⁷¹ “VGH: Annual Report for the year 1936,” 1937, 13. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

⁴⁷² Margaret W. Andrew, “The Course of Medical Opinion on State Health Insurance in British Columbia, 1919-1939,” *Histoire Sociale – Social History* 16:31 (1983). 141-142. Andrew stresses that a divided Liberal government was a major factor in watering down the bill which led to doctors resisting it.

that a shortage of beds and occupancy being unsafe.⁴⁷³ Walsh gave the board independent support by confirming its hypothesis, which aided in negotiations with the city and province. In the 1936 report he suggested nursing accommodation should be a top priority. The board had rough plans sketched to replace the “number of antiquated buildings which are now used for that purpose,” but could not act as the entire hospital had “almost reached the breaking point” and need a more complete approach.⁴⁷⁴ The main building was running at 100% capacity with beds lining the hallways.

The years 1936-1942 were frustrating for VGH administrators and patients. The Walsh Report estimated \$1,500,000 was needed for new buildings, something Dr. Haywood—also of the commission now VGH superintendent—saw as out of reach and an underestimate.⁴⁷⁵ He used the 1936 annual report to argue for funding. “In the hospital field, when one refers to the size of a hospital, one generally refers to an active treatment hospital, and one of the reasons that we are so crowded is that our main building should only accommodate 400 patients, whereas the daily average is 475.”⁴⁷⁶ Other departments compensated at the expense of efficiency. In 1937 provincial architect Whittaker and Dr. Walsh worked together on plans for a 587-bed acute facility; however, the outbreak of the Second World War halted all major building. In 1938 a small interne residence opened, which added 51 beds in the main building. Such statistics can be misleading. For instance, the removal of interne beds from the main building was not a 1:1 ratio. Internes numbered around 20, but their larger rooms could be converted to add multiple beds.

The Second World War strained Canadian health care providers, and hospitals in particular felt squeezed.⁴⁷⁷ For the VGH 1939 was an especially bad year. The hospital was already haggard from overcrowding and austerity; now it faced nurses and doctors leaving for service overseas.

⁴⁷³ “Minutes of the Board of Directors” 20 February 1936, 2 Box 534-F-7, VGH Fonds, CVA.

⁴⁷⁴ VGH: Annual Report for the year 1936,” 1937, 16. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

⁴⁷⁵ “Minutes of the Board of Directors” 3 December 1936, 5. Box 7, VGH Fonds, CVA.

⁴⁷⁶ “VGH: Annual Report for the year 1936,” 1937, 17. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

⁴⁷⁷ Ruddy and Sue C. Sullivan, *This is Public Health*, 76-90.

Materials, labour and capital were nearly impossible to acquire. The 1939 report stated that “The building programme which has been referred to now for several years has received an indefinite postponement. Adequate sketch plans...were completed but Canada’s participation in the war may result in the plans being completed revised...hospital construction and facilities for treatment of the sick are changing rapidly.”⁴⁷⁸ The board hoped the war would increase employment and lessen demand on public wards and outpatient care. However, in many cases the income of soldier’s dependents was not enough to remove them from public wards. Other chaos ensued, such as the building inspector condemning the wooden buildings used as nursing residences.

In 1940 the board levelled its direst warning to the community. “In so far as this Hospital is concerned we have done nothing...we find our accommodation and services in rather a dangerous position.”⁴⁷⁹ Further, the hospital would have “serious problems ahead,” as existing facilities were obsolete. Administrators accepted wartime austerity, but countered that the hospital dealt with life and death and should be treated differently than other public agencies. Plans were drawn in 1941 for a new outpatient department, a semi-private pavilion and physiotherapy building. However, “owing to the difficulty of securing materials and necessity of priorities...encountered considerable delay.”⁴⁸⁰ In April 1942 construction began on a semi-private pavilion with capacity for 186 patients divided among wards of two, four, and six as well as a smaller lab unit. Due to the demand and overcrowding the administration opened the ground floor to provide physiotherapy while the upper level remained under construction.

Two of the semi-private pavilion’s three floors opened to patients on 1 November 1943. Typical of hospital expansion, it solved some problems while raising others. The beds it provided

⁴⁷⁸ “Vancouver General Hospital: Annual Report for the year 1939,” 1940, 17. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

⁴⁷⁹ “VGH: Annual Report for the year 1940,” 1941, 10. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

⁴⁸⁰ “VGH: Annual Report for the year 1943,” 1944, 15. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

were sorely needed, but the added consumption of electricity put an unanticipated strain on the power house, and the building committee at once began drafting plans for expansion or a total rebuild. The pavilion itself was financed solely with government monies, equal parts from the municipality and province. Trustees discovered the greatest obstacle to wartime building was acquisition of materials, noting that “apart from the effort put forth by the architect and contractor to complete the building, a great deal of credit should be given to our purchasing agent...”⁴⁸¹ Throughout the war architects drew blueprints, but they were rarely realized.

Between 1911 and 1945 the VGH survived two global wars and a major economic crisis. Where the VGH of the early 20th century saw expansion and prosperity ahead, what emerged after 1945 was a soberer institution. The internal politics and tone that had always been a bit dramatic hardened as administration experienced overcrowded wards, archaic equipment, insolvency, condemned buildings, and an exodus of staff into the military. However, major opportunities emerged at the end of the Second World War. The spectres of material, labour and capital shortage were greatly diminished. Administrators hoped that as Canada moved towards a more prosperous period hospitals would be at the forefront.

There were more subtle changes as well—to say nothing of advancements in medical techniques—specifically the extent to which governments rather than citizens had taken a leading role in financially backing institutional expansion. The hospital had become integrated into the larger governing structure of society due to its role in marshalling civilians into soldiers, healing their injuries, maintaining public health, and facilitating research and education. The VGH was much larger in 1945 than in 1911, but its size did not reflect a long-range plan. Administrators undertook expansion when and where they could. Even in an age of hospital consultants and architects capable of providing guidance the VGH was hostage to the exigencies of its time.

⁴⁸¹ “VGH: Annual Report for the year 1942,” 1943, 11. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

Conclusion

The Depression and austerity of the Second World War were significant antecedents to the building boom of the later-1940s and 1950s. The decrepit nature of buildings, the overcrowding, the inability to add new services or take on more patients—all exacerbated by economic turmoil and austerity—did for hospitals what rhetoric could not. These factors convinced the public how necessary new buildings were. Administrators and hospital professionals began to see that the dream of economically self-sustaining institutions would never be realized. The WGH's self-appraisal as a 'private enterprise performing a public service' revealed the conundrum at the heart of these hospital projects. In the final years of the Second World War administrators began to anticipating a shift towards a model supported by regular influxes of federal capital.

The task of spatial arrangement was growing more complex and began taking into consideration more than just bed capacity. Accommodation had to compete with other functions during renovation. Administrators adapted their conception of a hospital campus to comprise laboratories, physiotherapy rooms, large nursing homes, and surgical space. Increased accommodation strained the ecosystem. To add a bed was to add a lab, operating room, or nurses's residence. VGH administrators in 1929 expressed: "We are again confronted with a calamitous lack of space for routine work; to say nothing of other functions which a laboratory or the largest hospital in Canada should preform, namely research, instruction of internes, and technicians."⁴⁸² The hospital grew physically and professionally. Its scope of service and range of purpose became increasingly tied to producing doctors, nurses, and research.

The most dramatic events of 1911-1945 were the two world wars. They provided a burst of medical and technological advancement, and the treatment of soldiers reshaped procedure and administration. The effect of mobilization on hospitals was palpable. Returning troops had to be

⁴⁸² "VGH: Annual Report for the year 1929," 1930, 56. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

cared for, potential recruits inspected, nurses and doctors left to serve, and the federal government began viewing the institution as crucial for rehabilitation. Administrators were eager to show a brave face to their communities, as much out of necessity as to earn public and political capital. The influx of patients stretched hospitals to the brink. The war affected daily medical practice too. For instance, in 1915 the VGH had to stop using its best X-ray machine because replacement parts from Germany were unattainable.⁴⁸³ For much the late-19th and early-20th centuries, nascent general hospitals in Canada aimed only to provide active treatment. As discussed in the previous chapter patient stays were long, expensive, and produced negative statistics if the stay did not end in recovery and discharge. The realities of war changed that. Soldiers were maimed, traumatized, and poisoned. They returned home, at times untreatable, but not quite dischargeable either. The long-established line drawn by doctors that presented their skills as solely for active treatment had to be crossed.⁴⁸⁴

The hospital's financial dependency is as important a question for historians of medicine as it was for rate payers and administrators in the early 20th century. Unlike other enterprises where more work generally meant more profit the opposite was true of hospitals. Operating costs were relatively low if patient levels were too. Staff costs were generally low too, since doctors saw public ward patients gratis, and received payment directly in private wards. Consumption of food, utilities, and medical supplies in addition to construction caused cost to spiral.

The enterprises most readily comparable—or at least seemed to be at the time—were hotels. At face value the hotel provided a near-identical list of services: sleeping space, food, comfort, and entertainment. Of course, hotels did not provide services like surgery, childbirth, or bone setting. VGH administrators argued that hotels existed to make profit; hospitals did not; hotels provided

⁴⁸³ Clare Marcus *History of the Vancouver General Hospital: 75th Anniversary Edition* (Vancouver: Vancouver General Hospital Public Relations Department, 1977), 14.

⁴⁸⁴ Terry Copp and Bill McAndrew, *Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army, 1939-1945* (Montreal: McGill-Queen's University Press, 1990)

services to paying patrons; hospitals only sometimes did; hotels could close during off-seasons or deny patrons who could not pay; and hospitals could not.⁴⁸⁵ In 1921 the WGH released a pamphlet stating that “The WGH is a large business which exists for the care of the sick. In management not unlike a hotel, yet on a dividend paying basis it would offer a very poor field for financial investment, because its revenue rarely equals the expenditure.”⁴⁸⁶ There was an important optical difference in that hotels existed to profit, whereas the hospital was an institution for the public good.

The prairies story is important. Winnipeg and Calgary had grown into the fourth and ninth largest cities in the country by 1945. They faced changing civic expectation for hospital availability under the challenges of a swelling population. As David Laycock has argued, the prairies prior to the Second World War are not well-characterized simply by descriptions of farmer revolt. They were a region of “concerted and diverse attempts to reconstitute the democratic experience within the Canadian polity.”⁴⁸⁷ Social institutions such as hospitals reflected this impulse. The tenacity with which citizens clung to their general hospitals by volunteering time and treasure takes on more lustre considering how hard the Depression hit these regions.⁴⁸⁸

The period 1911-1945 saw a significant increase in communication and collaboration between case study hospitals. Some were mundane. In November 1929, the TGH sent nine poppy wreaths to the CGH for display in the public wards.⁴⁸⁹ Others were medical such as in 1923 when the WGH wrote to the University of Toronto requesting advice for handling diabetics; Banting’s work

⁴⁸⁵ “VGH: Annual Report for the year 1925,” 1926, 30. Box WX 2 DC 2.2 V2, VGH Fonds, CVA.

⁴⁸⁶ “Hospitalville – A town within a city,” [1921], 2. Folder 6, Box 27 WGH Fonds, PMA

⁴⁸⁷ David Laycock, *Populism and Democratic Thought in the Canadian Prairies, 1910 to 1945* (Toronto: University of Toronto Press, 1990), 3, 166.

⁴⁸⁸ J. E. Conway, *The West: The History of a Region in Confederation* (Toronto: James Lorimer & Company, Publishers, 1983), 98-99.

⁴⁸⁹ “Poppy Fund to CGH,” 6 November 1929, 1. File TG 2.3.18 Box 15 TGH Fonds UHN Archives

on insulin in 1921 hardly requires mentioning.⁴⁹⁰ Many discussions were substantive. J. Barnes of the CGH corresponded extensively in 1929 with F. C. Bell the VGH Superintendent about building patterns and organization. Bell described not only the main hospital buildings in detail but also auxiliary spaces such as the laundry and kitchens. He also detailed some internal arrangement such as its experiment with 126 single-bed rooms known as the ‘Pasteur technique.’⁴⁹¹ Other interchanges are mentioned in previous sections as well. Some of the impulse for increased communication owed to the difficult times of the 1930s and early 1940s. By the same token, the entrenchment and expansion of hospitals between 1910 and 1930 provided a motive for administrators, doctors, and educators to establish professional networks.

There were limitations to professionalization. The local still mattered. Though the refinement of hospital management accelerated between 1911 and 1945 there was still a great deal of inconsistency in how statistics were to be calculated, what designs or principles were paramount, and how to balance the competing uses of the hospital in healing, research, and education. How per diems were calculated, the funding arrangement with the province and municipality, who the administrators were, and what were their goals and competition were all differed by city. Architecture and society played a role too. As J. Barnes, CGH secretary noted in 1934: “The hospital staff is increased or decreased by the layout of the building they have to operate, the services expected from the staff by both doctor and patient, the patient turn-over at ours is high, which increases both work and costs and I believe tends to lower revenue.”⁴⁹² Barnes’s ultimate analysis was that other than the physical shape of the building—which could be reordered but the dimensions

⁴⁹⁰ “Minutes of a Meeting of the Hon. Attending Staff,” 22 March 1923, 1. File 5, Box 13 WGH Fonds PMA. For a more complete take on insulin research, the University of Toronto, and Frederick Banting see Michael Bliss, *The Discovery of Insulin* (Toronto: McClelland and Stewart Limited, 1982)

⁴⁹¹ “F. C. Bell, General Superintendent VGH to J. Barnes Manager CGH,” 1 March 1929, 1-2. File 1 Box 10 AHS Archives. Barnes also wrote letters to the Superintendent of the Royal Alexandra Hospital in Edmonton, H. R. Smith.

⁴⁹² “J. Barnes to J. H. Garden,” 1. 28 June 1934 File 2 Box 9 CGH Fonds AHS Archives

were fixed—local context, institutional quirks, and the political climate were among the most important factors in determining the hospital’s trajectory.

Chapter IV – “approximating the economical layout of a modern hospital;” Post-war development, modernization, and the rhetoric of building, 1946-1960

At the end of the Second World War Canadian general hospitals were in a state of crisis. Depression and austerity had prevented major construction or renovation for almost two decades. Departments purchased only the most important new equipment.⁴⁹³ Yet, administrators and doctors were optimistic. They predicted peace would bring funding and construction, since returning soldiers would require therapy, rehabilitation, and general care.⁴⁹⁴ New buildings were needed to accommodate medical and surgical advancements made during the war.⁴⁹⁵ Peace liberated the labour pool and building materials required for large-scale construction projects. The industrial demands of total war helped end the economic tumult of the 1930s, but voters were not content with a return to half-hearted social programs.⁴⁹⁶ The federal government prepared to expand its financial role in social welfare in general and health care in particular.

Unprecedented hospital construction defined the years 1946-1960. The number and influence of consultants and architects specializing in hospital design also increased. Institutions become more rounded in services on offer, rebranded as medical centres, and expanded accommodation for semi-private care.⁴⁹⁷ The growing demand for semi-private beds owed in large part to an increase in private insurance. Use of tax-payer funds to operate and build hospitals was not new, but the post-Second World War era saw an important shift.⁴⁹⁸ Now the federal government would join with the province and municipality as an important source of capital. However, this was not a takeover.

⁴⁹³ G. L. Granatstein, *Canada's War: The Politics of the Mackenzie King Government, 1939-1945* (Toronto: University of Toronto Press, 1990), 195.

⁴⁹⁴ Jeffrey A. Keshan, *Saints, Sinners, and Soldiers: Canada's Second World War* (Vancouver: UBC Press, 2004), 258. Keshan argues the federal government realized it needed to play a more active role in helping soldiers adjust after this conflict, revealing how health care was becoming a more serious concern in the realm of high politics.

⁴⁹⁵ For a good overview see Mark Harrison, *Medicine and Victory: British Military Medicine in the Second World War* (Oxford: Oxford University Press, 2008).

⁴⁹⁶ Alvin Finkel, *Social Policy and Practice in Canada: A History* (Waterloo: Wilfred Laurier University Press, 2006), 95-97, 125-127.

⁴⁹⁷ Robert Cunningham and Robert Maris Cunningham, *The Blues: A History of The Blue Cross and Blue Shield System* (Chicago: Northern Illinois University Press, 1997)

⁴⁹⁸ Aleck Ostry, *Changes and Continuity in Canada's Health Care System* (Ottawa: CHA Press, 2006), 48-49.

Provinces leveraged the hospital's civic significance and role in medical education to acquire or justify federal funding.

Construction was not the only arena in which the federal government's relationship with general hospitals was changing. In 1957 the St. Laurent Government passed the Hospitals Insurance and Diagnostic Services Act (HIDS). The act was modelled after Saskatchewan's 1947 legislation to subsidise health costs.⁴⁹⁹ The 1957 act was voluntary, and by 1960 five provinces—Ontario, Newfoundland, Alberta, British Columbia, and Saskatchewan—opted into the programme. The act aimed to provide approximately half the costs associated with inpatient care and diagnostic services. In 1961 federal medicare passed, and applied hospital insurance nationally. The federal government did not have jurisdiction over health care, but could design programmes that provided funding for provinces that accepted its terms. Thus, it took several years for each province to fashion its own system and work out an arrangement with Ottawa.

Construction could not begin immediately at the end of the Second World War. Administrators knew funds were coming, but it was not until the 1950s that major projects could be completed, staffed, and equipped. This window provided an opportunity during which administrators interfaced with professional consultants and the general public. Hospital administrators engaged as many voices as possible to get the most out of the opportunity in front of them. Trustees hoped that by layering the input of architects and consultants with the goodwill and support of tax payers they could maximize funds. Doctors were enthusiastic as well. They saw opportunities for research and education. Citizens grew more convinced in the efficacy of the hospital, and their expectations rose accordingly. Hospital construction during the 1950s produced campuses bearing the imprint of these varied constituents.

⁴⁹⁹ P. E. Bryden, *Planners and Politicians: Liberal Politics and Social Policy, 1957-1968* (Montreal: McGill-Queen's University Press, 1997), 146.

Toronto 1946-1960

In 1946 the management and staff of the TGH were exhausted. They had met increased wartime responsibilities and maintained their high standard of care amidst a protracted period of limited construction. Still, the TGH was not as strained as other institutions. Jim Connor and W. G Cosbie—two of the TGH’s chief historians—present vastly different interpretations of the post-war period. Connor placed it within his final section covering 1930-2000. There he emphasised the role of technology inside hospital space, the idea of the facility as a workshop, and how this led to patient alienation.⁵⁰⁰ Cosbie viewed both wars as flashpoints in the institution’s history, but not in the same way. One was a moment of maturation, and the other of metamorphosis. Both accepted that losing staff to military service strained the institution, but did not see the same significance in their return.

For Cosbie the Second World War ushered in an age of maturity and growth. Medical staff returning from service brought new knowledge and experiences that applied to daily operation.⁵⁰¹ He described 1946 as a moment of social, economic, and professional ‘metamorphosis.’ His view was that government controls forged during wartime would not melt away. Thus, the hospital faced a new environment requiring new administrators. Members of the board and medical school Duncan Graham and W. E. Gallie resigned in 1947. They were replaced by men such as K. J. R. Wightman, Robert Kerr, and Ray Farquharson.⁵⁰²

In some ways the diverging views of these historians is not surprising. Cosbie was a medical doctor at the TGH. He focused on individuals that he believed shaped the institution. Connor, a specialist in the history of medical technology and surgical implements, emphasised interior changes

⁵⁰⁰ J. T. H. Connor, *Doing Good: The Life of Toronto’s General Hospital* (Toronto: University of Toronto Press, 2000), 214. Connor is influenced by historian Stanley Reiser who examines the intersection of medicine and technology. See Stanley Reiser, *Medicine and the Reign of Technology* (Oxford: Oxford University Press, 1986).

⁵⁰¹ W. G. Cosbie, *The Toronto General Hospital 1819-1965: A Chronicle* (Toronto: Macmillan of Canada, 1975), 162-163.

⁵⁰² *Ibid*, 243-244.

relating to technology and workflow.⁵⁰³ The most visible changes of the post-war era related to building. Toronto, unlike Winnipeg, Calgary, and Vancouver, did not rush to expand existing facilities. Connor's emphasis on internal technology helps explain why this was possible. Renovation and upkeep had been delayed during the war, and took place in the second half of the 1940s. It was not until 1954 that the first major construction began. From 1946-1954 piecemeal work took place that dealt less with patient accommodation than with the amalgamation of existing institutions and improving the grounds.

In 1948 the Wellesley Hospital integrated with the TGH. Initially it provided additional space and facilities. Cosbie described it as "well-equipped for its time," because it had two operating rooms, a labour room, and accommodation for almost 100 private patients.⁵⁰⁴ The building was a private residence that converted to medical use in 1911. Later it received an addition that increased bed capacity to around 100 and added an X-ray. Its name derived from its location at the corner of Sherbourne and Wellesley Street. For administrators in 1948, fixated on modern construction, it seemed an odd property to want; however, the acquisition personified the long-term planning of the post-war era. The building may have been imperfect, but it also came with four acres of prime land. The Wellesley changed its name to 'The Wellesley Division of the Toronto General Hospital.' The province stepped in and assumed \$2,000,000 of the Wellesley's debts under the condition that the TGH use the newly-acquired space as public wards.⁵⁰⁵ Acquisition was one way to stave off construction.

Internal reorganization was another way to avoid construction. In 1947 TGH neurosurgeon Dr. K. G. McKenzie wrote his predecessor, Dr. Robert James of the University of Toronto, about his

⁵⁰³ For an example of Connor's work on history of medical technology see J. T. H. Connor, "Medical Technology in Victorian Canada," *Canadian Bulletin of Medical History/ Bulletin canadien d'histoire de la médecine* 3:1 (1986): 97-123.

⁵⁰⁴ Cosbie, *The Toronto General Hospital 1819-1965*, 293.

⁵⁰⁵ Ibid, 294-296.

desire to expand and improve patient organization within his department. His foremost concern was that ward arrangements remained conducive to education. He also hoped to establish an X-ray sub department. A host of other spatial concerns, such as centralizing patients, pervaded McKenzie's discussion. Previously, there was no neurological ward. McKenzie estimated that 60 such patients were scattered throughout the campus. This, he argued, was detrimental to patients who did receive care from doctors or nurses specializing in their ailment. For several months he had attempted to have such patients transferred to ward D, but that caused several problems. Permanently converting the ward meant general beds had to be made up elsewhere.⁵⁰⁶ Furthermore, centralization necessitated structural alterations to allow private, semi-private, and semi-public accommodation in the new area. McKenzie faced the classic challenge of a hospital administrator which was the inability to act due to interconnected, static space.

The futility of department-driven expansion helped make consulting firms more attractive. In 1951 the TGH engaged the first of several consulting firms in order to prepare a long-range plan for expansion. However, not all firms specialised in architectural or administrative matters. The John Price Jones Company's (JPJC) expertise was fundraising. Its preferred method to acquire funds was by cultivating sympathy through public appeals about the inadequacies of existing structures. The report is too long for an exhaustive summary, but some aspects warrant examination. The rhetorical suggestions of a professional fundraising firm are a powerful indicator of where hospitals were located in the vortex of public opinion, how it could be marshalled, and through which methods.

The decision to engage a firm like JPJC was somewhat curious given the public relations context of the TGH. In 1950 Ron Kenyon of *The Telegram* had written to a staff doctor hoping to spur the formation of a public relations department. He wrote, "There was really no reason

⁵⁰⁶ "Dr. K. G. McKenzie to Professor Robert James, Department of Surgery, University of Toronto," 30 September 1947, 1-2. Files TG 2.30.1 Box 56 TGH Fonds, UHN Archives

whatsoever why the press and your hospital should not co-operate very closely. Yet I, and I am quite sure, most other newspaperman feel that the TGH is surrounded by an iron curtain.”⁵⁰⁷ Kenyon referred to a situation where the nursing staff had come close to striking. He believed poor handling of the press had worsened the situation. He had phoned several doctors and administrators only to be told ‘no comment’ by all. By refusing to issue statements the TGH waived its opportunity to shape public perception. According to Kenyon’s letter, hospitals in the United States had taken that matter “up very thoroughly.” The VGH and WGH founded public relations departments in the 1950s. The CGH waited until the 1970s, but it benefited from the guidance of Alderman versed in courting public opinion. Kenyon’s closing comment was harsh: “we have responsibilities to the public to give facts, and the greater effort made to prevent us getting them the more we are likely to work on a story.”⁵⁰⁸ The TGH ultimately sought guidance, but it was a by-product of JPJC fundraising and carried out by an external agency.

The JPJC believed that the key to securing donations was in finding a strong emotional hook while also avoiding technicalities. It stated, “The hospital has every reason to go to the general public and expect adequate public support. Unfortunately, however, the public and many of the community leaders have very little personal or real knowledge of these needs or the hospital’s activities.” Other statements were blunter, “they regard it impersonally as something approaching a public institution. For instance, it lacks the dramatic appeal of the Sick Children’s Hospital.”⁵⁰⁹ The report concluded that garnering endorsements from high-ranking politicians was the best method to ‘sell’ the hospital to the city’s wealthiest donors.

⁵⁰⁷ “Ron Kenyon of *The Telegram* to Dr. Doyle, TGH,” November 1950, 2. File TG 2.16.3 Box TG 0009-TG29 TGH Fonds UHN Archives

⁵⁰⁸ *Ibid.*, 5.

⁵⁰⁹ “Survey and Plan for the TGH – Prepared by the John Price Jones Company, Canada,” 20 June 1951, 1. File TG 2.30.7 Box 56 TGH Fonds UHN Archives

The true value of such internal reports was the frankness with which they discussed plans. A consultant wrote, “The lack of new beds in the table of needs for this campaign is a recognized weakness in the public appeal. Therefore, the improved services resulting from modern and centralized facilities will be stressed; plus that will mean shorter stays and therefore more beds for others will in effect be available.”⁵¹⁰ It was true if facilities treated patients faster more beds would be available, but that required two conditions. First, patients could not seek treatment at a rate greater than or equal to overall accommodation within short intervals. Second, that those new facilities would affect the rate at which patients were treated and released. Length of stay trended downward during the 20th century, but new facilities attracted more patients as new services addressed maladies previously untreatable.

The report made its appeal by way of rhetoric rather than statistics. Had the firm’s audience been hospital or management professionals it would surely have discussed the facility’s scope, what services it provided, and how it measured against industry benchmarks. Instead it appealed to the ‘common sense’ of a lay donor. The first half of the report excoriated the current buildings. The JPJC took on a tone of disappointment rather than warning. “With the exception of the Private Patient’s Pavilion built in 1930, the principal buildings of the TGH date back to 1913. The result is operating rooms and wards which were the last word in 1913 have become hopelessly out of date in the progress of 38 years.”⁵¹¹ The report forwarded the time-honoured complaints of poor centralization and obsolescence.

The second portion of the report outlined a strategy to make new additions by appealing to potential donors. A section with the loaded title ‘The Hospital of the Future,’ discussed the tenets of how such an institution would look and function. Sticking to rhetoric that blamed buildings rather

⁵¹⁰ Ibid, 2.

⁵¹¹ Ibid, 3.

than people the JPJC stated, “In terms of human beings it is well abreast of the requirements of modern medical science; in bricks and mortar it is hopelessly outmoded.”⁵¹² The consultants believed that nurses and doctors were best treated as beyond reproach. Boosting this constituency made a case for better facilities; why not provide resources to a first-rate staff?

Architects Alvan Matheson and Eric Haldenby (Mathers and Haldenby Firm, 1921-1991) were in contact with the board during the early 1950s. They provided technical knowledge to the JPJC. For months they liaised with the departments of surgery and medicine to ensure current renovation would align with future expansion. Patients and medical students were at the centre of the most urgent needs: establishment of a neurosurgical unit with operating rooms, private and public wards, radiology, four additional lecture theatres with seating for 350, 200, and 75, a central bank of operating rooms, separation of the radiotherapy and radiology department, and improve wards A, B, and C. The list included less urgent actions such as establishment of a women’s department to combine the obstetrical and gynaecological departments, 150 beds for chronic cases, an ophthalmology department, new library, staff dining rooms, and prosthetic appliance shop. The project carried an estimated cost of \$2,070,000.⁵¹³

From 1952 through 1953 administrative focus at the TGH centred on justifying new buildings—per the JPJC report suggestions—and searching out the funds to do so. The 1952 annual report suggested the main building was “in some respects obsolete and outmoded,” and that “a building rehabilitation programme was necessary.”⁵¹⁴ Further, the report noted how a building campaign committee had been formed consisting of volunteers from ‘all walks of life’ for the purposes of overseeing subscription collections and fundraising. The report preferred to describe

⁵¹² Ibid, 10.

⁵¹³ “Mathers and Haldenby Architects to Mr. Norman Urquhart Chairman, Board of Governors TGH,” 30 January 1950, 1-4. File TG 2.30.34, Box 57 TGH Fonds UHN Archives. See Appendix IV, Image 3.1 for a sketch of a double corridor floor of the new building.

⁵¹⁴ “Annual Report for the Toronto General Hospital 1952” 1953, 4. File TG 1.2.16 Box 3 TGH Fonds UHN Archives

funds acquired as “many” rather than list a value. The administration intended to complete fundraising within the year and begin construction 1953.

By 1953 administrators were confident that construction was imminent and transformed the annual report into a promotional brochure. The inside cover read, “In this report you will notice a concentration on our building programme because we feel that the plans now coming into fruition are probably the most important step taken in the Hospital’s one hundred and thirty-three years of service.”⁵¹⁵ The Central Building would reshape the medical campus by adding a modern core. Administration boasted about the planning involved. “Only after a period of painstaking and extensive planning did the Trustees feel prepared to start construction. Soon work will begin a major project; a new Central Building and a South block...”⁵¹⁶ The building would be thirteen storeys, and add 400 beds and 200 bassinets.

Unlike earlier expansions where new structures tended to address a specific need the Central Building offered a range of facilities. Space was set aside for administrative offices, diagnostic imaging, public operating rooms, surgical supply, obstetric and delivery rooms, neurological services, and laboratories for biochemistry, bacteriology and surgical pathology. There was also a new section for medical records, a lecture area for students, and a centralized kitchen and cafeteria. The south block fronted onto Gerrard Street. It stood three storeys plus basement for admitting, emergency, rehabilitation, physical medicine, radio-therapy, and eye service departments. Some of the facilities the Central Building replaced dated back to 1913. The JPJC report demonstrated that administrators of the early 1950s saw rhetorical power in discussing building conditions to justify expansion and draw donations.

⁵¹⁵ “Annual Report for the Toronto General Hospital 1953” 1954, 1. File TG 1.2.16 Box 3 TGH Fonds UHN Archives

⁵¹⁶ Ibid, 8.

Despite the architectural rhetoric of TGH administration they did not lose sight of human actors. The night of 2 June 1954—a day before the sod-breaking ceremony for the Central Building—Dr. J. Sharpe spoke to a meeting of the nurse’s alumnae. He reminisced about the TGH’s architectural past: the first hospital on King Street in 1820, the Gerrard Building in 1855, the College in 1913, the Private Patients Pavilion in 1930, and the Wellesley acquisition in 1948. Casting the institution’s past in architectural terms made sense on the eve of a major expansion. But Dr. Sharpe was also aware of his audience noting, “Whilst one is inclined to speak of buildings...buildings do not make the hospital, the people who work within do.”⁵¹⁷ Nurses were indispensable, but laying bricks and running wires rarely fell within their purview.

The Central Building stood 13 storeys and had two, three-storey sister structures, one in its court, and another on Gerrard Street. It added 300 beds to the campus, but more importantly centralized operating rooms, labs, x-rays, and other departments ranging from gynaecology to neurophysiology. Addition usually included reorganization. Dr. Sharpe wrote: “In addition to this new building of course a great deal is going on in the way of re-planning and modernizations.”⁵¹⁸ Ward divisions changed to accommodate more single rooms, growth in the maintenance and laundry departments, and streamlining to logistics and daily management.

The Central Building was the largest project carried out between 1955 and 1958, but it was not the only one. Some small projects took place including the partial demolition of the Dunlap building—it would be fully demolished in 1959—home to the medical records department. Additionally, kitchen facilities were overhauled in 1956, and the tunnel between the Private Patient’s Pavilion and laundry was repaired and reopened.⁵¹⁹ 1957 saw minor upkeep in the private pavilion

⁵¹⁷ “Memo Dr. Sharpe to Miss L. Bailey,” 27 July 1954, 2. File TG 2.20.129, Box TG 0009-TG42 TGH Fonds UHN Archives

⁵¹⁸ Ibid.

⁵¹⁹ “Annual Report for the Toronto General Hospital 1956” 1957, 12. File TG 1.2.16 Box 3 TGH Fonds UHN Archives

where some of the ninth floor operating rooms were renovated, the nurse's residence was completely refurbished, food services in ward G altered, and a public medical ward in the main building completely remodelled.⁵²⁰ One feature added to the private pavilion in 1957 that was the addition of an intercommunication system. It allowed patients and nurses to communicate at any time with the press of a button. On other fronts problems emerged. A plumber's strike in 1958 stalled construction on the Central Building.

By 1959 the Central Building was incomplete, and administration had to admit defeat. The expansion programme that included the Central Building as well as renovation and refurbishment of existing facilities had been underway for seven years, and cost roughly \$15,000,000. Administrators were uncomfortable given that the building's exterior appeared complete. They explained in the annual report that, "The planning of the new facilities which was shared by architects, professional and technical staff, hospital personnel as well as the administration in the form of the building committee and Board of trustees was done with future expansion in mind so the hospital can always be kept up to date in terms of layout, equipment, and facilities."⁵²¹ Administrators split the blame as many ways as they could. Still, it did not change the fact a significant amount of public money had been expended with very little functional space to show for it. From January to May 1959 equipment and staff relocated, which altered the organization of other buildings. For instance, the Private Patients Building repurposed its 8th floor to provide a cardiovascular service that treated private and public patients. The report promised an opening by 1960.

The Central Building was a major development in the history of the post-war TGH. It was also one of the most advanced facilities in the country by medical, engineering, and architectural standards. In the fall of 1958 the TGH convened a 'committee of official opening' to plan for

⁵²⁰ "Annual Report for the Toronto General Hospital 1957" 1958, 3-4. File TG 1.2.16 Box 3 TGH Fonds UHN Archives

⁵²¹ "Annual Report for the Toronto General Hospital 1958" 1959, 1,4. File TG 1.2.16 Box 3 TGH Fonds UHN Archives

completion. Though short-lived, the committee provided a unique vista from which to glimpse administrative realism about the building process. One member noted, “The progress of construction must be an item of first consideration...I am sure now that the contractor will be substantially complete although we must expect that mechanics of one trade or another will be with us for some months after occupancy.”⁵²² Indirectly, the comment disclosed that a major urban hospital was a site for ceaseless construction. The committee had other responsibilities, such as deciding whether to hold public tours before or after patients had been moved in. The frank discussion of buildings delays as part of the process—rather than feigned outrage or handwringing—demonstrated that administrators had come to terms with the challenges of major building projects. Health facilities and the construction industry had developed in tandem, and were becoming increasingly complex. Hospital administrators found themselves overseeing one of the most challenging organizational tasks endemic to affluent cities in the 1950s.

On 15 May 1959, the Central Building was officially opened to the Toronto public. A pamphlet gushed, “This new structure contains the most modern equipment available, cheerful, well-furnished patient accommodation, improved teaching facilities, extensive laboratory services, and will be available for public inspection.” The celebratory literature was strikingly optimistic. In a section discussing the extent to which research and preparation went into the design process it described the last several years as “the efficient completion of a most complicated construction programme...How well the main problems have been solved can only be appreciate by a tour of inspection.”⁵²³ Administrators believed they had built the hospital of the future. A structure capable of pre-empting whatever problems the upcoming decade held.

⁵²² “Minutes of Committee of Official opening - TGH Building Group,” 2 September 1958, 1. File TG 1.6.4 Box 8 TGH Fonds UHN Archives

⁵²³ “TGH Central Building Group, Souvenir Booklet,” 15 May 1959, 1 File TG 1.6.4 Box 8. Source of both quotes.

The opening revealed the hospital's shift from a domestic to technological space. The sub-basement was the "mechanical heart" regulating the elevators, fire alarms, public address system, and heat. On its double corridor floors all patient rooms encircled a core of service rooms, clinics, and elevators. The design reduced walking for nurses by 45%. Pneumatic tubes connected every department, and a call system allowed patients to verbally communicate with nurses who could respond or activate an indicator light.⁵²⁴ The hospital's purpose was to heal, but in method and form was unrecognizable when compared to its genesis in 1820.

The hospital was a significant economic boon to the community. Excluding medical and clerical staff the TGH employed a substantial number of tradespeople. In 1963 it had a staff of 65 engineers, plumbers, steamfitters, electricians, carpenters, bricklayers, machinists, gardeners, painters and general labourers. In addition to routine maintenance and repairs trade staff was "frequently called upon to devise and construct special equipment necessary for the treatment of patients."⁵²⁵ Scrubbing floors, repairing walls, emptying bed pans, compounding medications or performing surgery were all crucial to the institution, and thus to patient experience and healing. The diversity of the trade staff was an important reminder of the breadth, and at times non-medical nature of hospital needs. Further, more than routine maintenance and cleaning were involved. The high-skill engineering work of various functionaries was required to keep the hospital operational.

Unpaid staff members, namely volunteers, were an important hospital constituent and also a type of public outreach. They performed roles ranging from patient transfers to scribing letters,

⁵²⁴ Ibid, 3-5. See Appendix IV, Image 4.2 for a photograph of the campus from the air, as well as sketches of previous buildings.

⁵²⁵ "Annual Report for the Toronto General Hospital 1953" 1954, 5. File TG 1.2.16 Box 3 TGH Fonds UHN Archives. For one of the few scholarly economic histories of hospital see Peter Temin, "An economic history of American hospitals." in *Health Care in America: The Political Economy of Hospitals and Health Insurance* ed. H. E. Frech (San Francisco, Pacific Research Institute for Public Policy, 1988), 75-81. Temin's essay reads more like an annual report than an academic history; however, it deserves recognition for its statistical contribution. It does not emphasise the relationship between hospitals and local economy.

reading, and feeding. In 1957 Dr. Sharpe addressed a group of volunteers. His words deserve full quotation. By 1957, public relations had become part of the administrative outlook.

Mr. Urquhart has expressed to you the appreciation of the Board of Trustees and the hospital for the excellent services which you as volunteers are giving to the Hospital. I would like to heartily concur... You know very frequently when we speak or think of a hospital we think of a building or group of buildings, or a group of beds, highly technical equipment and so forth. But actual hospitals are people those that come for treatment, and those specially qualified and trained to take care of them. Whatever our particular responsibility is we centre our attention on the patient and we each in our own way within the limits of our abilities, make our contribution to this welfare.

You, as volunteer workers, have an extremely important function in the hospital. You have among other things the opportunity to interpret to the patient, and therefore to the community, the services offered by the hospital because, being volunteers, you are not simply in the hospital hoping to pass away a few leisure hours but you must feel the need and see the goal towards which we are striving or you would not be here. The patient knows this and places you in a preferred and trusted position. You become essential to the patient and without you the hospital could become cold and scientific. They say that good public relations is the art of not treating the public like relations and in this regard too your place in the hospital family becomes most important.⁵²⁶

Administrators held an idealistic perspective of how the institution drew together space, place, technology, community, and human experience. The speech was more aspirational than analytical. In minute books and buildings reports administrators rarely articulated romantic ideas about buildings as ‘people.’ Still, they had accepted the significance of public perception. The TGH’s position was no longer economically or functionally precarious, but it had also become increasingly impersonal, hectic, and focused on research and education.⁵²⁷ Still, for the public to remain a source of revenue and proxy for acquiring provincial and federal monies it had to view the institution positively.

The late-1950s saw an increase in attempts at providing a social safety net for health care. These preliminary efforts at something resembling Medicare were often ineffectual or never fully implemented—such as the BCHIS—however the reaction of hospital administrators warrants some exploration. The Ontario Hospital Insurance Plan (OHIP) was one effort that remains active. Malcolm Taylor—author of the influential Taylor Report (1954)—recalled that the guiding premise of the scheme was that all health costs were currently borne by society. Costs were incurred

⁵²⁶ “Dr. Sharpe speech to Volunteer workers at request of Mrs. Kennedy,” 30 January 1957, 1. File TG 2.20.129, Box TG 0009-TG42 TGH Fonds UHN Archives

⁵²⁷ Connor, *Doing Good: The Life of Toronto’s General Hospital*, 340.

indirectly through misery, premature death, and disability, and directly through the fees for treatment and preventative services.⁵²⁸ Thus, it was in the interest of both individual and society to reduce the indirect costs by ensuring security for all in the first place.

The Ontario Hospital Services Plan went into effect on 1 January 1959. The board had some concerns but presented a generally optimistic outlook stating, “We are looking forward to this with great interest. Some adjustment will undoubtedly be necessary, but we are confident that with mutual understanding the Plan will be successful and hospitals relieve of the financial burden of stating indigent in-patients.”⁵²⁹ The mechanics of the plan involved Blue Cross working with the province to provide the logistics and coverage. Monthly premiums were \$2.10 for individuals and \$4.20 for families. 91% of the population enrolled in 1959, and that number increased to 94% by 1960. The insurance did not cover outpatient diagnostic care, but it did include mental hospitals, which was a progressive step.⁵³⁰ After the plan had been in effect for a year, the 1959 report presented a fairly positive appraisal. “To say that there have not been problems would be incorrect. With the birth of a new scheme of this magnitude and the growth of a hospital already of considerable size there have been difficult decisions to make on both sides. With mutual understanding and an appreciation of what each is trying to accomplish, satisfactory solutions have been arrived at in most instances.”⁵³¹ Municipalities were the biggest beneficiaries in the project as paying constituents would now outnumber the indigent.

The immediate post-war period strained the TGH, but in ways different from previous years. For much of its history the TGH was one of Canada’s most developed hospitals. It offered advanced facilities and access to first-rate research and education. The buildings erected between 1950 and

⁵²⁸ Malcolm G. Taylor, *Health Insurance And Canadian Public Policy: The Seven Decisions that Created the Health Insurance System and Their Outcomes* (Montreal: McGill-Queen’s University Press, 2009), 109

⁵²⁹ “Annual Report of the TGH for the year 1958,” 1959, 3. File TG 1.2.16, Box 3 TGH Fonds UHN Archives

⁵³⁰ Taylor, *Health Insurance And Canadian Public Policy*, 112.

⁵³¹ “Annual Report of the TGH for the year 1959,” 1960, 5. File TG 1.2.16, Box 3 TGH Fonds UHN Archives

1960 were among the best on the continent; however, the cost in time, political capital, and treasure reflected this. Between 1946 and 1960 the TGH experienced its first periods of distress and false starts since before the 1880s. That it should happen when other hospitals were expanding is important. Part of the answer lies with the TGH's maintenance of efficacy during the war. It was not as run down as its counterparts in other cities, and lacked the undeniable image of an institution in need desperate need of upkeep.

Winnipeg 1946-1960

In Winnipeg both the city and board felt hospital facilities were inadequate and overcrowded. The 1946 chairman's address described the year as one of "over-crowded facilities, waiting lists, shortage of help and a generally over-worked staff..." Pivoting to the idea of building it noted, "There is now another opportunity which definitely is within our reach and that is the building of a modern maternity pavilion, which will be a part of the Medical Centre and dedicated to the Mothers of Manitoba."⁵³² Such a building was in the interests of more than just the 'mothers of Manitoba.' It would increase accommodation for nurses, and free up beds and space in the main building. The WGH expected to reclaim sixty-five beds in its main building, and accommodate some fifty nurses without building a new residence. The board forwarded its plans to Ottawa for consideration as a 'post-war project of merit.'⁵³³

Work began on the maternity pavilion in 1946. Progress halted in late-May as the architects—the local firm Northwood & Chivers—discovered materials would be scarce for the remainder of the year and nothing further could be accomplished.⁵³⁴ Throughout 1947 financial uncertainty frustrated the construction process. Pledges from business and individuals for the building remained in place, but the city sought to renege on or reduce its previous commitment of

⁵³² "Minutes of the Board of Trustees" 28 May 1946, 1-2. Folder 1, Box 1 WGH Fonds HSCAM Archives

⁵³³ "Minutes of the Board of Trustees" 9 February 1945, 1. Folder, 1 Box 1 WGH Fonds HSCAM Archives

⁵³⁴ "Minutes of the Board of Trustees" 31 May 1946, 1. Folder 1, Box 1, WGH Fonds HSCAM Archives

\$900,000.⁵³⁵ Faced with the prospect of unguaranteed financing and rising material cost the WGH had to either halt construction or become solely responsible for the final cost.⁵³⁶

War's end did not bring immediate relief. The 1947 chairman's address argued, "The difficulties of the war period remain with us and is accentuated by sharp increase in cost of maintenance, and shortage of nursing and other personnel. The cost of food, fuel, and medical supplies advanced appreciably [and] are continuing to advance."⁵³⁷ The address also revealed financial issues. For instance, public ward patients that had cost less than \$3.00 per day, now cost \$4.77. With the combined per diems of the municipality and province amounting to \$2.50 the hospital lost over \$200,000 per year on public wards alone.

By 1948 the WGH felt, "the shortage of beds was so serious it [was] compelled..." to act, and awarded a building contract despite uncertainty of its ability to raise capital. As an independent institution the WGH could take such an aggressive, or desperate, action. The federal government stepped in and offered a grant of \$1,000 per bed on the condition that the province provided matching funds. By year's end the city relented and passed a by-law paying out \$900,000 over thirty years.⁵³⁸ At the end of 1948 four of the maternity pavilion's five storeys were bricked, and much of the utility infrastructure was in place. A 1949 opening proved impossible as it took the entire year to furnish the interior and acquire supplies for daily operation. When the maternity pavilion opened on 6 May 1950 it marked the first construction since 1932.⁵³⁹ Between 6 May and 25 May 188 babies were born in the new pavilion. That included patients transferred from other WGH facilities.⁵⁴⁰

⁵³⁵ "Minutes of the Board of Trustees" 13 May 1947, 2. Folder 1, Box 1 WGH Fonds HSCAM Archives

⁵³⁶ "Annual Report of the WGH, 1946" 1947, 14. Folder 29, Box 10 WGH Fonds HSCAM Archives

⁵³⁷ "Minutes of the Board of Trustees," 14 May 1947, 1. File 1, Box 1 WGH Fonds HSCAM Archives

⁵³⁸ "Annual Report of the WGH, 1948," 1949, 13, 16-17. Folder 30, Box 10 WGH Fonds HSACAM Archives. Source of above quote.

⁵³⁹ "Minutes of the Board of Trustees" 9 February 1945, 1 Folder 1, Box 1 WGH Fonds HSCAM Archives.

⁵⁴⁰ "Report to the Finance Committee" 26 May 1950, 1. File 3, Box 1 WGH Fonds HSCAM Archives

The chairman's address following the opening of the maternity pavilion painted a bleak picture. "The WGH has completed another year of service, handicapped as in previous years by shortage of funds, staff, beds, and equipment. For 76 years this voluntary hospital has within and beyond the limits of its capacity treated all who have applied for admission and given service in spite of the unfair load."⁵⁴¹ It went on to note operating income for 1949 as \$140,997 which had decreased by \$51,910 the year previous. Coping with such losses took the combined effort of municipal and provincial grants plus aid from the Community Chest and Winnipeg Foundation.

In spite of these efforts the board remained responsible for \$13,614. The WGH had no endowment, and thus any deficit became overdraft. When adding teaching grants to governmental bed per diems \$4.50 came in per patient compared to \$6.50 in expenses. With an average of 200 public ward patients per day the annual losses were staggering. The chairman offered a dire warning, "It is clear that we must seriously curtail our free services. There is no other possible alternative." It was the classic threat of hospital administrators, and unsurprisingly comments on construction followed. Administration walked a tight rope when discussing the new building. It was 'practically' completed in 1949, but patient admission could not begin. Still, they could not disparage the project. "We are very proud of our new building and equipment and of the service it will provide. The work of the furnishing campaign committee...deserves our highest praise for the long hours of effort and the successful result."⁵⁴² Yet the building remained unfurnished and unusable with fundraising continuing into 1950.

The official opening of the maternity pavilion took place on 20 April 1950. It was not marked by tours and dignitaries, but Superintendent Dr. H. Coppinger delivered a speech. He made some uplifting comments. The new building put an end to "the distressing problem of the shortage of

⁵⁴¹ "Minutes of the Corporation of the Winnipeg General Hospital," 13 June 1950, 1. File 3 Box 1 WGH Fonds HSCAM Archives

⁵⁴² Ibid, 2. Source of above quote as well.

beds,” and that “for years to come it would be possible to accept all cases applying for admission.” He also discussed the building in a way directed at the patients, “It is designed and equipped to give maximum safety and comfort to both mother and baby.”⁵⁴³ The building was a respectable five storeys. It also represented educational opportunities for nurses and obstetricians. The notion of maternity wards designed for comfort of mother and baby is not entirely straightforward. For nurses and doctors comfort meant maintenance of technique and procedure. Prospective mothers would likely have found that definition incomplete. Childbirth had in large part moved into hospitals, but Dr. Coppinger still presented arguments against home birth. The value of a maternity hospital was in the “protection offered to patients by the labour room and delivery room services. Here the patient is under the constant supervision of specially trained medical and nursing staff employing the most modern methods and equipment known to science, these facilities are available at a moment’s notice.”⁵⁴⁴ Specialization was one pillar of the argument. Inside this space expertise produced a certain set of results, and equipment therein could be marshaled to her aid.

“Modern” was staple jargon for hospital administrators, but Coppinger employed it when addressing the public as well as consultants. In that sense prospective patients appeared as more than a source of revenue. Coppinger treated them as an entity capable of forming expectations about hospitals. The comment on speed was important also. A longstanding concern for expectant mothers was that physicians were less patient than midwives in waiting out labour and would often miss the delivery.⁵⁴⁵ Delivery rooms that could be prepared in mere moments alleviated this concern. Coppinger also took time at the end of his speech to mention all ten labour rooms and 8 delivery

⁵⁴³ “Safeguarding Motherhood – Official Opening of the Maternity Pavilion,” 20 April 1950, 7. File 6, Box 10 PMA

⁵⁴⁴ Ibid, 11.

⁵⁴⁵ Cheryl Krasnick Warch, *Prescribed Norms: Women and Health in Canada and the United States Since 1800* (Toronto: University of Toronto Press, 2010), 92. Sylvia Rinker, “To Cultivate a Feeling of Confidence: The Nursing of Obstetric Patients, 1890-1940,” *Nursing History Review* 8 (2000): 119-121. This was discussed in chapter 2 in more detail.

rooms were air conditioned, well lighted, and newly furnished. While the new mother convalesced she would enjoy her own pillow, radio, and bathroom.⁵⁴⁶

The address darkened as Coppinger turned to the costs borne by patients. After both the provincial and municipal governments refusing to increase per diems the board passed its own resolution. Starting 1 January 1952, patients would not be admitted until the municipality agreed to provide \$5.00 per day. The board argued the cost of indigent patients was not the responsibility of a voluntary hospital, and they had taken indigents for too long without sufficient reimbursement.⁵⁴⁷ The bluff spoke to the WGH's sense of security in the community. Threatening to turn away patients was one thing, but holding services for ransom demonstrated nerve and guile. The city had been outmanoeuvred and accepted the ultimatum.

Money was not the only problem. The maternity pavilion was open hardly two weeks before complaints emerged. "Every department in the institution has outgrown the space it occupies, and we desperately need a new operating room set-up, pathological laboratory, general and diet kitchens, additions to the Nurse's Home and x-ray expansion."⁵⁴⁸ The report went on to describe the aforementioned upkeep as 'absolutely essential,' despite a complete lack of funds to do so. In this address the board leveraged the importance of the maternity pavilion, noting how only two floors were in operation. A third remained in stasis due to lack of staff. Dr. Coppinger promised by 1 January 1952 enough nurses could be hired to open the third floor.

Administration sought to solve staff issues internally, but looked for outside help on issues of expansion. Dr. Coppinger met with Dr. Harvey Agnew and A. E. Johnson—who had consulted for the VGH—and agreed to have Agnew's firm conduct a survey of the hospital's needs and produce a priority list for construction. The Agnew firm was becoming an important pillar of

⁵⁴⁶ "Safeguarding Motherhood – Official Opening of the Maternity Pavilion," 20 April 1950, 12. File 6, Box 10 PMA

⁵⁴⁷ "Board of Trustee Minutes," 8 May 1951, 2. File 1, Box 1 WGH Fonds HSCAM Archives

⁵⁴⁸ Ibid, 1.

hospital consultation and planning in Canada. Agnew worked for the Ontario Hospital Commission in Ottawa. However, his philosophies stemmed from contact with administration throughout Canada and the United States. By 23 November 1951 the survey had been completed and a basic summary was presented to administrators.⁵⁴⁹ Release of the report was delayed. Preliminary copies were delivered to the Board on 28 August 1952, at which point they were distributed among the executive. The rest of the membership would be “advised” when copies were available for perusal.⁵⁵⁰

Despite overcoming significant logistic and economic challenges to build the maternity pavilion administrators were not satisfied to end the construction programme. The trustees’s 1951 public report lamented the “pressing need for additional service facilities,” and noted the hiring of hospital consultants to survey existing buildings.⁵⁵¹ The board speculated that more than \$3,500,000 was needed to modernize the main building let alone add amenities such as a children’s hospital. Its estimate soon grew to over \$5,500,000. Knowing federal and provincial grants would not cover all costs the board engaged the public in an ambitious ‘Joint Hospital Building Fund Campaign’ (JHB) aiming to raise \$8,000,000 for refurbishment and expansion.⁵⁵² From 1952-1953 Winnipeg residents donated approximately \$3,000,000 to the fund, and voted in favour of a referendum whereby the municipality would contribute \$2,000,000. These large, publicly-generated sums ensured that administrators factored civic expectation into their arguments for new buildings alongside the advice of medical professionals and architects.

Progress was not immediate. In 1953, excluding the maternity pavilion, the most recent building on the premises was 41 years old. Of the 800 available beds approximately 97% were in use on a daily basis. In 1954 and 1955 Medical Centre Apartments “A” and “B” were erected to provide

⁵⁴⁹ “Report to the Finance Committee,” 23 November 1951, 1. File 3, Box 1 WGH Fonds HSCAM

⁵⁵⁰ “Board of Trustee Minutes,” 28 August 1952, 1. File 4, Box 1 WGH Fonds HSCAM

⁵⁵¹ “Annual Report of the WGH 1951,” 1952, 17. File 3, Box 11 WGH Fonds HSCAM Archives

⁵⁵² “Annual Report of the WGH 1953,” 1954, 17. File 5, Box 11 WGH Fonds HSCAM Archives

accommodation for nurses and internes and ensure adequate staffing. As recently as 1951 parts of the maternity pavilion closed due to shortage of nurses. One measure of the financial problems was that until a major construction project—‘North Wing’—began in early 1956 the WGH still used the A and B block buildings from 1883.

In response to deficits and outmoded structures the board sought to induce more charitable donations. Thus, from 1952 to 1953 the JHB emerged as a significant form of community engagement. The board produced a 70-page canvassing guide to outline its goals. It spoke directly to prospective volunteers, “you have become a partner in a great community enterprise. The WGH and Children’s Hospital need \$8,000,000 for new construction and remodelling. Of this amount \$3,000,000 must be raised from corporations, individuals, and employee groups. The appeal is the largest ever undertaken in Manitoba.”⁵⁵³ Presenting two large sums, the second of which being smaller, and thus seemingly more attainable, demonstrated the guile of its authors. The JHB worked closely with the board, but was technically a separate entity. It shared concerns with the hospital about being perceived as inefficient. “Asking the public for millions for capital expenditure is a major project. That is to be appreciated not only in terms of money but in the quality and scope of the organization...While the volunteer campaign body is divided teamwork is essential to maintain its efficiency.”⁵⁵⁴ The JHB was cognisant of its place as a tool of new-era administration informed by theory, science, and statistics.

The campaign and preparatory literature is rich, but fraught with analytical challenges. It contained an immense amount of information beyond what a donor might want to know. Under a section explaining why hospitals needed new buildings it stated, “Almost at every turn in the present hospital there is evidence that it is antiquated and overcrowded – [unable] to meet the needs of

⁵⁵³ “The Canvasser’s Companion: The Joint Hospital Building Campaign, WGH Children’s Hospital,” 1953, 2. File 1, Box 23 WGH Fonds PMA.

⁵⁵⁴ “Plan of Campaign for Commerce & Industry General Corporation,” 1953, 1. File 1, Box 24 WGH Fonds PMA

modern medicine. In the effort to make it modern, needed new units have had to be crammed in anywhere possible. The result is that many of them are inconveniently located and none has sufficient space.”⁵⁵⁵ The board was concerned about spatial allocation, but was this true of donors? Use of the word ‘modern’ and references to spatial order felt better suited to the pages of *Hospital Management* than to canvassing material. The levels of discourse within canvassing literature ranged from professional to popular and revealed the breadth of audiences. Municipal and provincial politicians, health boards, hospital administrators, and of course voters would all read parts. The language is a fascinating cross-section of rhetorical scope. Some designed for persuasion at the front door. “The building is a fire hazard, a constant source of worry to all who are responsible for the children within it. Plumbing facilities are inadequate. There are no bathrooms on the ward floors. One floor is without running water. Nurses waste much of their time in walking that should not be necessary.”⁵⁵⁶ Such an appeal spoke to citizens more than an administrative lament about the inefficient setup of an X-ray development room.

Many of the appeals present in JHB literature reinforce currents of hospital historiography associated with the David and Rosemary Gagan, in particular how these institutions interfaced with civic pride. “Other Canadian cities have raised money for their hospitals. Winnipeg can do it too! In the current Children’s Hospital, space does not permit a waiting room in the outpatient departments. Patients for the hospital’s 50 weekly clinics must wait in the corridors.”⁵⁵⁷ Administrators marshalled civic pride by noting what other cities achieved. The reference to the wait times spoke to the demand for WGH services. Other appeals were more dramatic. There was an “urgent need for

⁵⁵⁵ “The Canvasser’s Companion: The Joint Hospital Building Campaign, WGH Children’s Hospital,” 1953, 3-4. File 1, Box 23 WGH Fonds PMA.

⁵⁵⁶ Ibid, 37-38.

⁵⁵⁷ “Plan of Campaign for Commerce & Industry General Corporation,” 1953, 2, 5.. File 1, Box 24 WGH Fonds PMA David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950* (Montreal: McGill-Queen’s University Press, 2002), 4-7.

larger, improved and modern hospital facilities...Winnipeg has lagged behind her sister cities in Canada in the construction of hospitals. This lag has caused a serious shortage of beds and of space for modern treatments, surgery, research and teaching.”⁵⁵⁸ If Winnipeg were to be a premiere Canadian city it would have to match the hospitals of other metropolises.

Administrators utilized history to demonstrate institutional value. “For its day this building was as modern a hospital as was to be found in all Canada, yet it was a hospital built for an age in medicine and surgery that is today virtually extinct.”⁵⁵⁹ The idea of expansion became part of the notion of progress. Older buildings had done their part, but it was time to move forward. In canvassing literature a hospital profile emerged that involved more than medicine and healing. However necessary these were to its social utility, acquiring buildings and equipment, attracting staff and even patients belonged to a complex constellation of factors including politics and local culture. In Winnipeg, like anywhere, this included pride. The canvassers sought a careful balance between practical considerations and emotion. In a more affluent city like Toronto, for instance, the pursuit of a ‘state of the art’ facility was an end in itself.

The board also pursued less glamorous projects. Medical centre apartment A opened on 1 May 1954 and B followed on 1 September 1955. Neither provided patient care. Their purpose was to help attract a “good supply” of graduate nurses.⁵⁶⁰ The first apartment block A contained 51 suites and B had 81. The buildings were erected under provisions set out by the Canadian Mortgage and Housing Corporation (CMHC). The WGH owned all project shares, and the total cost came to \$973,930. These apartments were of a higher overall quality, and more akin to the type of housing a professional would have. They differed from the school of nursing residence which began

⁵⁵⁸ “Annual Report of the WGH 1953,” 1954, 3. File 5, Box 11 WGH Fonds HSCAM Archives

⁵⁵⁹ “The Canvasser’s Companion: The Joint Hospital Building Campaign, WGH Children’s Hospital,” 1953, 70. File 1, Box 23 WGH Fonds PMA.

⁵⁶⁰ “WGH Centennial Plan: Submitted by the Manitoba Hospital Survey Board,” 14 July 1960, 4. File 1, Box 27 WGH Fonds PMA

construction in January 1955. The residence contained 224 single rooms, and could bear as many as two additional floors that would add up to 108 more beds. The hospital put effort into attracting students, but applied special emphasis on potential staff.

The North Wing's design and internal organization was a compromise between competing forces. In 1954 the executive committee ordered drawings with a double corridor design. The committee believed this design would provide the versatility needed to satisfy doctors and patients. Opinion was split inside the executive as to whether the most pressing need was additional beds or increased laboratory services.⁵⁶¹ In theory more beds equated to more income, and more income enabled investment. In practice, paying patients could not always be found. Meanwhile, public wards drained the hospital's resources. Ultimately the committee agreed to a formula by which 20 feet of laboratory space would be assured per bed. Hoping for 825 beds, initial plans specified 16,500 feet of lab space. Economic realities reduced the final shape of the North Wing to single corridor; however, it still reached seven storeys plus a basement with load-bearing capacity for up to two additional floors. The basement housed lab services—clinical pathology, biochemistry, bacteriology—while the first floor provided for out-patients and administration. Floors 2-6 had two semi-private wards of 36 beds. The seventh was a surgical floor with 17 operating theatres and related facilities. The final bed count was 325 and cost \$5,732.860; or \$17,640 per bed.⁵⁶²

New ideas of 'management science' shaped ward arrangements in the North Wing, but were less precise than the name implied. Administrators tinkered with public ward arrangements out of a belief that better layouts were always possible. However, once new arrangements were completed—guided in part by professional theory—evaluation was a matter of study. Reliable projection had yet to become a major part of administrative science. Reorganization of public wards was temporary in

⁵⁶¹ "Meeting of the Executive Committee Minutes" 5 January 1954, 1 Box 14 Provincial Archives of Manitoba

⁵⁶² "Annual Report of WGH 1958," 17. Box 11 HSCAM Archives. See Appendix IV, Images 4.3 and 4.4.

nature and often done in order to see the results.⁵⁶³ The 1960 report of the attending medical staff covered topics from ward allocation to patient behaviour. It straddled the divide between post-war building and the developmental period of the 1960s and 1970s. In 1959 wards allocated to public medicine and clinical investigation underwent substantial remodelling. For instance, the largest public ward—F3—received new beds with curtain enclosures. It also gained two examining rooms and a four-bed room through the removal of a wall.⁵⁶⁴

Completion of the North Wing in 1958 eased overcrowding for patients and staff, but did not alleviate pressure on the administration to continue building. A new project, ‘H’ Wing was already beginning construction. It would not be completed until 1961. In 1948 the WGH struggled to provide services and maintain nursing and medical staff equally. By 1960 administrators perceived the challenge for hospitals to be mainly spatial. In 1960 WGH administrator—its equivalent of superintendent—Dr. L. O. Bradley wrote, “More space is needed. Despite some rebuilding and new equipment it is still inadequate. Staffing is no longer the primary problem; it is now one of space, layout, and equipment and is an urgent need.”⁵⁶⁵ Part of the need arose from medical advancements that expanded the array of treatable conditions and required equipment. However, public demand and expectation also swelled hospital population.

1959 saw the start of construction on the Lennox Bell House, and a dramatic moment as the old A and B buildings—known as H2 and H3 at the time—were demolished. The Lenox Bell House was an apartment block that began construction on 20 June 1959. It contained 41 units and was primarily intended to house married, intern and resident staff. It was named in honour of Dr. Lennox

⁵⁶³ John C. Burnham, *Health Care in America: A History* (Baltimore: Johns Hopkins University Press, 2015), 324-325.

⁵⁶⁴ “Attending Medical Staff Annual Report 1960,” 1961, 1. File 1, Box 14 PMA

⁵⁶⁵ “Annual Report of WGH 1960” 26. Box 11 HSCAM Archives. L. O. Bradley had previously overseen the CGH. In 1956 he resigned in order to work for the WGH. In 1967 he left the WGH for an administrative posting in Minneapolis.

Bell who worked at the WGH from 1930-1967.⁵⁶⁶ First erected in 1883, the A and B buildings had been visually intrinsic to the WGH's identity. Their age was undeniable and administrators had grown tired of attempting to work around them. The WGH administration hid this frustration from the public. In the 1959 annual report the moment was described as "a nostalgic occasion for medical, nursing and other staff who had trained and served in these quarters. The old centre fireplace stood tall and lonely as the wreckers pulled down outside walls and floors."⁵⁶⁷ Nostalgia obscured the suffering, death and sadness that were indelibly part of the building's history. It also diverted attention from the fact that Winnipeg had some of the country's oldest hospital buildings, a fact that clashed with the modernity of hospital medicine.

In the post-war period the WGH significantly expanded its existing physical plant, replaced outmoded buildings, entrenched its role in medical education, and received an unprecedented amount of community donations. It increased bed capacity from 660 to 1050, demolished its oldest structures, expanded laboratory services, and carried out a major public fundraising campaign. The physical shape of the hospital was more sprawling, and host to new services. It has become what administrators would consider, at least for a few years, 'modern.'

Assessed against its own past, the WGH had moved ahead. Assessed against the TGH, it had affirmed the realities of regional disparities. Seen this way the community efforts to modernize an essential institution are all the more impressive. The financial outpouring was remarkable, too, in that it occurred only three years after the devastating 1950 flood. The shape of the medical campus in 1960 derived from professional consultation, public donations, and one bold move against the province. Administrators were not entirely satisfied with the shape of the medical campus, but they were contented. Moreover, the legacy of stagnation and austerity had been surpassed, and new

⁵⁶⁶ Ian Carr and Robert E. Beamish, *Manitoba Medicine: A Brief History* (Winnipeg: University of Manitoba Press, 1999), 155. He also became dean of University of Manitoba Faculty of Medicine in 1949

⁵⁶⁷ "Annual Report of WGH 1959," 18. File 11, Box 11 WGH Fonds HSCAM.

memories were forged of expansion and progress. The WGH was now better-suited for the increased pressure Medicare would put on the networks of healthcare distribution.

Calgary 1946-1960

The 1949 erection of the CGH ‘IV’ marked the fourth time in its history that the main building was demolished. It was also Calgary’s most significant post-war hospital building project. CGH administrators, like their Winnipeg counterparts, cited overcrowded wards and the threat of denying service as cause for rebuilding. In 1947 James Barnes, business manager for the CGH, wrote to the city about the necessity of a new CGH building. He noted, “the most important reason is that the Hospital is not able to admit all sick persons coupled with the fact that patients are crowded into a non-fire proof building.” Furthermore, demand was at times so great that it had to refuse urgent patients and accident victims “[were] often admitted to corridors which are not good for the patient or general public passing by them. Corridors are draughty, technique is hard to maintain, and this practice overloads the staff and the hospital and reduces the quality of service and there is no degree of privacy.”⁵⁶⁸ Barnes presented the CGH IV as necessary to prevent denial of service to patients and to ensure proper medical practice.

Between 1946 and 1947 final drafting took place for the CGH IV or ‘New General.’ In January 1946, the board began discussing a location for the new hospital and wrote to the city engineer. The board requested a report on possible flooding, water levels, and footings near the “Eau Claire Site;” an area in use as a market garden south of the main building.⁵⁶⁹ A month later the city hospital commission responded. It was of the “unanimous opinion that the present general hospital site plus the additional acreage presently owned by the City in the vicinity is the most suitable from all points of view...we would recommend for Council’s approval that there be no change from the

⁵⁶⁸ “J. Barnes to Mr. D. S. Moffat, City Solicitor, Calgary” 17 October 1947 AHS Archives, Box 10, File 4. Source of above quotes

⁵⁶⁹ “Minutes of the Board of Trustees,” 16 January 1946, 2., File 1 Box 5 CGH Fonds AHS Archives

present location.”⁵⁷⁰ The board did not relish demolishing another major building; however the current situation was so untenable that they valued speed over sentiment.

Once the board reached its decision about the location its attention shifted toward the logistics of the demolition. Demolitions were costly, and this expense would take away from funds for the new building. Other parts of the plan also received scrutiny from board members. For instance, they debated if replacing the power house could be avoided to reduce cost and downtime due to construction.⁵⁷¹ The idea of relocating the hospital to an alternate site arose again too. One alderman argued that moving to a new site would be more efficient since it saved the cost of demolition, and the old building could be converted to convalescence.⁵⁷² Bickering aside, the board and citizens alike were eager for construction to begin. In 1947 voters passed a referendum providing \$4,500,000 for the purposes of demolition and reconstruction.⁵⁷³

The board engaged the province in negotiation as well as the city. On the subject of care for the mentally ill the board took up an issue outside its responsibility in exchange for additional funding. On 2 June 1947 W. Cross, Minister of Health, wrote the CGH stating: “re: a grant to help provide a psychiatric ward in your proposed new hospital. I took this matter up with my colleagues in the government and it was agreed that we would give a grant for this purpose of \$5,000 a bed for a twenty-bed ward or half of that cost, whichever is less not to exceed \$100,000.”⁵⁷⁴ The ward remained under the authority of Dr. R. MacLean, Provincial Supervisor of Mental Hospitals, but it was a lot of capital in exchange for a task likely to be downloaded anyway. Moreover, if the province decided to treat patients elsewhere the ward could not be moved.

⁵⁷⁰ “Minutes of the Board of Trustees,” 28 February 1946, 10. File 1 Box 5 CGH Fonds AHS Archives

⁵⁷¹ “Minutes of the Board of Trustees,” 28 February 1946, 10. File 1 Box 5 CGH Fonds AHS Archives

⁵⁷² “Minutes of the Board of Trustees,” 25 April 1946, 5. File 1 Box 5 CGH Fonds AHS Archives

⁵⁷³ “Changes between 1910-1956,” 33. Box 33 File 13, AHS Archives

⁵⁷⁴ “W. Cross Minister of Health to Mr. J. Barnes, Secretary CGH,” 2 June 1947, 4. File 1 Box 5 CGH Fonds AHS Archives

On 3 June the CGH, CHB, and several city alderman met to decide on a development programme. The plan retained the Perley Pavilion as a maternity hospital, but transferred the children's wards to a new building. The group also discussed ward arrangements. Private and semi-private would remain as rooms with 1-2 beds. Public wards would be somewhat smaller in the form of 4-6 bed units. Semi-private and private wards were the same size, 11'6" x 16'0" or 184 square feet per patient to accord with provincial regulations requiring 90 square feet per patient.⁵⁷⁵ The overall goal was flexibility through variable room occupancy.

The experience of patients was a central aspect of planning. Psychiatric patients faced oppressive and isolating measures. "Psychiatric Section: At grade level, single room wards with necessary services are located so that the windows are not visible from public thoroughfares and away from other patient's rooms."⁵⁷⁶ Other architectural elements affected staff. For example, the out-patient, emergency operating theatre, X-ray, and laboratories were located in the same wing to prevent public circulation through these departments. A tray conveyor system was planned to carry dishes back to the basement kitchen to control hallway traffic during meal times. Semi-private and private rooms had toilets so that bedpans would not be carried into the hallway. On public wards, there were several shared 'sink rooms' for the disposal of waste. There was one quiet room per nursing unit for 'disturbed cases.' Despite the successful referendum financial problems remained central. In 1948 by-law No. 3775 authorized the sale of debentures up to \$3,000,000 for constructing new hospital buildings. All were sold by 1 July 1948 when interest began accruing. Principal payments were delayed until 1952. City Comptroller E. A. Hookway hoped that by then "the Hospital will be completed and revenue producing."⁵⁷⁷ During the 20th century hospitals increased

⁵⁷⁵ "Letter No. 17 – Report on Revised Plan for CGH Scheme," 3 June 1947, 10. File 1 Box 5 CGH Fonds AHS Archives

⁵⁷⁶ *Ibid*, 11.

⁵⁷⁷ "E. A. Hookway City Comptroller to Mayor and Council," 15 December 1949, 1. File 7, Box 9 CGH Fonds AHS Archives

surgical success rates, lowered infant mortality, and reduced length of stay. However, these institutions had no such successes in the realm of cost. Hookway's sentiment spoke to genuine optimism of the late 1940s that it was possible to utilize the hospital in a way that provided revenue. Given the municipal nature of the CGH all parties hoped that revenue production would release both city and province from funding new buildings.

In November 1949, the Alberta Hospital Association (AHA) held a meeting at the Pallister Hotel on the subject of hospital design. The convention hosted such speakers as G. H. Hughes Chief of the Hospital Design Division of the Federal Department of Health and Welfare who presented a paper titled "Some Principles of Design and Construction in Hospitals of Over One Hundred Beds and Some Principles of Design and Construction in Hospitals of Less than One Hundred Beds." Several Calgary architects were on hand to participate in the discussion. There was a political aspect to the meeting. Hughes had the last word on approving any application for federal building grants pertaining to hospitals. Board members saw an opportunity to engage with him on the topic of hospital design and learn his preferences.⁵⁷⁸

The conference was also a venue for medical supply companies to showcase products. A "larger space in the hotel has been taken over this year for displays and a complete line of hospital equipment and supplies will be shown."⁵⁷⁹ It is hardly fair to comment on the irony of showcasing hospital equipment in a hotel for administrators to inspect and purchase. The convention demonstrated the Province-wide nature of expansion, especially since the second time it was held delegates were limited by hospital size. A further reason administrators were keen to entrench provincial connections was fresh action on health insurance legislation. Throughout the 1940s there was growing public pressure for state-run medical and hospital insurance. The Social Credit

⁵⁷⁸ "Associated Hospitals of Alberta Notice," 29 September 1949, 1. File 7 Box 9 CGH Fonds, AHS Archives

⁵⁷⁹ "The Assorted Hospitals of Alberta Convention," 19 September 1950, 1. File 7 Box 9 CGH Fonds AHS Archives

Government made some concessions such as a 1944 act that provided care for maternity cases. In 1950 it passed legislation creating a patchwork program using provincial and municipal funds. However, administration was at the municipality's discretion. This lasted until 1957 when HIDS spurred a more comprehensive system.⁵⁸⁰

In 1951 construction was underway on the CGH IV, but discussions were ongoing about internal aspects of design such as paint colour. Colour is a fundamental aspect of the human experience, but also one of the most obscure. Scientists have determined how the eye and brain perceive colour; however, colour itself remains difficult to describe using language. Colour was important to patients, architects, and administrators. It sent a message to those inside the hospital building, and these effects differed with prolonged exposure. Colour selection also interfaced with gender. In March 1951, the house committee could not decide on paint for the new wards and “enlist[ed] the aid of the Ladies Auxiliary and the Nurses Alumnae...Yesterday Mrs. O’Keefe, Mrs. Mair and Mrs. Duncan met and considered sample colours.”⁵⁸¹ At the conclusion of the meeting the women recommended painting general wards a cream colour, and that a wide green stripe and small mahogany stripe for the furniture be placed in both the women’s and men’s wards. They also selected two colours for exclusive use in private wards and four for semi-private.

Room colour was of pragmatic interest to the architect and contractor who wanted the construction finalized. It was also on the minds of administrators. However, they saw it as an aesthetic factor rather than a therapeutic or functional one. The house committee chairman stated, “It has proven difficult to get a night which all members of the House committee could attend a meeting...if the committee is prepared to accept the ladies judgement in this matter of colour there

⁵⁸⁰ Taylor, *Health Insurance And Canadian Public Policy*, 169-170.

⁵⁸¹ “J. Barnes to Chairman and Members of the House Committee,” 6 March 1951, 1. File 8, Box 9 CGH Fonds AHS Archives. See Appendix IV, Images 4.5 and 4.6 for an overview of the CGH in 1950, and some perspective on its architectural journey.

will be no need or a further meeting on this point.”⁵⁸² So while the colour was of practical import administration regarded it as within the feminine domain, and a rare component of the building process where women could have a decisive say.

Staff members such as doctors wanted a role in shaping the institution’s future as well. In April 1952, a meeting of the medical staff passed a resolution stating: “That the position of superintendent of the Hospital had to be a medical man who is trained in hospital administration.”⁵⁸³ The idea that hospital administration was a distinct profession was not new to the 1950s. Harvey Agnew, for instance, would have been well-known to CGH doctors. He held an M.D, making him the perfect model for what the medical staff had in mind. By addressing administration doctors sought a degree of control over institutional direction. They knew approaches to hospital design were changing to include a larger role for architects and consultants. By ensuring administrators were also doctors there was a higher chance of combining medicine, spatial design, and therapeutics.

Not all staff relationships were on solid ground. In the spring of 1952 negotiations between the CHB, and nursing staff and students reached an impasse. On 29 February 81 nurses tendered resignations effective 31 March. A report in the *Calgary Herald* on 1 March publicised that no further negotiations would take place.⁵⁸⁴ It was not the intention of the nurses to leave the hospital; the threat of resignation was a negotiation tactic. The *Herald* identified its source as CHB chair Mrs. T. L. O’Keefe. A. W. Hobbs, a lawyer representing the nurses, wrote to O’Keefe on 3 March stating, “on behalf of my clients [they] have at no time taken the position that they will not enter into further negotiations. It must be clearly understood that any breakdown of negotiations at this state will be responsibility of the Board.”⁵⁸⁵ The CHB showed its teeth in such a transparent effort to turn public

⁵⁸² Ibid.

⁵⁸³ “H. H. Black, Secretary CGH to J. Barnes,” 23 April 1952, 1. File 10 Box 9 CGH Fonds AHS Archives

⁵⁸⁴ “Nurses to Leave on March 31,” *The Calgary Herald* 1 March, 1952, 1.

⁵⁸⁵ “A. W. Hobbs, Barrister to Mrs. O’Keefe,” 3 March 1952, 1. File 10 Box 9 CGH Fonds AHS Archives

opinion against the nurses. Among the nurses's grievances was the house committee's decision to renew Dr. J. D. Heaslip as medical superintendent. They had complained that he was "unsympathetic attitude to the training schools."⁵⁸⁶ The same day that the Hobbs letter was received, Dr. Heaslip wrote to O'Keefe and resigned. He wrote "I feel this is in the best interest of the hospital."⁵⁸⁷ Without support of their chief, appointed administrator the CHB lost all negotiating leverage. It capitulated, and sent Barnes to address remaining demands.

In 1952 a period of acute shortage of graduate and student nurses, internal miscues, and public pressure forced Barnes into offering concessions to the staff. The CHB started modestly by offering to allow sick nurses to report an illness at any time and to choose which doctor saw them. Previously they had to report before the start of a shift, and had to see whoever was on duty. The challenge of finding sufficient staff to operate new buildings was not lost on CGH nurses, and they were not swayed by table scraps. They knew, based on the rate of graduations and outside applications, that only five nurses would be availing on 1 April if their resignations went into effect; that was 114 fewer than usual. Salaries had not been a major point of contention, but Barnes approved a 'substantial' increase to wages anyway, reduced the probation period to thirty days, and allowed maximum wages to be reached in six months. As a final concession, the CHB agreed that "Married nurses are to be accepted on the same basis as single for the year 1952." The board preferred unmarried nurses whom would live on site and pay room and board.⁵⁸⁸ Nurses won the negotiation, but had not raised their professional standing.⁵⁸⁹

The new CGH completed in 1953 coincided with the completion of a three-storey laundry building and the start of renovations to the Perley Pavilion. Bed capacity was around 320 in the CGH

⁵⁸⁶ "Nurses to Leave on March 31," *The Calgary Herald* 1 March, 1952, 1.

⁵⁸⁷ "J. D. Heaslip to Chairman of CHB," 3 March 1952, 1. File 10, Box 9 CGH Fonds AHS Archives

⁵⁸⁸ "J. Barnes to Miss E. E. Jameson," 6 March 1952, 1 File 10 Box 9 CGH Fonds AHS Archives

⁵⁸⁹ Gagan and Gagan, *For Patients of Moderate Means*, 145. The Gagans have an excellent chapter relating to nurse-doctor relations.

III, but rose to 628 with the new building. The basement had a section set aside for ‘Psychopathic’ patients though it was not fully functional until 1954 when 20 beds were opened for that purpose; including four in “seclusion rooms.”⁵⁹⁰ The new building had a lot to live up to. In 1945 Toronto-based columnist Richard J. Needham addressed the matter in the *Calgary Herald*. His tone was pointedly sarcastic:

The Calgary General Hospital has had some pretty harsh words applied to it, the commonest among them being the word “obsolete.” Just when the building became obsolete is a matter of debate, but some doctors maintain it was obsolete the day it was opened. Building on the present site in 1910 the General Hospitals has suffered from its poor layout for 35 years. It is still suffering. For example the kitchen with all its heavy equipment is on the fifth floor of the building. The food has to go up five floors the garbage has to come down five floors. The ventilation system has never worked properly and seemingly nothing can be done about it. The wards and offices are far too small. No provision was ever made for a laundry chute so linen (of which a hospital uses fabulous quantities) has to be lugged downstairs in trucks...the building seems to have been erected by someone who has never seen a hospital, but had had one vaguely described to him.⁵⁹¹

Needham presented the building as a healing technology, and planning as though it were a science. It would be difficult to construct a paragraph more befitting the state of post-war hospitals that carried a legacy of twenty years of stagnation.

The planning process of the Perley renovations demonstrated the relationship between production of space and the social class of those who would occupy it. For example, architects Stevenson and Dewar initially drew plans for five-bed wards to appease administrative desire to maximize accommodation. However, this conflicted with the Dominion Government General Standards for Hospital Construction—PG 3403—because wards were short 14 square feet. The board settled on four-bed wards since increasing overall size would be too costly. The architects conceded that “in cases of emergency” a fifth bed might be added to the room.⁵⁹² Other times gender influenced spatial decisions. For instance, when considering whether to add a shower to the ‘lady

⁵⁹⁰ “CGH Historical Dates,” 1981, 9. File 15, Box 30 CGH Fonds AHS Archives, D. Scollard *Hospital: A Portrait of Calgary General* (Winnipeg: Hignell Printing, 1981), 180.

⁵⁹¹ Quoted in Scollard *Hospital: A Portrait of Calgary General*, 184.

⁵⁹² “Stevenson and Dewar Architects to Dr. L. O. Bradley,” 27 October 1953, 1. File 4, Unlisted Box CGH Fonds AHS Archives

doctor's room' in the Perley, Dr. Bradley commented "From our experience and observation it would not be used very frequently and we could put the space to much better use, either as locker space or just as additional floor space."⁵⁹³ Here the male administration made a decision for female doctors without consulting them. Space was not just architectural theory, doctor recommendations, patient needs or even fundraiser expectations. It was also a reflection of gender and class relations.

Public opinion also influenced space. In February 1957 in response to a series of "recent articles in the local newspapers," the hospital board suggested reallocating rooms in the old hospital building for patients with mental illnesses.⁵⁹⁴ The articles highlighted the presence of such individuals being detained in police cells. This detention practice coupled with the board's attention was revealing. It demonstrated that individuals deemed mentally ill were a group that the public and medical community took an interest in. Subtler observations may be made as well. The wards set aside for this in the CGH IV were filled, and the hospital had become ideal space for anyone 'ill.' Administrators faced a difficult choice when it came to balancing medical preferences and public demands. Ultimately the board opted to take in these patients in the hopes of pre-empting city council from feeling public pressured and forcing them to do so anyway.

The CGH added a new nurses's residence and school—a ten storey structure known as M-building—and North-South extensions to the main building in 1956. The medical executive committee initially had reservations about extensions so soon after completing the new plant. The committee estimated the renovations would cost \$1,050,000 and felt that it could be wasteful to invest so large a sum into a completed building rather than using it to construct a "third hospital."⁵⁹⁵ Again the spectre of obsolescence arose in committee minutes. The CGH IV had hardly settled on its foundations when there was handwringing that expanding was unwise compared to adding a new

⁵⁹³ "Memo by Dr. Bradley," 9 November 1953, 1. File 4, Unlisted Box CGH Fonds AHS Archives

⁵⁹⁴ "Hospital Board Minutes," 27 February 1957, 2. File 2 Box 6 CGH Fonds AHS Archives

⁵⁹⁵ "Minutes of the Medical Executive Committee," 17 February 1956, 1. File 1 Box 6 CGH Fonds AHS Archives

building. However, those with doubts did not represent the majority—or perhaps the cost of a ‘third hospital’ was so much in excess of the \$1,000,000 cash on hand that it was an unrealistic desire—and the local firm Stevenson and Dewar were again contracted to draft plans. By April the estimate increased to \$1,401,000, excluding a 5.5% increase in building cost, \$70,000 in architect’s fees and \$100,000 in equipment. However, with a joint federal and provincial grant of \$125,000 the board did not fear going slightly over budget.⁵⁹⁶ The board approved the project. Construction began on the North in 1957 and on the South in 1958.

The financial situation for the CGH was unique compared to other general hospitals. Not only was it tied into the city council through a formal committee, it could exploit this proximity when requesting funds. The CHB prepared a formal request for the province, suggesting that “the Government notwithstanding present plans for improved financial assistance to hospitals, if, as and when, a further sum of the surplus of gas and oil revenue become available for distribution to the people that [you] give consideration to the advisability of using all or a major portion of these funds to provide more or better hospital services for all the people of the Province.”⁵⁹⁷ The language was demanding, noting the source of the funds, and claiming they should be used to serve the health needs of its residents. The CGH was beginning to believe it should expand service to the province more generally; a similar process that was occurring at the VGH. Meanwhile the WGH was still focused primarily on its own community.

The CHB hoped that such funds would be used in the construction of additional hospitals to ease waiting periods. Wait times at the CGH had reached “a number causing grave concern to the local medical professions to say nothing of the anxiety of those seeking admission.” Additional monies would increase hospital per diem payments for traditional patients but also for “those

⁵⁹⁶ “Minutes of a Meeting of the Committee of the Whole of the Calgary Hospital Board,” 4 April 1956, 1. File 1 Box 6 CGH Fonds AHS Archives

⁵⁹⁷ “Minutes of the Calgary Hospital Board,” 26 September 1957, 2. File 1 Box 6 CGH Fonds AHS Fonds

patients who are considered to be entitled to free hospitalization such as the blind, maternity, OAP [Old Age Pensions], mother's allowance and so on, so that the government issues rate will more nearly approximate the costs and thereby diminish the deficit."⁵⁹⁸ The per diem complaints were rooted in the fact that they had never been updated with a frequency acceptable to the hospital board, and any opportunity for an increase was worth trying. The desire for more buildings spoke to two mutually-enabling ideologies. Namely, a sense that constant expansion was a necessary part of the board's task, and current buildings could not remain functional for a protracted period of time. Administrators saw in the revenue from oil and gas that streamed into the province a possibility for constant hospital expansion.

Between 1958 and 1960 the CGH turned toward survey and study rather than building. One 1958 project involved a comparison with the Royal Alexandra Hospital in Edmonton which was approximately the same size and primarily funded by the municipality. The process was highly political. The CGH stated in regard to its facilities, "It was felt the level of service in all departments, particularly nursing, was excellent. However, it was felt that at the present time the City could not afford to maintain this level if the Provincial Government was not prepared to substantially increase their payment."⁵⁹⁹ The threat of denying service was as potent as ever.

Direct access to the Municipality had some upside for administrators. The CGH IV replaced a primary building that was only 38 years old. A complete replacement would have been extravagant for most Canadian hospitals. The CGH III had escaped the limiting image of a charitable donations institution, and did not represent the communal effort that the WGH did. There was less reticence on the part of administrators to identify its structures as obsolete. Rather than acknowledge the good produced by the CGH III Barnes stated, "It is not laid out to economically give all the services

⁵⁹⁸ Ibid, 3.

⁵⁹⁹ "Minutes of the Meeting of the Committee of the Whole of the Calgary Hospital's Board," 29 January 1958, 2. File 1 Box 6 CGH Fonds AHS

required of a modern hospital, many of which services have developed since the hospital was built. The Hospital is trying to meet present demands for services with an obsolete plant. There are some services required which the present building cannot house.”⁶⁰⁰ Barnes statement cast the board as caught in a valiant but hopeless struggle—despite its role in the design and that other hospitals in Canada operated in much older buildings—and forced the city to respond in favour of new construction or appear to condone the seemingly miserable conditions. The combination of a strong, regional economy and the hospital’s ties to civic government meant the board did not require fundraising appeals that stressed thrift or emotional appeals. It had the means to embrace modern architecture and employee relations.

Between 1954 and 1960 the CGH expanded and altered existing facilities, citing city growth and lack of space. Population increased from approximately 100,000 residents in 1948 to 170,000 in 1955 while hospital beds city-wide had only increased from 600 to 1000, leaving Calgary with fewer beds per capita after building the CGH IV.⁶⁰¹ The Perley Wing saw substantial renovation under the supervision of the architectural firm Stevenson and Dewar. The architects converted it solely to maternity care which added 95 beds and 110 bassinets.⁶⁰² A convalescent rehabilitation centre, offering 205 beds, began construction but was not finished until 1962. The CGH IV was one part of a series of additions. The CGH rebuilt its main building, added three new wings, expanded services, and increased capacity from 320 to 728 beds. Still, the CGH had a troubled post-war legacy. It more than doubled accommodation while lagging behind population growth. Its tactics differed markedly from counterparts in Winnipeg by avoiding sentiment, leveraging public outcry, and engaging a

⁶⁰⁰ “J. Barnes to Mr. D. S. Moffat, City Solicitor, Calgary” 17 October 1947, 1. Box 10, File 4 AHS Archives

⁶⁰¹ “Memo from Mr. Dyck to Dr. L. O. Bradley” 31 March 1955, 1 Box 5, File 1, AHS Archives

⁶⁰² Evelyn Hardwick, Eileen Jameson, and Eleanor Tregillus, *The Science, the Art and the Spirit: Hospitals, Medicine and Nursing in Calgary* (Calgary: Century Calgary Publications, 1975), 46-48

building campaign that lasted into the 1970s. CGH administrators did not enjoy any sense of completion. In 1960 its grounds were still essentially in a state of semi-completion.

Vancouver 1946-1960

The second half of the 1940s and the 1950s were years of construction, marked by increased use of external consultants on matters of design and organization. Among the firms involved was the Minneapolis-based J. A. Hamilton and Associates. The 1947 Hamilton Report became the most influential document in the VGH's post-war development. Administrators were anxious to expand following the war. Almost no building occurred during the war other than military annexes that were generally of poor quality. With a windfall of men, materials, and capital—or so administrators hoped—they moved to enlarge facilities.

In 1946 the VGH took a preparatory step towards adding buildings by erecting a new power house and contacting Hamilton's firm. The province had reimbursed approximately 50% of capital expenditures during the war which allowed the VGH to stockpile enough money to begin construction. The power house was a modest building that required the addition of another boiler in 1952.⁶⁰³ Hamilton came to Vancouver in 1946 to survey existing facilities, and returned his finding the following year. A core suggestion from the report related to how much territory the VGH was accountable for. For much of the 20th century general hospitals feared patients from other municipalities would receive care, and then leave without paying. This left the hospital badgering the patient's municipality for payment. It was an old problem in a young country whose social welfare provisions, including hospital care, relied on municipal organization and grants, but whose economic opportunities promoted migration and transiency. The Hamilton Report appraised this practice as archaic. "To an institution considered the 'mother hospital' for the whole Province for several

⁶⁰³ "VGH Building Progress Report," 1952, 2. Box 535-D-7, file 1, VGH Fonds, CVA

decades there was truly no geographic boundaries to some of its function and service.”⁶⁰⁴ In essence the report affirmed the VGH could not remain entirely local. A similar process was underway in the United States where hospitals grew in size and scope.⁶⁰⁵

As far back as 1928 administrators at the VGH began discussing the need for enlarged facilities for the provision of acute care. After the Second World War, the funds materials and labour became available in sufficient quantities to allow such a project to move ahead. Plans began to take shape for an ‘Acute Building,’ and from 1948-1955 a process of architectural consultation, fundraising, grant petitioning and public relations dragged out. During this time many of the intended features of the building changed, as did its name. Its final title was the Centennial Pavilion which commemorated when British Columbia became Crown Colony in 1858.

The end of the Second World War was an opportunity for hospitals to expand and reorganize. With the prospect of securing major grants for new buildings came a shift in administrative thought. Nurtured by firms like Hamilton and Associates, hospital boards started increasing the range of services in order to secure capital. Wartime processes likely factored in the shift as well. During the war soldiers from all over the country, were treated at different hospitals, and had their care paid for by federal dollars.⁶⁰⁶ As such hospitals saw many out-of-region patients, and also had a direct channel to consistent funds. Growing popularity of state and private insurance also helped make patients attractive regardless of their origin.

The Hamilton Report made several recommendations. These included expanding accommodation through the establishment of a 500-bed sister hospital located at the University of

⁶⁰⁴ “A Study of the VGH By James A. Hamilton and Associates, Hospital Consultants” 1947, I-1. (Hereafter Hamilton Report) Box 1, File 24 VGH Fonds CVA.

⁶⁰⁵ Burnham, *Health Care in America: A History*, 337-339. For a classic in the field see George Rosen, *The Structure of American Medical Practice, 1875-1941* (Philadelphia: University of Pennsylvania Press, 1983).

⁶⁰⁶ Keshan, *Saints, Sinners, and Soldiers: Canada’s Second World War*, 78, 271.

British Columbia to form a “medical center.”⁶⁰⁷ The idea of a medical centre as opposed to a general hospital gained prominence in the 1940s and 1950s due to the swelling size of health campuses that strove to provide the services, labs, and patient accommodation necessary for education and healing. The WGH, for instance, became the Manitoba Medical Centre in 1945. In 1954 the VGH discussed the idea of a medical centre, and noted how this path had been followed in Houston, Los Angeles, and Winnipeg.⁶⁰⁸ The industry and administrative mindset began to change. The hospital was being re-conceptualized from its role as a building for surgery, convalescence, or examination and into a vast complex providing state of the art medical care, training and research while remaining adaptive to future discoveries.

Consultants relied on formulas to calculate hospital usage and capacity. These methods considered projected population, mortality, age of the citizenry, growth of city boundaries, and urban versus rural residents. The use of vital statistics is noteworthy because it was data produced outside the medical community. The American Commission of Hospital Care developed a formula for determining bed capacity based on birth and death statistics that become the standard calculation for the 1940s and 1950s. Using that method, the Hamilton Report concluded by 1971 Vancouver needed to add 1000 beds.⁶⁰⁹ The Hamilton Report described health care facilities in greater Vancouver as in a state of disarray. It recommended closing the Heather Street Annex—constructed during the 1918 influenza pandemic—and converting the main building to a 300-bed convalescent and chronic care facility.⁶¹⁰ The Heather provided over 80 isolation beds which was a lot to abandon. Moreover, the

⁶⁰⁷ “Hamilton Report” 1947, I-17. Box 1, File 24 VGH Fonds CVA.

⁶⁰⁸ “The VGH as a major medical centre?” 1954, I. File 1 Box 535-D-7 VGH Fonds CVA. In the 1990s the VGH entered into a broad partnership with other hospitals and the University of British Columbia. In the 1950s there was some hesitancy on the part of the board to wade into the type of negotiations necessary to bring so many institutions together; however, internal documents demonstrate administrators saw the VGH performing this role already.

⁶⁰⁹ “Hamilton Report” 1947, I-18. Box 1, File 24 VGH Fonds CVA.

⁶¹⁰ Ibid, I-24.

main building could only be shifted to non-active care if a significant number of beds were made up elsewhere.

The report also favoured a closer relationship with the university to bolster the VGH's profile in medical education and research. In fact, the report made this recommendation so strongly that it suggested no active planning or expansion take place until a decision had been reached relating to undergraduate teaching at the proposed medical school.⁶¹¹ Logistically it made sense to hold off on piecemeal construction until a broader understanding could be reached. However, the fact that consultants placed education above the most pressing stated need of more acute beds revealed long-term expectations about hospital use and function. It also demonstrated how the inter-connectedness of healthcare interests could shift design, finance, and management from a series of disconnected buildings to a more organized, functional campus. Managing the sequence of demolition, renovation, and building remained the challenge.

The second half of the Hamilton Report addressed this perpetual dilemma. It developed a building programme, and proposed alterations to better utilize existing space. Of primary import was replacing the main building—erected in 1906—which had outlived its usefulness as anything other than a chronic bed area where patients were more warehoused than treated. Other recommendations foreshadowed planning trends of the coming decades such as the “outstanding need” to centralize activities. The current plant spread over an area equal to approximately five city blocks, and presented a challenge for medical staff and administration alike. The infectious disease hospital also became expendable. Heretofore buildings segregating contagious patients were necessary, but the report noted “in modern medical practice, such hospital care could be combined effectively under modern nursing techniques within the medical wards of the acute general hospital.”⁶¹² Where the

⁶¹¹ Ibid, I-28.

⁶¹² Ibid, II-2.

only medical—and spatial—response had been isolation new techniques and knowledge rendered a class of hospital structure obsolete.

Thoughts of hospital growth flourished in the mid-1940s, but not without concerns that they could become unwieldy. The Hamilton Report admitted reservations about acute hospitals with more than 1000 beds. It acknowledged that several American hospitals had surpassed this number and “depending upon the arrangement of units and organization controls,”⁶¹³ noted that it could be done safely. However, the consultants still feared that a building for 2,000 or 3,000 beds would carry great risks and untenable costs. The report had an international tone. It addressed specific VGH issues, but with frequent asides toward the state of the industry and many references to the United States. The report demonstrated transnational optimism for building and hospital expansion. Whereas once a request for 300 beds that resulted in 150 was a decent success, planners now looked to expand by thousands.

Bed distribution was one of the biggest complications for the VGH in 1947. It had a total of 1,210 beds spread over eight different buildings with the largest collection being 401 in the main structure. That figure included 28 beds for patients suffering mental illness.⁶¹⁴ Moving patients between buildings strained the staff and contributed to administrative overhead. For the patient it was a hassle as well, and surely recoveries were slowed by the need to shift location or endure extended waits when physicians were held up elsewhere. The Hamilton Report made several suggestions for rearranging wards and adding buildings. Specifically, it called for a new structure between the present private and maternity pavilion to centralize auxiliary services for the acutely ill and add roughly 815 beds. The board was impressed by the content of the report, but did not believe

⁶¹³ Ibid, II-3.

⁶¹⁴ Ibid, II-6.

it could be followed in totality. For example the building committee had reservations about the ventilation systems and brought in a different firm to advise on it.⁶¹⁵

The main building had the longest list of problems. Nursing units, for instance, lacked proper auxiliary rooms which caused unnecessary movement for staff and patients. The larger wards were too flexible to be remodelled. Time had caught up with the older buildings. Since the time of initial construction, renovation and remodelling shoehorned services into existing spaces and medical staff found compromises between convenience and basic operation. The Hamilton Report rejected this method of spatial organization bluntly, “In general the major functions do not have sufficient space and their locations do not lend themselves to development as the main units of the hospital’s future. To remodel this building would be far from approximating the economical layout of a modern hospital.”⁶¹⁶ The only option was to demolish and rebuild. When Winnipeg’s board had let go of a far older building it indulged in nostalgia and gave an appearance of sad necessity. In Vancouver, the board presented quiet exasperation and leaned on specialized advice.

By 1947 architectural plans for a nurse’s home and school were completed, despite indecision as to location. One of the reasons both the Hamilton Report and board felt comfortable doing so stemmed from the surprising belief that “Such facilities do not need to be as much of an integral part of the hospital care facilities as do patient’s beds. The contemplated land is too valuable to be unused.”⁶¹⁷ The land in question was a parcel at the corner of Laurel Street and Tenth Avenue in the northwest corner of the site. In simplest terms it was true that such space did not contribute to healing as directly as a patient bed. Land being too valuable for use as nursing accommodation revealed a paradox within the professional world of hospital organization. Throughout the 20th century administrators had converted nursing residences into active-care sections of the hospital, and

⁶¹⁵ “Minutes of the Building Committee,” 1. 16 December 1947 Box 535-A-10 VGH Fonds, CVA

⁶¹⁶ “Hamilton Report” 1947, II-14. Box 1, File 24 VGH Fonds CVA.

⁶¹⁷ Ibid, II-15.

expended scarce resources to provide infrastructure such as covered walkways to allow nurses to walk to work with a measure of protection from the elements. On one hand, centralization had become a guiding principle, under which it made sense to keep the nursing staff near the wards. However, it also demonstrated nurses were still treated unfairly. Despite growing import to hospital operation an attitude of dismissiveness and disposability remained. Nurses were not ‘valuable’ enough for administrators to place them on prime land. The ballooning amounts of money tied up in hospital buildings, equipment, and land which made it harder for boards to indulge in acts of compassion or ‘fairness.’

The words of the Hamilton Report remained in the minds of administrators; however, between 1946 and 1950 they were only able to pursue small-scale projects. Post-war shortages and the outdated nature of infrastructure restricted full-scale construction. In 1947 work commenced on a new power plant, as well as an overhaul of the ventilation system in the east and west operating suites. More space was devoted toward the dietary department so that badly-needed ‘modern’ equipment could be added.⁶¹⁸ The power house was slated for completion in 1947, but strikes among construction workers—referred to as ‘delays’ in the annual report—led to a 1948 opening instead.

Administrators executed significant reorganization in 1948 and presented it to the public as growth. Bed capacity increased from 1,245 to 1,327 through tinkering with ward arrangements. The laboratory gained 3000 square feet of space allowing for new equipment to provide “a fully modern department.”⁶¹⁹ The additional space came from reductions to the purchasing department and print shop, which emphasized the zero-sum nature of reorganization compared to growth or expansion. A new nurses’s home also began construction, but it was located between 12th and 13th Avenues away from the more ‘valuable’ location suggested in the Hamilton Report. The most significant building

⁶¹⁸ “Forty-Sixth Annual Report of the VGH 1947,” 1948, 12-14. Box 4, VGH Fonds CVA

⁶¹⁹ “Forty-Seventh Annual Report of the VGH 1948,” 1949, 12-13. Box 5, VGH Fonds CVA

development of the year involved no construction. Agreement was reached between city and province for the construction of an addition to the old main hospital building, providing between 300 and 350 beds. The use-case was for ambulatory convalescents; those not ready to return home but who could be cared for without occupying an acute bed. Administrators hoped by adding this new area that funding would follow to allow for a new acute hospital with a similar number of beds. Initial expectations were that this would require a 14-16 storey building.

In 1949 a new BC Hospital Insurance Service (BCHIS) went into effect, resulting in a major change to hospital finances. The initial hospital response was far from positive. Administrators wrote that “It has placed a great strain upon the resources of the Hospital by reason of the tremendous increased demand by utilizing space not previously occupied by hospital beds.”⁶²⁰ Only Saskatchewan had a comparable program at the time. Historian Douglas Turnbull argues the differences in population and municipal structure between the two provinces proffers little comparative value—and indeed a 1948 study conducted by the Provincial Government of British Columbia came to a similar conclusion.⁶²¹

A fascinating link between the development of the system and the hospital consultant industry is that Hamilton and Associates assisted the provincial government in designing the insurance plan. In part the province engaged the Hamilton firm due to its work on Blue Cross plans in Cleveland. In 1949 the head of BCHIS stepped down, and James Hamilton took over as acting head of the organization through 1950. Though the initial result of the BCHIS was to stress hospital accommodation—in part because premiums were not enacted until 1950—there were benefits. For instance, the increased demand for accommodation gave administrators a position of strength from which to argue for new buildings. The BCHIS felt community demand for new hospital buildings so

⁶²⁰ “Forty-Seventh Annual Report of the VGH 1949,” 1950, 2. Box 5, VGH Fonds CVA

⁶²¹ A. Douglas Turnbull, “Memoir: Early Years of Hospital Insurance in British Columbia,” *BC Studies* 76 (1988): 57-59.

strongly that in 1950 it established its own Hospital Construction Division to provide advice to communities planning to build. The services of this division included approving proposed sites and blue prints as well as counselling on trends in hospital building and organization.⁶²²

The most substantial building added between 1946 and 1960 was the Centennial Pavilion, but it was not the first idea administrators had or attempted. In 1950 plans for a 900-bed acute unit were ordered by the board. Additionally, the VGH embarked on major renovations hoping that the acute unit might be the only new structure needed. In 1951 renovations were carried out in Wards A, B, and C of the main building as well as an addition which added 328 beds. In January 1951, the main building addition was completed, and its A and B floors opened each adding 160 beds. In March, D floor was occupied by patients and staff from the Haro Street annex which had been in use as an infant's hospital. Meanwhile C floor was completed and converted into temporary operating room facilities for use by the University Of British Columbia. A significant amount of renovation went on in the main building, “old and outmoded plumbing, sewers and electrical wiring together with inadequate space for expanding facilities and services made it necessary to completely rehabilitate the 45-year old building.”⁶²³ Plans were taking shape in relation to the acute building. It would have six nursing floors as well as other facilities such as emergency department.

By 1954 the plans of a 900-bed hospital shrunk to a more modest 500. Chairman A. L. Wright of the board of trustees described this change to the Provincial Minister of Health and Welfare as coming after “four years of careful review and planning.” In reality as early as 1951 the VGH had indicated its intention to pursue a smaller project of around that size. Wright wrote, “The nursing floor has been reduced and the area of all lower floors sharply curtailed. In the process of redesigning, special attention has been given to every detail by the building committee, trustees,

⁶²² Ibid, 66.

⁶²³ “Fiftieth Annual Report of the VGH 1951,” 1952, 3-5. Box 5, VGH Fonds CVA

staff, architects and consultants. Wherever possible alternate materials and methods considered.”⁶²⁴ He wanted to present the image of a board that had gone ahead with much due diligence because the following project would be very costly. Wright went on to elaborate on the importance of this new structure by arguing that over 90% of increases in health care costs resulted from patient stays lasting longer than 30 days. He saw two reasons for this: due to the shortage of acute beds patients had long waits prior to admission during which time their condition could worsen, and that a number of post-polio, paraplegic, chronic, and senile cases came from outside Vancouver which filled beds but provided no revenue.

In 1954 final posturing took place to advance construction of the Centennial Pavilion. A report from the board read: “The Hospital has had the benefit of the best advice obtainable in Canada and the United States...Only ideas which have proved sound both economically and efficiently have been incorporated. The Board and BCHIS are in agreement as to the importance of building a modern up to date unit, not one built down to bare minimum requirement which would probably be out of date before completion.”⁶²⁵ The natural way to position the possibility of a new building was celebration. However, the board worried about overplaying their hand. From their vantage expansion was the natural course of action stemming from professional advice, but some members worried the public would be less understanding. The main building renovations and additions were highly publicised. The last thing administrators wanted was for the public to perceive the centennial building as a response to failed renovation.

In March 1955 Chairman Wright received approval from the Province of British Columbia. In a letter, Health Minister Eric Martin wrote: “The government of British Columbia concurs in your

⁶²⁴ “A. L. Wright, Chairman Board of Trustees VGH to Eric Martin, Minister of Health and Welfare , British Columbia,” 4 October 1954, 1. File 2, Box 535-E-3 VGH Fonds CVA. Also source of above quote.

⁶²⁵ “The VGH – Alternative Construction costs – Acute building report,” 1954, 1-2. File 2, Box 535-E-3 VGH Fonds CVA

hospital's proposal to call for tenders for the 504 bed acute building, the laundry unit and the emergency unit," however it did so with conditions. The government would not contribute to the cost of stone or brick exterior finishing, and any costs for painting and cement rendering had to be exclusive of its grant. Additionally, a further \$310,000 reduction in costs was required or had to be acquired independently.⁶²⁶ The government also took issue with some 'modernisms' sought by the board. For instance, plans called for wiring patient rooms to accommodate radios and televisions. Radios were not new, but televisions were. Administrators envisioned them as a strong source of future revenue. The province has reservations about financing potentially profitable infrastructure from which it would not see a return.

The VGH Public Relations department treated the Centennial Pavilion as the crown jewel of a new medical centre, and the last piece in a process that began in 1928 with the first discussions on the need for more acute accommodation. It served the trifecta of hospital aims: diagnosis, treatment, and research and education.⁶²⁷ The building was designed by Vancouver architectural firm Townley and Matheson. The board gushed that it was an "ultra-modern, four-winged cruciform building of class A construction, reinforced concrete, fireproof, nine stories above ground level with a complete sub ground floor, partial basement and sub-basement."⁶²⁸ Fulfilling one of the lingering questions from the Hamilton Report, the UBC Faculty of Medicine agreed to construct a three-storey medical school building on VGH property.

In May 1955, the board released a detailed description of the building to the local press. The report paid special attention to surgical capacity and patient accommodation. It noted how the new operating rooms could be used to perform any procedure needed by a patient on the medical campus.

⁶²⁶ "Eric Martin, Minister of Health and Welfare British Columbia to Mr. A. L. Wright, Chairman VGH," 24 March 1955, 1. File 11, Box 535-E-2 VGH Fonds, CVA.

⁶²⁷ "VGH A Centre of Hope for the sick and injured by J. Norman Robertson Public Relations Director," 1955, 1. File 11, Box 535-E-2 VGH Fonds, CVA.

⁶²⁸ Ibid, 2.

This meant the building would not exclusively serve its own patients as the private pavilion did, but also that no patient would need to be transferred elsewhere. It also stressed the presence of available nurses. In effect, it was a promise to patients that there would be no shortage of attention. To stress this point it noted the new call system to contact nurses.⁶²⁹

The release also offered a floor-by-floor description which tediously demonstrated the board's perceptions of desire for specific knowledge by the press and public. The first-floor housed offices for the departments of nursing, social services, purchasing, accounting and admitting. The second floor contained central supply, operating and post-operative recovery rooms. The third floor was designed primarily for the dietetic department, with a kitchen capable of preparing 5000 meals per day for itself, the private ward and women's pavilions. Electrically-heated food wagons would move meals to other building while a tray conveyor system would service internally. Floors four through nine were designated exclusively for nursing, each with two such stations. The wards on these floors were typically four-bed, with dressing tables, lockers, overheard rails for curtains and electrical outlets.⁶³⁰ Despite the technical nature of these descriptions the board stressed that "every decision, every move has been influenced by the needs of the patients."⁶³¹ The building was technologically modern, but patients still mattered.

Unlike earlier VGH buildings the centennial opened with much ado. Dignitaries included Lieutenant Governor Frank N. Ross, Eric Martin Provincial Minister of Health, Acting Mayor Evelyn A. Caldwell, and trustees and hospital staff.⁶³² Ceremonial tours for the public were held on 18 and 20 June 1959. The tours were carefully planned to emphasise the civic and medical value of

⁶²⁹ "A Description of the Acute Building 504-bed Addition to VGH: As released to the Press," 13 May 1955, 3. File 11 Box 535-E-2 VGH Fonds CVA

⁶³⁰ Ibid, 2-4.

⁶³¹ "The Centennial Building," 4. File 1, Box 535-D-3 VGH Fonds CVA

⁶³² "The Centennial Pavilion of the VGH to be officially opened 20 June 1959 by the Lieutenant Governor of BC The Honourable Frank N. Ross," 1959, 1. File 7 Box 570-A-5 VGH Fonds CVA

the facilities as well as draw attention to “interesting facts about the construction and facilitates within the building.”⁶³³ These tours were run by volunteers armed with talking points from the hospital’s public relations department. Volunteers were to stress the hospital’s record as one of the foremost teaching and medical centres on the continent. The descriptions were grandiose: “With the official opening of the Centennial Pavilion, we record the culmination of great dreams and hope which through planning and application have become a most promising reality.”⁶³⁴ The rhetoric stressed the difficulty for the public to appreciate the project’s magnitude and the decades of planning that preceded the final call for tenders on 14 May 1955.

The talking points emphasised architecture and organization in detail. Some features such as the presence of 504 regular and 27 emergency beds was not surprising. However, the board marshalled the production of space as a means to awe the public. The points noted how 50,000 cubic yards of earth had to be removed from the site before construction could begin, that the concrete used in construction was equal to a solid cube the size of a fifty-foot, ten-storey tall city block, that 150,000 tons of steel were fabricated and erected along with 700 miles of wiring installed. The total floor area including laundry annex amounted to 492,272 sq. ft, 156,000 of which being devoted to nursing floors. Elevators moving 500 ft. per minute connected patients and staff to its 18 operating rooms, recovery areas, patient spaces, and storage units.⁶³⁵

Such descriptions spoke to an architectural disconnect. The building was not beautiful. On the contrary it was plain, utilitarian, and the product of theoretical and statistical projection rather than passion. Yet that did not make it less grand, the board sought to impart the notion that it was an undertaking worthy of a great city. There was, however, another set of details with a different purpose. The report mentioned such amenities as electronically adjustable beds that did not require

⁶³³ “VGH to Volunteers,” 12 June 1959, 1. File 3, Box 535-D-3 VGH Fonds CVA

⁶³⁴ “Centennial Pavilion,” 1959, 1. File 3, Box 535-D-3 VGH Fonds CVA

⁶³⁵ Ibid, 2.

the assistance of a nurse to operate, personal lights, and lockers in each room. Spatial comforts and comments on the architectural and engineering grandeur were intended to impress the tour attendee who was ultimately a patient or donor in waiting. By presenting the hospital space as a technological marvel and haven of comfort the board prepared citizens of Vancouver for their eventual stay.

Such salesmanship helped justify the project's \$10,000,000 cost. Not all services were fully functional at the time of opening, and volunteers were posted outside rooms that still required touching up or lacked equipment.⁶³⁶ The control over which areas would be accessed, indeed the very practice of a tour itself, spoke to the artificial, constructed nature of the space and the fundamental importance administrators placed upon the perceptions of those who entered. Though the Centennial Pavilion opened in a state of incomplete operation, with almost half the number of beds intended, and nearly \$3,000,000 over budget it was less disappointment than common story. The art of negotiation between province and board account for some of the discrepancies such as size, and hospital buildings routinely went over budget, especially when the lowest bid was accepted on that basis alone as was the case in 1955.

The centennial building remained in service beyond 1980, and despite renovations to the main building fulfilled its original intent of becoming the centrepiece of the medical campus. Unlike other buildings constructed or renovated between 1946 and 1955 that required consistent upkeep the Centennial held up. The pains of contractor and architectural excess experienced when the building opened in 1959 were mitigated by its service over the next two decades. The use-case of the building itself spoke to the cementation of acute, general care as the key role of the modern hospital and the heightened expectations by both society and the medical staff of shortened, comfortable stays.

⁶³⁶ "The Centennial Pavilion of the VGH will be Officially Opened," 20 June 1959, 6. File 7 Box 570-A-5 VGH Fonds CVA. See Appendix IV, Image 4.7 for exterior view of the Centennial Building in 1959.

The Centennial Pavilion was one building on a medical campus consisting of several structures, but the process from design to building to day-to-day operation provides a useful window into the myriad factors that influenced spatial ordering and organizational practices. These two elements formed the basis of experience within hospital space for patients and those who visited them, but also for the nurses, doctors and ancillary staff who worked there. When the building opened, unfinished, in 1959 politicians and administrators celebrated it as a moment of success and promise of a bright medical future for the community. The public presentation demonstrated the important role of civic perception in defining hospitals in the 20th century.

Conclusion

For the period 1946-1960 hospital building occurred at a start and stop pace, as much hindered by staffing as material and capital shortage. The essential motivation of post-war building came from the general public's steadfast belief—demonstrated by fundraising, referendums, and donations—in the hospital's civic value, and ability to heal. The post-war building period is among the most significant in the history of Canadian general hospitals. This was the first major, well-funded period of expansion where trustees did not need to justify the hospital's existence and value to the community. The reputation of the institution had been ransomed from dark images of past decades, and now promised effective care, education, modernity, and discovery.⁶³⁷ Reality was not so neat. Despite the availability of funds, capital only flowed after much posturing between boards and provincial governments. The provincial hospitalization insurance schemes helped in the long run, despite initial resistance and failure.⁶³⁸

Building was a constituent element of the post-war period, so much so that it became almost inseparable from every other aspect of hospital management and operation. A 1952 progress report

⁶³⁷ Gagan and Gagan, *For Patients of Moderate Means*, 181. The Gagans refer to this dramatically as the hospital becoming 'the temple of scientific medicine.'

⁶³⁸ Finkel, *Social Policy and Practice in Canada: A History*, 125-135.

from the VGH read, “Doctors, nurses and other personnel have added the terminology of the construction business to their everyday talk...Renovation, alterations and rehabilitation are as much a part of their conversation as stethoscopes and thermometers.”⁶³⁹ After approximately two decades of meagre and highly contested expansion construction was back on the agenda. Architects, builders, and consultants were again in demand. Likewise, doctors and administrators who survived austerity saw an opportunity to expand and turned towards expansion. Citizens continued turning to the hospital for care which erased doubt over whether these institutions were wanted. Donations, opening ceremonies, tours, and especially the volunteers testified to the hospital’s eminent standing among civic institutions. Of all a large city’s services, it had become among the most sizeable, dynamic, and challenging to manage. But it had also matured from charity’s step-child to a beacon of civic pride and stability.

The rate of post-war building demonstrated a divide between patient expectation and medical reality. The image spun by consultants and administrators about the efficacy of modern hospital worked almost too well; general hospitals began to see that there was such a thing as being too successful. Dr. Burns of the WGH advised the executive committee in 1945 that “patients [are] still staying longer than necessary in the hospital...We might write the Manitoba Hospital Service Association, and see if they can find places for these people to live out.”⁶⁴⁰ The same sentiment was echoed hardly a year later when a report by the WGH accommodation committee commented: “[due to] the crowded conditions of the hospital something must be done to hasten the discharge of patients. Because of the urgent need for beds a committee...should make rounds of the hospital once a week and in any instance where a patient is being detained unnecessarily.”⁶⁴¹ Though funds were available buildings still took time to erect. This meant the only solution to overcrowding was

⁶³⁹ “VGH Building Progress,” 1952, 2. File 1, Box 535-D-7 VGH Fonds CVA

⁶⁴⁰ “Minutes of the Executive Committee Meeting,” 13 February, 1945, 1. File 2, Box 14 WGH Fonds PMA

⁶⁴¹ “Minutes of the Executive Committee Meeting,” 17 December 1946, 1. File 2, Box 14 WGH Fonds PMA

increasing rate of discharge. It was not a simple approach. As much as medical efficacy had improved to allow for shorter stays, patients were more convinced of safety and in no rush to leave. That is not to suggest a patient would prefer the hospital to home. Yet with vanishing stigmas, lowered mortality rates, and higher surgical success rates altered the impulse to avoid becoming an inpatient.

The production and experience of space may be captured outside dramatic moments of architectural expansion or engineering calculation. The most frequent parties to interface with space were nurses, patients, maintenance workers, and doctors. These individuals walked the halls, slept in the wards, and used the facilities. Spatial organization and change frequently came about without professional assistance through trial and error; often because administrators lacked the budget and time to wait on studies to be completed. In 1946 the CGH had an issue with ventilation in its drug storage area. The floor was made of a single concrete slab. It aided in fireproofing, but also restricted air circulation and hobbled the ventilation system. Rather than calling in professionals the maintenance staff experimented by removing the top panel in the door and installing iron bars.⁶⁴² Pleased with the result, the same procedure was used in similar areas of the building. Though a relatively minor issue, it was one of many modifications to space that took place daily. Even in a time of sophisticated planning the hospital remained a place of ad hoc adaptations. In a sense, it was the complexity itself that necessitated constant maintenance.

Architectural historians of hospitals and health care facilities, such as David Theodore, have associated the idea of obsolescence with the 1970s and the advent of ‘design after’ hospitals and facilities utilizing interstitial space.⁶⁴³ However, with both the CGH IV and VGH Centennial

⁶⁴² “Minutes of the Board of Trustees,” 16 January 1946, 2. File 1 Box 5 CGH Fonds AHS Archives

⁶⁴³ David Theodore, “Planning the Hospital of the Future: Montreal’s Royal Victoria Hospital, ca. 1970” (paper presented at Hospital / Hôpital IHSP 2015 Conference, Montréal, Quebec, October 1-2, 2015). Stephen Verderber, *Innovations in Hospital Architecture* (New York: Routledge, 2010), 153-154. The concept of design after rested on the

Building there were overt references to concern for buildings being out of date before completion. Administrators had not moved on to some of the later solutions such as interstitial space, and viewed the only real response as acquiring the ‘newest’ machinery. Thus, the idea of hospital buildings as machines of healing was not new to the latter third of the 20th century. Rather, it existed beforehand in the minute books of administrators and maintenance departments rather than architectural journals.

Though optimism defined the post-war building period administrators did not abandon all semblance of caution. In a 1954 letter CGH administrator Dr. L. O. Bradley confessed to WGH superintendent Dr. H Coppinger that “Calgary will be handicapped for the next 100 years because sufficient time and care was not taken in the planning of this hospital.”⁶⁴⁴ Bradley’s bluntness was proportionate to his concern that the current rate of construction might not be sustainable. If he was right, current additions would need to last. In his letter, he sought to convey how seriously deciding what type of building to erect was. Bradley was interested in the WGH, and told Coppinger he wanted to visit during the next bout of construction. The relationship between the WGH and CGH was mutual; Coppinger had previously written to Bradley for advice on how much time architects needed to plan a major expansion.⁶⁴⁵ The hard times of the preceding forty years did not numb administrators to hope, but they were not entirely convinced the boom would last.

The increased speed that patients moved through hospitals in the 1950s was an important change. Operations that once required weeks of rest and observation now needed only a few days. Maternity cases in the 1930s typically entailed two weeks as an inpatient. By 1950 long stays were only for complications. The days of large, open wards were over but patients still shared rooms.

assumption that a design would become outmoded in the time it took to move from drawing board to physical reality. To counter this, architects designed spaces that were flexible and open such that once the structure was erected it could then be laid out in a manner that accorded with cutting-edge planning principles.

⁶⁴⁴ “L. O. Bradley to H. Coppinger,” 13 August 1954, 1. File 3 [No Box number] CGH Fonds AHS Archives

⁶⁴⁵ “H. Coppinger to L. O. Bradley,” 10 August 1954, 1. File 3 [No Box number] CGH Fonds AHS Archives

However, these social moments were shortened, and patients had less cause and opportunity to communicate. Rules changed too. The lengthy 20-30 item lists of authorized behaviours stopped being produced by organizational committees. In part reduction in regimentation results from the hospital being more streamlined: patients entered, were treated, and were discharged. The same went for food preparations, laundry, supplies, and medications. The era of the ward was ending, replaced by a new philosophy of buildings as a technology in its own right. There were lines of people seeking hospital care, and less mystery about the cause and treatment of many conditions. The hospital process reached a pitch of mechanization far removed from delays and dysfunctions that administrators often associated with ‘the past.’ The same was true for physicians and nurses. Where once building rapport, trust, and familiarity had been normal functions of ward life the speed of recovery and the use of purpose-built wings for convalesce fragmented that social experience.⁶⁴⁶

Following the Second World War the general hospital in Canadian society became medicine’s premier institution. The future was bright, and rightly so as new technologies and successful research pointed toward seemingly endless advancement in treatment. Where once these institutions struggled to survive, they now held prominent positions in the social order of virtually all Canadian cities.⁶⁴⁷ Perhaps more striking is the way these institutions captured the imagination of other professions. Architects and administrative scientists threw their efforts into hospital organization with fervour, hoping to enable the next advancement in community medicine and public health. At the level of federal politics hospitals had not been forgotten. During the next two decades legislative incursions into hospitals further demonstrated how they were contested spaces; as difficult to maintain as they were sacred to social order, civic, and ultimately national, identity.

⁶⁴⁶ D. Scollard *hospital: A Portrait of Calgary General* (Winnipeg: Hignell Printing, 1981), 42.

⁶⁴⁷ Gagan and Gagan, *For Patients of Moderate Means*, 186-188.

Chapter V – “To avoid the atmosphere customarily described as ‘institutional.’” Medicare, Obsolescence, and Hospitals of the Future 1961-1980

A strong economy during most of the 1960s helped entrench public expectation that hospitals would continuously improve and expand. Ottawa’s commitment to the functions of a welfare state injected the federal government into health care as never before. Politics and medicine had come into contact many times previous, but the Hospital Insurance and Diagnostic Services (HIDS) Act of 1957 followed by Medicare in 1966 clarified funding, management, and recipients. For nearly a century the question of who would pay, govern, administer, and establish standards was addressed by a patchwork of compromises, professional networks, and quasi-governmental institutions. Clarification was at hand: the federal government would provide funds, the provinces would match and then dispense, and hospitals retained some administrative autonomy. In practice, it was not so simple, nor was the preceding provincial policy developments. In the 1970s Ottawa grew uneasy with its expenditure and scaled back the breadth of funding. Nonetheless, a major increase in available federal money helped define this period.

Like general hospitals, health and hospital insurance legislation developed within individual provinces such that there is no single antecedent. Economic historian Gregory Marchildon argued that the reason Canadian historians had paid scant attention to Medicare stemmed from the volume of provincial attempts prior to the 1960s.⁶⁴⁸ Saskatchewan’s attempts are the most venerated, but almost every province and territory dabbled in the messy business of insuring health. It was not until the end of the Second World War that public demand and parliamentary willingness aligned to begin the transition to a formal welfare state.⁶⁴⁹ More recent accounts have paid closer attention to the Depression and post-war political climate as important factors. A. W. Johnson’s biography of the

⁶⁴⁸ Gregory P. Marchildon, “Editors Preface and Acknowledgments,” in *Making Medicare: New Perspectives on the History of Medicare in Canada*, ed. Gregory P. Marchildon (Toronto: University of Toronto Press, 2012), ix.

⁶⁴⁹ Alvin Finkel, *Social Policy and Practice in Canada: A History* (Waterloo: Wilfred Laurier University Press, 2006), 95-97, 125-127.

Douglas government argues the 1944 CCF election victory was evidence of the electorate giving socialism a chance. In this account the election represented the public's desire for an improved standard of living after almost two decades of war and economic lassitude.⁶⁵⁰

Prosperity in the 1960s was a boon to architects who specialised in hospitals. In the 19th century their imprint was not always apparent on the scraped-together projects of cash-strapped administrators. The 20th century had some lean years as well. In the 1960s architects thrived as hospitals throughout North America rebuilt campuses to embrace new technologies both medical, like dialysis machines, and administrative, like computers. Computers also aided in research and record-keeping.⁶⁵¹ After the Second World War, hospital administrators experimented with a more technical type of architecture by implementing new systems to regulate temperature, ventilation, and power usage. Further, the advent of building techniques such as the use of interstitial space represented an architectural attempt to create buildings that would never become obsolete.⁶⁵² The building projects carried out in the 1950s often consisted of a series of specialized wings or additions constructed around a core building. Architectural enthusiasm in the 1960s and 1970s strove to use internal rearrangement and malleable infrastructure to create ageless structures.

The tools of the medical trade grew more sophisticated during this era with devices such as the implantable pacemaker in 1958, the EMI-Scanner in 1971, and wireless EKG heart rate monitor in 1977. For much of medical history the act of healing was 'to mend the body' by repairing the organic tissue innate to the individual. The perfusion of technology during the 1960s made 'improvement of the body' skyrocket to the forefront of medial praxis. Doctors could more accurately determine what was happening to a patient. A corresponding surge in research followed.

⁶⁵⁰ A. W. Johnson, *Dream No Little Dreams: A Biography of the Douglas Government of Saskatchewan, 1944-1961* (Toronto: University of Toronto Press, 2015), 4.

⁶⁵¹ David Theodore, "Towards a New Hospital: Architecture, Medicine, and Computation, 1960-75" (PhD Diss., Harvard University, 2014).

⁶⁵² Stephen Verderber, *Innovations in Hospital Architecture* (New York: Routledge, 2010), 86.

Clinical advancements also allowed for new ‘repairs.’ A worn out heart could be replaced mechanically, or an organ implanted from another body. Medicine advanced in efficacy and capability, but mysteries persisted and patients remain important. The 20th century may well be medicine’s century, but it is neither a story of complete triumph nor the end of humankind’s war against sickness, disease, and suffering.

The years 1960 to 1980 began with a sense of administrative confidence that projects could be completed before funding ran out, and cemented the centrality of hospitals to medical practice and social organization. In part this owed to federal hospital and medical insurance. Care was, theoretically, covered. The uneasy bedfellows of the health ministry and hospital boards compromised by accepting the guidance of outside professionals, and waves of consultants washed over general hospitals leaving behind a small library of long-term plans and institutional surveys. As medical campuses grew so too did their cohorts of students, the services provided, and their economic role in the community. By the 1980s the economy had slowed. This was worst in Alberta as oil prices crashed. Despite the best efforts of architects the 1960s and 1970s did not see the emergence of true ‘hospitals of the future’ immune to obsolescence or steep upkeep costs.

Toronto 1961-1980

The TGH added buildings during the 1960s and 1970s, but its main focus was on organization and ‘modernization.’ Initially finances troubled administrators less as the institution’s profile as a teaching hospital rose, and a stream of medical advancements poured forth.⁶⁵³ One of the most important influences on the TGH’s architectural development was an eight-volume study by Woods, Gordon & Co. Planning Consultants and Mathers and Haldenby Architects. The first two volumes, released in 1964, summarized the program and provided a planning overview. The following five

⁶⁵³ J. T. H. Connor, *Doing Good: The Life of Toronto’s General Hospital* (Toronto: University of Toronto Press, 2000), 262-263.

dealt with in-patient facilities, medical and hospital services, clinical teaching, and science facilities. The reports provided a language and form to administrative thought on building and spatial organization in late-1960s and 1970s. These studies had practical value, but TGH administrators also saw them as vehicles to bypass financial obstacles. With a more formal provincial apparatus in place for dispensing funds the TGH became one institution in line with many. At times, it was unable to act because of that, which revealed a break from its history of timely donations. Focusing on internal organization and efficiency was a way for the TGH to improve when funds were scarce. Furthermore, a plan in hand strengthened funding requests.

Between 1960 and 1961 administration struggled with several issues related to ongoing construction projects. In November 1960, the building committee met to discuss a “radical increase in costs” for renovations in the Mullock-Larkin out-patient wing.⁶⁵⁴ According to their findings the escalation in costs was due to wages for electrical and mechanical labourers. An initial quote of \$449,000 had risen to \$1,408,291. Dr. Norman Urquhart suggested Mathers and Haldenby review the entire construction programme, and asked them to refrain from making its figures public. The Central Building had been under construction since 1954. It was nearly done, but issues ranging from malfunctions in the ventilation and air conditioning system to draughty windows caused delays.⁶⁵⁵ Renovation of wards A, B, and C, first suggested in 1950, were still underway. In the non-medical areas sliding glass doors did not operate properly, terrazzo floors cracked, and lighting fixtures remained boxed. There was a seemingly never-ending list of loose ends that plagued administrators. The committee was open to organizational changes to save money or increase efficiency, but were not prepared to abandon some old habits. For instance, wards remained segregated by gender, and the committee preferred 7-8 beds per room over 3-4 despite high demand

⁶⁵⁴ “Minutes of Building Committee,” 30 November 1960, 1. File TG 1.13.19, Box TG 45 TGH Fonds UHN Archives

⁶⁵⁵ “Minutes of the Building Committee,” 8 June 1960, 1-4. File TG 1.13.19 Box TG 45 TGH Fonds UHN Archives

for semi-private and private accommodation.⁶⁵⁶ In other areas design readily adapted to new ideas. In an effort to consolidate ‘patient flow’ Dr. Sharpe advocated closing the emergency entrance to the public in order to reduce the number of required waiting rooms and nursing stations.

In 1964 the first two volumes of the TGH’s modernization programme were released. They demonstrated a detailed vision for the institution’s future rather than a practical plan. ‘Idealistic’ planning was a break from older models where an architect drew plans within a budget, and the contract was awarded as soon as possible due to a mix of shaky funding and urgent patient need. Now the board engaged consultants with a mind to establishing a specific plan in minute detail. The volumes abound with tables demonstrating the required square footage per bed, labs, and offices. The hospital of the future accorded to scientific and technical preferences rather than local exigency or shortage. Such planning also considered a wider range of details and interests such as how space might be repurposed or adapted as institutional needs changed.

The plan (hereafter Woods Report) was compiled by two firms. One specialised in architecture, and the other in organization. It included input from the board of trustees, medical, nursing, technical, and administrative staff, and University of Toronto faculty. The diversity of participants in the planning process demonstrated a notable development in hospital expansion. The hospital was more than a structure run by civic leaders, philanthropists, and doctors. It was a complex society whose fabric reflected, and smooth-running required, the input of its full-time occupants. Absent this list are patients. Patients were not forgotten during the design process, but consultants sought to understand their needs through different channels. Namely through the input of the professionals who cared for them. Despite this seeming oversight the goal of the Woods Report was to produce ‘an outstanding Canadian Health Sciences Centre.’ In 1963 that information went to the consultants who blended in their own ideas.

⁶⁵⁶ “Minutes of the Building Committee,” 22 June 1961, 2. File TG 1.3.20 Box TG 45 TGH Fonds UHN Archives

As consultants addressed one aspect of expansion they encountered new vistas from which complexities and heretofore unseen problems emerged. In 1966, The Woods Firm felt it could go no further without the architectural expertise of Mathers and Haldenby. In an introduction to the study consultants wrote, “It was felt essential that as the functional plans developed in more detail their practicality within the severe limitation of the site should be tested. In this way, the Planning Report would present a workable solution to complex problem.”⁶⁵⁷ As the planning phase continued, centralization of office staff became a pressing concern. There were other influences such as changes in University of Toronto curriculum which increased demand for educational space and ward access.

The concerns of planners designing the ‘hospital of the future’ were manifold, but coalesced around a fear of obsolescence. The Woods Report strove to ensure the facility did not “become obsolete in a short period of time,” and projected it could remain current through 1980. In order to achieve this goal “space was planned in such a manner as to permit flexibility in its use and allow growth of the activities taking place in it, in order to minimize future major renovations.”⁶⁵⁸ It was an architectural philosophy of functionality instead of beauty; the space had to work. A ‘plastic’ interior meant that as demands changed the space could too. The addition of new wings had been part and parcel of hospital expansion in the 20th century. Administrators preferred new structures because medical requirements for a building often changed rapidly. To meet these through renovation typically involved removing exterior walls in order to alter utilities such as plumbing, heating, and electrical. The costs of these alterations quickly matched those of new construction.⁶⁵⁹

⁶⁵⁷ “Toronto General Hospital: Planning Report. Volume 1 Summary Programme: Prepared by Woods, Gordon & Co. Planning Consultants and Mathers and Haldenby Architects,” 1964, i. File 2.25.1 Box TG 84 TGH Fonds UHN Archives. See Appendix V, Image 5.1 for an example of the report’s drawings.

⁶⁵⁸ Stephen Verderber and David J. Fine *Healthcare Architecture in an era of Radical Transformation* (New Haven: Yale University Press, 2000), 97.

⁶⁵⁹ “Toronto General Hospital: Planning Report. Volume 1 Summary Programme: Prepared by Woods, Gordon & Co. Planning Consultants and Mathers and Haldenby Architects,” 1964, 5, 11. File 2.25.1 Box TG 84 TGH Fonds UHN Archives. Above quote on page 5.

Preventing obsolescence meant more than the superficial flexibility of movable partitions could offer. To keep pace with medical changes a truly malleable space was needed.⁶⁶⁰

Authors of the Woods Report did not neglect the building's role in healing the sick. Initial plans considered a single tall edifice that would constitute a healing tower to overlook the city and its hinterland. Further revision shifted to a network of structures that could be easily expanded. One section of the report noted, "To avoid the atmosphere customarily described as 'institutional' a conscious and continuous effort is being made to introduce daylight penetrations and eliminate long internal corridors wherever possible." Its admission of an 'institutional' feel incorporated emotion into a consciously scientific exercise. The report went on to state, "Within a very large building complex of approximately 2,000,000 square feet, the maintenance of human scale can only be achieved by separating the complex into its principle elements and by separating these elements into logical component parts none of which is excessively large or overwhelming."⁶⁶¹ The professionals sought utility, efficiency, and efficacy; however, they also took the emotions of patients and staff into consideration when suggesting internal arrangements.

An important change in post-Second World War hospitalization was the speed with which patients were treated and released. Despite this, administrators still sought large bed counts. The double corridor layout was common in North America after 1945, but the Woods Report warned "as increasing numbers of patients are treated through the clinic, and with the growth of preventive medicine the ratio of in-patients to out-patients will decline, but the medical severity of in-patients conditions may intensify."⁶⁶² In 1965 consultants took this a step further. They suggested instead of

⁶⁶⁰ Ann Sloan Devlin, *What Americans Build and Why: Psychological Perspectives* (Cambridge: Cambridge University Press 2010), 81-90.

⁶⁶¹ "Toronto General Hospital: Planning Report. Volume 1 Summary Programme: Prepared by Woods, Gordon & Co. Planning Consultants and Mathers and Haldenby Architects," 1964, 7. File 2.25.1 Box TG 84 TGH Fonds UHN Archives

⁶⁶² Ibid, 29.

rushing patients through wards they should be kept out entirely if possible. As hospitals became more effective and safe the public naturally grew more comfortable in them. Administrators faced with the ironic problem of trying to keep patients out unless absolutely necessary.

A major bent of the Woods Report was the idea that institutions should move toward more single rooms to enhance privacy. The consultants referred to research by the Nuffield Foundation in 1955 that established criteria for placing a patient in a private room.⁶⁶³ Some reasons were classic such as the patient being contagious, or susceptible to contagion. However, the other three were more complicated to evaluate: those who were seriously ill or dying, patients likely to disturb those near them, or anyone requiring special attention. Since the late 19th century hospitals sought to avoid the dying. In part due to the risk of contagion and the deleterious effect on the morale of those around them. In the hospital of the 1960s the possibility to keep patients alive, or even pull them back from the brink, was more plausible, and ‘dying’ became a harder category to establish. The fact patients could disturb each other serves as a reminder about shared rooms.

Legislative developments also affected the TGH during the 1960s. The Ontario Medical Services Insurance Plan (OMSIP) came into effect on 1 July 1966. It became the Ontario Health Services Insurance Plan (OHSIP) in 1969. In 1972 the plan was shorted to Ontario Hospital Insurance Plan (OHIP). TGH administrators saw the legislation as an opportunity to advance the institution’s identity as a teaching hospital. In 1967 Chairman Thomas J. Bell explained that in light of the new program “traditional patterns of care through which the hospital has served the community for well over a century would have to change with the times.” He argued that if staff and patients were to enjoy maximum benefit from the teaching and research programme the “former

⁶⁶³ The Nuffield Foundation was a charitable organization established in 1943 by British motor manufacturer and philanthropist William Morris. The foundation’s goal was to provide funding for innovative research at first in education and social policy before establishing a separate branch to fund science projects in the 1960s. For more information on this organization see Mary Waring, “Background to Nuffield Science,” *History of Education* 8:3 (1979): 223-230. And Ronald Clark, *A Biography of the Nuffield Foundation* (London: Longmans, 1972).

‘private’ and ‘public’ system which had been the pattern for many years should give way to the modern, University Teaching Hospital approach.”⁶⁶⁴ In 1968 the TGH had a total of 1,243 beds spread over four buildings. Approximately 31% of these were private rooms.⁶⁶⁵ By changing a definition Bell added 31% to the teaching capacity without spending a dime or laying a brick. His actions demonstrated how expansion could be achieved through reorganization.

In the late-1960s the TGH took a more conversational, measured tone in its public outreach. The 1968 annual report referred to how “vibrant, alive, and constantly growing at all hours of the day,” a city such as Toronto was, and how a general hospital ought to befit its community. The exterior of the hospital did not match the pizzazz of administrative rhetoric. It was not a new problem. Hospitals had long been frustrated by the difficulty of explain seemingly complete exteriors with unfurnished or unfinished interiors to the public. Now administrators took a different tack. “From outside you may detect little change in the complex of buildings which is the TGH. Inside these buildings however there is constant change. In this age of technological progress to stand still is to fall behind.”⁶⁶⁶ It went on to note renovations, particularly in the College Wing, and mentioned some new departments such as the Coronary Care Unit. Administrators cleverly made the criticism they expected to face only to briskly explained why it was sensible but wrong. The board sought to speak in the same language—critical or otherwise—of those who stood outside its walls.

The final years of the 1960s were marked by internal disunity, power struggles, and wavering public confidence. In 1969 tensions flared between administrators and nurses. According to historian Jim Connor the result was nursing becoming its own branch of power alongside doctors and

⁶⁶⁴ “Annual Report of the Toronto General Hospital,” 1967, 1. File TG 1.2.17, Box 3 TGH Fonds UHN Archives

⁶⁶⁵ “Toronto General Hospital: Planning Report. Volume 3 In Patient Facilities: Prepared by Woods, Gordon & Co. Planning Consultants and Mathers and Haldenby Architects,” 1964, 1.9. File 2.25.3 Box 50 TGH Fonds UHN Archives.

⁶⁶⁶ “Annual Report of the Toronto General Hospital,” 1968, 3. File TG 1.2.17, Box 3 TGH Fonds UHN Archives. See Appendix V, Image 5.2 for an example of a drawing intended for public consumption.

administrators. In 1971 organized labour ascended into that triumvirate.⁶⁶⁷ Sarah Growe in *Who Cares? The Crisis in Canadian Nursing* (1991) argues that often patients trusted the machines and medicines around them, while harbouring concerns about the institution and its administration.⁶⁶⁸ Enduring public ambivalence towards hospitals rested on a strange polarity of reverential scientific faith and unflagging political distrust. Public cries for transparency in government are ubiquitous, but there is no corollary call for inquiry into how research funds were allotted. The doctor could be trusted but not the alderman. Nurses as a collective were caught between both sides.

Despite the amount of capital and time spent planning during the 1960s nothing had yet to come of it. A 1968 public building freeze ensured the decade would end without construction. The 1971 annual report tried to frame the situation in a positive light with its suggestion—in a section titled ‘groundwork for the future’—that “in spite of the fact your Hospital was unable to proceed with ‘bricks and mortar’ planning for the future, 1971 proved a year of achievement. Today as a result of these achievements we are in a stronger position to continue our roles in service, teaching and research.”⁶⁶⁹ The report was carefully vague as to what had gone on—internal planning related to demolishing two buildings in the near future—and instead celebrated that the average patient stay had dropped to 11.9 days.

Between 1973 and 1974 the TGH took preparatory steps towards expansion. Administrators, at the urging of the provincial government, abandoned the Burnside Wing. Following this the adult bed count fell to 1,103. Pending provincial proposals called for the reduction of a further 100 beds by 1974. The TGH’s political power rested upon its ability to provide teaching opportunities and fulfill a role in the broader profession of medical education. Thus, the board held “grave concerns” about any proposal that reduced beds. The 1973 annual report navigated the difficult terrain of

⁶⁶⁷ Connor, *Doing Good: The Life of Toronto’s General Hospital*, 235.

⁶⁶⁸ Sarah Growe, *Who Cares?: The Crisis in Canadian Nursing* (Toronto: McClelland & Steward, 1991), 17

⁶⁶⁹ “Annual Report of the Toronto General Hospital,” 1970, 4. File TG 1.2.18, Box 3 TGH Fonds UHN Archives

building demolition, as “two venerable hospital-owned buildings were razed.”⁶⁷⁰ One was the private patient’s pavilion first built in 1930. The site was quickly converted to use as a parking area.

Throughout 1974 the TGH claimed small victories and improvements where possible; however, frustration was mounting after a fruitless decade-long planning programme. The annual report listed a variety of changes to ‘soft infrastructure’ such as the implementation of a new fire safety programmes. Changes to procedure were an inexpensive way to make space more useful. The operating room receive a new air-conditioning system, and the results of a ‘signage study’ to make buildings easier to navigate came into effect. Demolition of an east residence represented the most substantive step toward expansion. Chairman Bell noted that “planning for the new facilities so desperately needed to replace outmoded areas progressed significantly.”⁶⁷¹ Other pieces fell into place, as Mathers and Haldenby produced a ‘functional’ programme. It could be reviewed against the internal drawings for the new buildings to ensure that the plans remained reasonably up-to-date after so many years of delays.

When 1975 passed without sod-breaking the administration used the annual report to cast blame on the municipality and province. The physical plant remained “an area of concern. Excellent progress has been made with the development of the functional program and early drawings of our planned construction. A start in 1976 of the actual building would do much to restore confidence in the future of our Hospital and with the cooperation of the City and Province this should be possible.”⁶⁷² The report blamed others for slowing the process, while presenting an active hospital that had drawn plans and was eager to build. To bolster this narrative the board mentioned a handful of minor renovations, such as adapting Ward A in the College Wing to serve as a headquarters for the division of ‘Nuclear Medicine,’ and alterations to the department of physical medicine.

⁶⁷⁰ “Annual Report of the Toronto General Hospital,” 1973, 1.4. File TG 1.2.17, Box 3 TGH Fonds UHN Archives

⁶⁷¹ “Annual Report of the Toronto General Hospital,” 1974, 4-5. File TG 1.2.17, Box 3 TGH Fonds UHN Archives

⁶⁷² “Annual Report of the Toronto General Hospital,” 1975, 1. File TG 1.2.17, Box 3 TGH Fonds UHN Archives

As hospitals grew more sophisticated, moving through the space required increasing organization. New procedures for the operating and recovery room occupied a significant portion of administrative time in the 1970s. Patients were central to the design of new facilities. “Access of the OR is difficult for patients and depends on a, multitude of elevators and comes from three directions – College Wing, N. U. Elevators, university wing, GB, and emergency south.”⁶⁷³ As noted in the third chapter patients had some influence on the design of operating room spaces—such as the way equipment was stored and the colour of the walls—but these provisions considered fear rather than convenience. The new model emphasised both. Surgery was safer, but still fear-inducing. It was also more successful, and administrators considered speed and volume. The paths that led to the operating room were beginning to matter as much as it did.

There was no major construction in 1976, but the Ontario Ministry of Health (OMH) approved plans for new buildings. The OMH subsequently released funds to the TGH. In turn the board issued a contract to excavate the foundation. City by-laws “remained in a state of flux,” preventing the building from going ahead and “leaving the hospital susceptible to seemingly never-ending cost escalation.”⁶⁷⁴ Late in the year the city approved the plan ‘in principle’ which cleared the way for construction to begin. The erection of the David Eaton building was the main, and hard-won, project of the 1970s. The TGH caught an updraft in 1971 when the province released funds for capital projects, but it still took five years to move forward. There were also non-medical reasons to build. Connor has argued an important factor was competition with the nearby Mount Sinai Hospital. The Sinai had moved to University Avenue, completed a fully-modern 18-storey structure, and

⁶⁷³ “Operating Room Traffic Control – Appendix A,” 19 March 1975, 2. File TG 4.9.7 Box 63 TGH Fonds UHN Archives

⁶⁷⁴ “Annual Report of the Toronto General Hospital,” 1976, 1. File TG 1.2.17, Box 3 TGH Fonds UHN Archives

become affiliated with the University of Toronto.⁶⁷⁵ It served as a visual reminder that the TGH could fall behind if it did not expand. It was not until 1976 that requisite fundraising, planning, and demolition was finished and construction could begin. Federal, provincial, and municipal governments contributed \$62 million of the total \$74.5 million. The difference of \$12.5 million had to be made up in public outreach.⁶⁷⁶

The first phase consisted of a 14-storey twin tower wing east of the Norman Urquhart Wing that included an ambulatory care tower with 155 medical specialists, examining rooms, and diagnostic testing facilities. The other tower offered 304 inpatient beds and an additional 69 for intensive care. Phase one was the most significant, costing \$53.7 million, and would open for occupancy in September 1980. The second phase, at a cost of \$12 million and scheduled for completion in 1982 would renovation the University Wing, adding air-conditioning, library and educational facilities, and expanded patient rooms. The final phase aimed for completion in 1985 at a cost of \$8.8 million, and it would convert part of the College Wing into a research centre. During construction accommodation decreased to 1,000 though the renovations of phases 2 and 3 would raise it. The parkade was slated for completion, and would accommodate 450 automobiles.⁶⁷⁷

The reputation of nurses improved during the 20th century, but old prejudices persisted. In December 1978, the operating room and recovery room committee discussed a seemingly trivial matter in the purchase of new coffee machines. However, this decision demonstrated the endurance of hierarchies among staff by gender, and profession. The dietary department noted new machines could combine hot and cold drinks, for under \$0.30 a cup. The committee chair ended the meeting with a telling summation: “After discussion it was decided to ask for a new machine for the

⁶⁷⁵ Connor, *Doing Good: The Life of Toronto's General Hospital*, 235-236. For a history of the Mount Sinai see Lesley Marrus Barsky, *From Generation to Generation: A History of Toronto's Mount Sinai Hospital* (Toronto: McClelland & Stewart, 1998).

⁶⁷⁶ “Renewal Plan,” 1980, 1 File TG 29.0.2 Box TG 103 TGH Fonds UHN Archives

⁶⁷⁷ “Annual Report of the Toronto General Hospital,” 1977-1978, 2. File TG 1.2.17, Box 3 TGH Fonds UHN Archives

surgeons's lounge, and to ask that the old machines be relocated to the nurses's lounge."⁶⁷⁸ Of all the technology in a hospital a beverage dispenser is among the least significant, but its deployment nonetheless reflected social and professional inequalities.

Between 1978 and 1980 progress sped up. In November 1978 the TGH held an 'almost done' celebration. Vice-chairman of the board of trustees Aldred Powis and Health Minister Dennis Timbrell poured the last load of concrete. Such efforts were transparent attempts to remind the public the project was nearing completion and to salvage some positive press. By March 1979 "the exterior was all but complete and already there have been many complimentary remarks upon its fine appearance." In further good news replacement bed facilities and the ambulatory care centre were on time and budget. The sentiment was shared internally as well. "Obviously there is still much to be done but already excitement is growing among the staff of relief from crowded and inadequate facilities."⁶⁷⁹ The TGH was relieved to be able to discuss construction after two decades of planning.

The 1970s—marked by economic slowdown and a national sense of pessimism—was not the TGH's finest decade. When the Eaton building opened on 6 July 1981 it was the culmination of a process that began in the 1960s. For an architectural era defined by fear of obsolescence such a lag time reminds historians of how difficult these projects were. Further, this era marked a changing of the guard for the TGH. The philanthropy of the past had faded. In the coming decades it would return in the form of branches such as the Munk Cardiac Centre. Still, in an era of increased provincial involvement the TGH had to wait in line for funds rather than exploit its ties with civic elites. Medicare and a lull in building put Toronto's premier hospital off-balance. Connor presents a conflux of declining professional prestige for doctors, bureaucratic intolerance to hospitals operating

⁶⁷⁸ "Operating Room and Recovery Room Committee," 20 December 1978, 1. File TG 4.9.5 Box 63 TGH Fonds UHN Archives

⁶⁷⁹ "Annual Report of the Toronto General Hospital," 1978-1979, 1. File TG 1.2.17, Box 3 TGH Fonds UHN Archives. Source of above quote as well.

at a deficit, and a fraying in relations with the nursing staff as causing the ‘glitter of technology to fade,’ and institutional survival to return as a guiding principle.⁶⁸⁰ Amidst the optimism of the 1960s, administrators entertained grand plans of campus expansion. The abrupt economic reversal of the 1970s produced significant delays.

Winnipeg 1961-1975

The 1960s dawned brightly for the WGH with a series of developments: steam boilers were converted from coal to oil, the service wing opened, and the old isolation wing was demolished. For the perpetually cash-strapped WGH such improvements were a source of pride. The events of the 1970s diverged from this path. The major developments of that decade related more to administration and bureaucratization—passing of the Centennial Health Sciences Centre Act (HSCA) in 1972 for instance—rather than construction. The University of Manitoba became more involved, and in turn increased the institution’s focus on medical education. Medicare did not prove a major disruption to the provision of health care. Winnipeg had long relied on public appeals as an important funding stream. Following the passing of the HIDS Act in 1957, the Manitoba Hospital Commission (MHC) oversaw healthcare financing and constructions funds. It became the Manitoba Health Service Commission (MHSC) in 1970.⁶⁸¹

The process that began in 1957 with the passing HIDS took the bulk of the 1960s to complete. On 1 July 1960 its first form took effect. It was limited to “the social allowances group” and required a “demonstration of need,” before medical benefits became available including: office and home calls, drugs, prosthetic appliances such as eyeglasses, hearing aids, and orthotics. There had been some initial unease on the part of WGH administrators who feared the outpatient population would shrink. The opposite occurred, and the board grew concerned that if the program

⁶⁸⁰ Connor, *Doing Good: The Life of Toronto’s General Hospital*, 234-235, 268.

⁶⁸¹ Ian Carr and Robert E. Beamish, *Manitoba Medicine: A Brief History* (Winnipeg: University of Manitoba Press, 1999), 133.

expanded it could affect the institution's teaching function and capacity.⁶⁸² The initial implementation was not 'universal coverage,' but it expanded during the 1960s to cover more and more. The findings of the federally-appointed Royal Commission on Health Care Services (Hall Report) rendered its verdict in 1964 that a universal health care plan was desirable.⁶⁸³ The 1966 federal passing of Medical Care Act (MCA) guaranteed fifty-fifty sharing of expenses with the province. The Manitoba Medical Association voted in favour of the proposal, but it was not implemented until 1 April 1969.⁶⁸⁴

More patients created a need of new buildings. The service wing—upon which the six-storey 'H' wing was added in 1964—was under construction in 1960. Administrators were eager to see that it remain on schedule, and had cause to fear delays. The Lennox Bell House, which was supposed to be ready for occupancy by 1 July, was behind schedule and quickly becoming a matter of "considerable concern."⁶⁸⁵ It was a less grand building than the service wing, but administrators did not want to acquire a reputation for overseeing inefficient construction. The basement and third floor for the service had been poured. The second was planned to be done by 27 May. By 24 June the building stood taller than G wing, and saw the completion of several internal fixtures: doors widened, additional lights installed, curtains added around each bed on ceiling tracks, and new flooring.⁶⁸⁶ On 16 September the executive committee met again noting the completion of bricking,

⁶⁸² "Annual Report of the WGH," 1960, 27. File 12, Box 11 WGH Fonds HSCAM

⁶⁸³ Canada. Royal Commission on Health Services. *Report of the Royal Commission on Health Services*. Vol. 1. Ottawa: Queen's Printer, 1964, 13. It is commonly referred to as the Hall Report after Chief Justice Emmett Matthew Hall who was chairman of the commission. It offers an eloquent argument for provision of health services as a fundamental public good, almost on the order of an investment. It recognized individual responsibility for their own health, noting such factors as diet, use of leisure time, exercise, safe practices and the like fell within that purview, but that modern medicine had also expanded the health needs of individuals well beyond what could reasonably be manipulated by behaviour alone.

⁶⁸⁴ Carr and Beamish, *Manitoba Medicine: A Brief History*, 135.

⁶⁸⁵ "Minutes of the Executive Committee," 20 May 1960, 2. File 1 Box 4 WGH Fonds HSCAM

⁶⁸⁶ "Minutes of the Executive Committee," 24 June 1960, 2. File 1 Box 4 WGH Fonds HSCAM

ventilation, and plumbing. The building was “approximately 20 working days ahead of schedule,” and administration hoped for an opening as early as 1 June 1961.⁶⁸⁷

Administrators knew their institutions were most vulnerable during construction because money had been spent but the results were not yet tangible, bed capacity often dropped, and delays or miscalculations smacked of incompetence. Quickly-completed renovations could help distract from this, and the board commissioned them when possible. In September 1961 the board contacted the Woods, Gordon & Co. Management Firm—then at work with the TGH as well—hoping they could provide some insight on how to effectively use extant buildings during renovations. A shorter Wood Report was issued in Winnipeg. Its comments focused on streamlining protocol for operating rooms reports and centralizing purchasing departments rather than planning new buildings.⁶⁸⁸ The largest project for the year was total renovation of wards F-3 and F-4 in the Jubilee Wing—built in 1898—which included new flooring and re-wiring. In the North Wing wards A-4, A-5, and D-4 received minor renovations to avoid disrupting ward routines. The nurseries T-1 and T-2 were updated so they could provide intensive care, and received a paint job for the first time since opening in 1950.⁶⁸⁹

Funding prospects in 1961 were good in light of a favourable report made by the MHSC calling for \$35,600,000 in expenditure over the next seven years. Large sums had already been released in Manitoba: additions were underway for \$2,000,000 in Brandon, \$1,400,000 in Dauphin, \$4,000,000 in Winnipeg plus another \$3,058,000 for the WGH service wing. The report prepared by Dr. J. D. Adamson a Winnipeg medical consultant, J. A. McNab, deputy director of the hospital service branch of the Ontario Hospital Services Commission, and Dr. Joseph Willard federal deputy

⁶⁸⁷ “Minutes of the Executive Committee,” 16 September 1960, 3. File 1 Box 4 WGH Fonds HSCAM. See Appendix V, Image 5.3.

⁶⁸⁸ “Report done by Woods, Gordon & Co. Management Consultants,” 1 September 1961, 4-6. File 1, Box P. 2169 WGH Fonds PMA

⁶⁸⁹ “Annual Report of the WGH,” 1960, 54. File 12, Box 11 WGH Fonds HSCAM

minister of welfare. It recommended the H wing project and J wing expansion continue. In addition it supported the idea of a new laundry and a building for cancer treatment. The report noted Winnipeg had received over \$13,000,000 in the last decade, and other regions needed funds too.⁶⁹⁰ Johnson called it “one of the most comprehensive hospitals studies completed in Canada,” and was especially pleased that it used a provincial perspective.⁶⁹¹

In 1962 the WGH saw its first construction lull in over a decade. The recession of 1959-1961 placed pressure upon the hospital, but it enjoyed strong community support and continued building. The 1959 annual report read “it is most encouraging to report a total of \$100,135 in donations and bequests. This seems to reflect the growing realization by the community that hospitals need continuing support.”⁶⁹² In the spring Health Minister George Johnson presented a program to reform mental health care in the province. It included adding a 200-bed wing onto the WGH.⁶⁹³ In December 1963 the board awarded the contract for a five-floor expansion above the service wing that administrators referred to as H wing. The H wing benefited from the Hospital Insurance Act which permitted hospitals to retain 20% of differential earnings for the use of capital construction. Renovations on B-2 were completed, and served as the pilot project for the remaining wards on B and E wings. Renovation added 25 beds which upped the total to 919.⁶⁹⁴

Some construction represented social, rather than medical or scientific impulses. In 1964 the WGH added an ecumenical chapel. It was the first religious space on its premises. Back in 1907 the Church of England donated \$1,000 to the WGH to build a chapel; however, the plans never materialized and the money was used for general expenditures. The 1964 chapel was a small

⁶⁹⁰ Joseph W. Willard, J. D. Adamson, and J. A. McNab, *Manitoba Hospital Survey Board Report on Hospital Services*, (Winnipeg, 1961), 128-133.

⁶⁹¹ “Survey Board Recommends \$35.6M Hospital Program: Emphasizes Need for More Chronic-Care Facilities,” 24 March 1961, 1. (Information Section: Dept. of Industry and Commerce, Winnipeg)

⁶⁹² “Annual Report of the WGH,” 1959, 17. File 12 Box 11 WGH Fonds HSCAM

⁶⁹³ “Annual Report of the WGH,” 1962, 18. File 12, Box 11 WGH Fonds HSCAM

⁶⁹⁴ “Annual Report of the WGH,” 1963, 18, 24. File 12, Box 11 WGH Fonds HSCAM

structure designed to be as inclusive as possible. It was a “quiet room” entered through bronze doors bearing symbols of “the six major religions,” Judaism, Buddhism, Islam, Christianity, Confucianism, and Hinduism.⁶⁹⁵ For most of its history the WGH had been carefully secular. The St. Boniface served the region’s Roman Catholic population. Now the WGH altered its campus to align with an emergent diversity. It was acknowledging that as a public institution all patients, and their loved ones, needed to feel accommodated within its walls.

In 1964 the Trident Construction Company began the new six-storey ‘H wing project.’ It would provide four floors for regular nursing wards, one for maximum care, and a service floor. Other projects were simultaneously under way. The Winnipeg architectural firm of Green, Blankstein and Russel Ltd (1932-2004) assisted in the design for a central laundry service, and architectural firm Moody, Moore, and Associates reprised their position with the WGH to prepare for a new emergency department. A recent decision by the Manitoba Legislature allowed the city to directly assist in the construction of hospital facilities rather than having to use by-laws.⁶⁹⁶ The new laundry buildings commenced in 1965, as did renovations in C wing.

By February 1965 trustees appraised construction progress as “favourable.” The fourth floor was due for completion during the first week of March, and the others at approximately five day intervals. By 21 May the buildings were furnished and patients had begun occupying the new wards.⁶⁹⁷ Most of these patients came from B3-B6 which, now empty, was renovated in turn. A shortage of nurses, and mechanical issues on the intensive care ward (H-7) caused delays. The cardiorespiratory unit on H-7 could not be operated properly in the space allotted to it. Last-minute

⁶⁹⁵ “Beatrice Fines Manuscript – A Hundred Years of Health,” 1972, 145-146. Fold 1, Box P498 WGH Fonds PMA

⁶⁹⁶ “Annual Report of the WGH,” 1964, 18. File 12, Box 11 WGH Fonds HSCAM

⁶⁹⁷ “Minutes of the Board of Trustees,” 26 February 1965, 3. File 4, Box 2 WGH Fonds HSCAM

alterations to the design called for a Kidney Unit (dialysis) but the implementation proved difficult.⁶⁹⁸ Administrators hoped H-7 could be opened by September.

Throughout 1965 the WGH strengthened its relationship with the University of Manitoba. Executive director, Dr. L. O. Bradley pledged that his board and administration would study how the WGH could “meet a greater responsibility for teaching of medical personnel and clinical research.” Bradley wanted to add a 200-bed extended care unit, a 200-bed psychiatric unit, and enlarge the emergency department. He also wanted to help the university, but felt “the financial resources of the WGH are now depleted from carrying out several recent major construction projects.”⁶⁹⁹ Only the department of medicine had a reasonable amount of lab space—15,000 square feet—compared to 12,000 in surgery and 10,000 in obstetrics with another 10,000 divided between the basement and small, scattered support areas.

In 1966 the university took a transformative step in its relationship with the WGH by hiring James Hamilton and Associates to explore renovations for the main medical department.⁷⁰⁰ That firm had worked for the VGH and Province of British Columbia during the 1950s. The WGH welcomed the assistance, having just repaired defects in the parking garage roof and built a five-bed dialysis unit at the cost of \$265,000. In 1945 when the Manitoba Medical Centre Act passed both institutions carefully ensured their autonomy. The WGH did not want to give up authority over its campus. This meant both sides trusted the Hamilton Firm to serve as an impartial broker. Bradley resigned in 1967 and left Canada to become president of the newly-opened Minneapolis Medical Center. Peter Swerhone became Executive Director on 21 April. In September he overhauled the board to

⁶⁹⁸ “Minutes of the Board of Trustees,” 21 May 1965, 2-3. File 4, Box 2 WGH Fonds HSCAM

⁶⁹⁹ “Dr. L. O. Bradley, Executive Director WGH to Dr. H. H. Saunderson, University of Manitoba,” 16 September 1965, 1. File 4, Box 2 WGH Fonds HSCAM

⁷⁰⁰ “Annual Report of the WGH,” 1966, 19. File 12, Box 11 WGH Fonds HSCAM. Located on E-wing.

strengthen its ties to the university. The executive shrunk, and new rules allotted more power to department heads in day-to-day operations for facilitating education and research.⁷⁰¹

Between 1967 and 1970 the WGH continued to build, but at a slower pace. In April 1967 renovations were underway in F-3, F-4, and C-5. The renovations in F wing provided better accommodation for clinical investigation and teaching while C wing alterations added administrative spaces. There was also the question of an emergency service department which had been on the agenda since the 1950s. In one of his final actions Bradley stated that despite the addition of this department being a “number one priority,” F-3, F-4, and C-5 were presently vacant and thus did not provide value for patients or staff making it more of a ‘real’ loss.⁷⁰² The emergency department had not yet been built, its cost to the institution was theoretical, as in wasted potential. However, the F and C wards were already built but unhelpful without renovation.

In March 1968 renovation on ward E-6 finished, which raised bed count to 968. The E-6 ward renovations included installation of a dropped ceiling to conceal heating pipes and recessed fluorescent lighting for the corridors. The board chose pale pastel colours for the walls to make them “bright and cheerful, yet soothing to the eye,” and the floors were gray vinyl designed to absorb the sound of footsteps. One of the most unique features of the ward—one that harkened to luxurious health care spaces built during the 1920s in cities like Toronto—was a dining room for ambulant patients. Six patients could sit in vinyl chairs the colour of coral—chosen to accent the off-white walls—vinyl around Arborite-topped tables. with a view above the rooftops toward a “wide expanse of sky.”⁷⁰³ Demand for nurses remained high so the board used third year students to staff the ward in summer and paid them on the unregistered nurse’s scale.

⁷⁰¹ “Annual Report of the WGH,” 1967, 18, 70. File 12, Box 11 WGH Fonds HSCAM. The quote is on page 70.

⁷⁰² “Minutes of the Board of Trustees,” 7 April 1967, 1. File 4, Box 2 WGH Fonds HSCAM

⁷⁰³ “Renovated Ward Re-Opened,” *The Generator* 10:4 April (1968): 1. File 4, Box 8 WGH Fonds HSCAM

Despite increased involvement with provincial ministries the WGH continued reaching out to its community. In the 1970s public relations publications began eschewing the stuffy formality of opening ceremonies and the Dickensian alarmism of fundraising literature. In an issue of the institution's publication—*The Generator*—focusing on surgery the editor wrote, “the drama of the Operating Room, the life and death decision, the mystery (from the patient's point of view), have captured the imagination of writers since the days when barbers were surgeons. But to the 110 people who work on the 7th floor, north wing, the OR is a day by day way of life, though it can never be called routine.”⁷⁰⁴ The article described the floor's layout in detail, explaining the division of labour between the 16 operating rooms. They were evenly split between D-wing on the west and A wing on the east. D wing saw to general surgery which included open heart procedures, renal transplants, neurosurgery, and plastic surgery. A wing handled ear, eye, nose and throat cases as well as urological procedures. *The Generator* was primarily for the staff, but contained some content for the general public or prospective patients.

In 1972 the WGH celebrated its centennial which coincided with the HSCA. The Act amalgamated six care facilities under one aegis and on a single site known as the Health Sciences Centre (HSC).⁷⁰⁵ These included the WGH, Children's Hospital of Winnipeg, Manitoba Rehabilitation Hospital, D. A. Stewart Centre, Manitoba Cancer Treatment and Research Foundation, and Winnipeg Psychiatric Institute. The University of Manitoba would be represented on the HSC Board. The HSCA also contained language to dissolve the amalgamating institutions. The WGH, upon word from the Lieutenant General, would transfer without payment all property to the new HSC Corporation. In turn it became responsible for any debts or agreements between the

⁷⁰⁴ “This is the OR,” *The Generator* 14:3 (1972): 1. File 8, Box 8 WGH Fonds HSCAM

⁷⁰⁵ In a sense the WGH ceased to exist. Though it had entered into the Manitoba Medical Centre agreement in the 1940s the institutions had retained autonomy. The HSC Act in effect nullified existing boards and set up a new top-tier administration. The WGH was the largest entity to join the amalgam, and as noted below the joining members sought to have it well-represented. For the remainder of the chapter I will refer to the HSC, rather than WGH in particular.

WGH and other parties. Furthermore, it repealed the 1968 Winnipeg General Hospital Act and any remaining legal references to the WGH would hence forth refer to the HSC.⁷⁰⁶ It also changed the governing structure, necessitating a new board that involved members from the Cancer Treatment and Research Foundation, the Sanatorium Board of Manitoba, and the Board of Governors of the University of Manitoba.

The WGH and its allies had decided in 1970 how they wanted the new organization to function. Such careful planning—well-aligned with the times—allowed the consortium to present the scheme as a *fait accompli*. As a member of the executive put it in 1970, “it is necessary that the Company operate under the umbrella of the WGH because it was exempt from municipal taxation...”⁷⁰⁷ The initial plan called for eleven voting shares, six of which being given to the WGH members and one each per additional institution. Early talks included the St. Boniface Hospital, but ultimately it did not join. The numbers had to be tweaked as a result, but the basic agreement remained intact.

In 1973 the ‘Basic Medical Sciences Building’ was erected, and in 1974 the central energy plant opened. The province brought in the Calgary-based consultancy of J. Graham Clarkson to provide a plan for redevelopment. Clarkson’s report noted that, “restrictions had been placed on the rate at which monies from the Health Resources Fund could be spent, and while some new medical schools were conceived and built in the heyday of the late sixties (Calgary, McMaster, Memorial) most building programmes ran into rough weather.” The Clarkson report was issued in three sections between 1975 and 1977, the first of which appraised existing facilities. In 1975 the HSC included 1,363 beds and was one of the largest in Canada which “gives the impression of being unwieldy and

⁷⁰⁶ Manitoba. Legislative Assembly. “The Health Sciences Centre Act” Bill 108, 4th Session, 1972. [Winnipeg]: The R. S. Evans Queen’s Printer, 1972. (Assented to July. 20, 1972). 533-534, 539. See Appendix V, Image 5.4 for an outline of the campus.

⁷⁰⁷ “Minutes of a meeting of the Board of Trustees,” 27 November 1970, 2. File 4, Box 3 HSCAM

impersonal.” For decades administrators struggled to acquire adequate space, now they feared growing too large. Further “there are gross imbalances in the amount and quality of space allocated to major functions, with patient services, in general being very poorly provided for...about one quarter of the buildings are now time expired.”⁷⁰⁸ ‘Time expired’ was a softer word than obsolete, but it held the same sentiment.

Among the most pressing concerns cited in the Clarkson Report was the provision of diagnostic treatment services. It noted that a new hospital in Victoria had purposefully left room for additional beds in case they had devoted too much space for diagnostics. Such ‘plastic’ design accorded with the thrust of architectural thought related to hospitals in the 1970s that sought to make interiors versatile and adaptable. In setting out an agenda for the final design the first volume of the report noted it hoped to retain 75% of existing HSC buildings and mostly in their present use. However, the most important tasks came in managing human movement and ‘logic’ of the site. “Particular emphasis has been placed on the upgrading of the environment and the improvement of access to the facilities and cross site communication system,” achieved by closing roads presently crossing the site to a ‘HSC precinct’ with restricted access, the creation of a new main entrance for hospital and education staff, and provision of a ‘radical’ new internal street system that would connect all parts of the complex.⁷⁰⁹

The second Clarkson volume laid out a more specific design that it described in inflated architectural rhetoric. “The opportunity to develop horizontal relationships between the various parts of the complex is exploited, and wherever possible the buildings are continuous. At the upper levels they take the form of extension and infill between existing buildings so as to form a network of continuous strands of accommodation appropriate for inpatient areas, research labs, and offices,”

⁷⁰⁸ “Health Sciences Centre Winnipeg Manitoba Vol.1. Prepared by Dr. Graham Clarkson of J. Graham Clarkson Consultants LTD of Calgary Alberta.” 1975, 2, 4. File 1 Box 37 WGH Fonds PMA. Previous quotes on page 2.

⁷⁰⁹ Ibid, 94.

further that “it is an essential characteristic of these buildings that they are everywhere the same, and can be used interchangeable for these and similar functions because of the flexibility which is imparted to them by the design of their structural servicing systems.”⁷¹⁰ The HSC was to be a structure capable of recalibration, adjustment, and if necessary radical physical adjustment.

In some respects the Clarkson report is the end of the WGH’s story. The WGH remained important for HSC going forward due to its ability to avoid taxation, and strong standing in the community. The final chapter of the Clarkson report offered three phases for redevelopment, and a sketch of what the ‘levels’ of care should address. The first phase called for a new entrance and communications system, the erection of a ‘bed tower’ with around 80 beds to link the north wing of the General Centre (WGH buildings prior to the 1972 Act) with the Children’s Centre, a materials handling building to serve as a hub, and a relocation of referral clinics. Phase two would demolish the General Centre’s older wings, expand cancer wards, and begin new construction on the site of the Psychiatry Institute. Phase three represented the completion of the HSC; a new concourse to facilitate cross site circulation, and a system of pedestrian walkways. Finally, the campus would be a precinct with landscaped grounds to limit vehicular access.⁷¹¹

The WGH had travelled far. It served the city through floods, epidemics, two world wars, a depression, social unrest, and the expansion of provincial oversight that made its autonomy an obstacle rather than an asset. Throughout 1972 *The Generator* ran a wistful historical blurb:

To our patients: We are entering a significant year in the history of the WGH. In December we will celebrate our 100th Birthday. The hospital was organized by citizens concerned over an epidemic of typhoid in the growing settlement of ‘Red River.’ They secured a room over a drug store near Main Street, set up five beds and hired a steward to take charge. The first patient was admitted on Christmas Eve 1872. Now the WGH has 970 beds and extends over 18.57 acres. It is known all over the world for achievements in the care and treatment of the sick.⁷¹²

⁷¹⁰ “Health Sciences Centre Winnipeg Manitoba Vol.2. Prepared by Dr. Graham Clarkson of J. Graham Clarkson Consultants LTD of Calgary Alberta.” 1975, 5. File 1 Box 37 WGH Fonds PMA

⁷¹¹ Ibid, 47-49.

⁷¹² “To our Patients,” *The Generator* 14:3 (1972): 1. File 8 Box 8 WGH Fonds HSCAM. Some of the facts are apocryphal, but that was largely unimportant to the editors, their interest was connecting with the public.

Health provision carried on in Winnipeg, as did medical education. However, the WGH was no longer a distinct or autonomous entity. For consultants, this was a sensible amalgamation to make health care more efficient. For the community it marked a different moment. The institution was—by virtue of its history of donation-driven expansion—more public, more civilian, more Manitoban than other hospitals. It saw the most significant changes in the Medicare era by becoming more closely linked the university, and by its architecture drawn back from the city. The hospital would continue caring for the sick, but it had crossed into a more impersonal realm that focused on education and research. Ultimately, and by a more winding course, the WGH had come to mirror its Toronto counterpart.

Calgary 1961-1980

The CGH gathered steam during the 1960s with modest expansion, and mushroomed in the early 1970s as Alberta's economy soared along with global demand for hydrocarbons. In 1960 the CGH had 728 beds; by 1973 this number had risen to 952, and in 1988 when the Peter Lougheed Facility opened capacity rose to 1,000. In Calgary development was fragmentary. Administrators demolished and built when times were good, and coped when they were not. The cadence of boom-bust was an important facet of the lived experience of Albertans, and left its mark on hospitals.⁷¹³ The period of renovation and consultation in the 1960s prepared the field for a frenzy of expansion in the 1970s and 1980s that was often bankrolled by windfalls in oil development.

⁷¹³ Harry H. Hillier, *Second Promised Land: Migration to Alberta and the Transformation of Canadian Society* (Montreal: McGill-Queen's University Press, 2009), 14-15, 90-94. The boom-bust cycle of the 1970s and early 1980s produced a small library of literature popular and academic. For a popular book that largely holds Peter Lougheed and his party responsible for failing to safeguard the province see Andrew Nikiforuk, Sheila Pratt, and Don Wanagas, *Running on Empty: Alberta After the Boom* (Edmonton: NeWest Publishers, 1987) for more academic examination see John Erik Fossum, *Oil, the State, and Federalism: The Rise and Demise of Petro-Canada as Statist Impulse* (Toronto: University of Toronto Press, 1997), 26-34. Fossum argues the intent of Diefenbaker's 1961 National Oil Policy was to expand the domestic oil industry. There was, however, an oversupply of oil in world markets so it was not until the 1973 OPEC crisis that Lougheed was able to capitalise for Alberta.

Occasionally all general hospitals received dissension from local newspapers, but the CGH's position as a branch of the municipal government made it ripe for criticism. In November 1961 Mr. McKenzie Dyck, business manager for the CGH, wrote to city Alderman Don McIntosh in response to "recent publicity given to thievery and wastage at the CGH," and reassured him that "the situation has been magnified out of all proportion to the actual condition; as the facts at our disposal would indicate that any thievery that is present is certainly at a minimum."⁷¹⁴ On 3 November the *Calgary Herald* reported 'thousands' of dollars in petty theft at the CGH. It based the report on testimony from an undercover private investigator hired by the board. The *Herald* claimed to have known since the summer, but refrained from printing anything so the investigation could be completed. According to its report an employee said 'we just take as much as we can get away with,' and an administrator admitted the problem was 'serious.'⁷¹⁵ The article was sensationalist, but conceded that the theft was limited to linens and utensils—meaning no medication had been pilfered—and that the perpetrators comprised a small fraction of the staff.

Internal documents suggest Dyck was less concerned. To Alderman McIntosh he wrote "in all honesty I must agree that there is likely some petty stealing present in our hospital buildings; however, if there were none we would be in a most enviable position, for this is a problem facing all large hospitals in Canada."⁷¹⁶ Dyck blamed the last decade's growth of hospital buildings. The campus now covered a four-block area, but had not increased its staff which reduced supervision for all employees. Early in November the CGH dismissed two men who worked in the kitchen area.⁷¹⁷ Theft was an old problem. During the 1930s safe rooms became common for medication. In the

⁷¹⁴ "Mr. Dyck, Business Manager CGH to Alderman McIntosh Calgary Hospitals Board" 13 November 1961, 1. File 2 Box 6 CGH Fonds AHS Archives

⁷¹⁵ "Thousands of Dollars in Theft Uncovered At General Hospital," *The Calgary Herald*, 3 November 1961, 27.

⁷¹⁶ "Mr. Dyck, Business Manager CGH to Alderman McIntosh Calgary Hospitals Board" 13 November 1961, 1. File 2 Box 6 CGH Fonds AHS Archives

⁷¹⁷ "Thousands of Dollars in Theft Uncovered At General Hospital," *The Calgary Herald*, 3 November 1961, 47.

early 20th century the TGH stamped crockery to make it identifiable. Theft crossed staff and class lines; staff stole from patients, patients from patients, staff from the hospital, and patients from the hospital. By the early 1960s it was a political problem. Unlike embezzlement in the private sector this theft affected an institution funded by and for the public.

A convalescent-rehabilitation (C-R) building upon the former site of the CGH III had been under construction since 1958, it would add between 175 and 200 beds and was nearing completion in January 1962. The CHB invited the public to join in the celebration.⁷¹⁸ An official opening was planned for 4 February with formal invitation issued to approximately 275 people. CGH surgical and psychiatric services were limited; the C-R was a direct response to the former and an indirect solution to the latter. The increased bed count relieved pressure in other buildings, especially the main where existing operating rooms were located. Staffing remained a bugbear for administrators. However, unlike traditional staffing issues—lack of skilled candidates—the current dilemma was partly seasonal. During the summer vacationing surgeons disrupted operating room schedules.⁷¹⁹ The other half of the equation was physical space. Population increase—doubling between 1956 and 1971 to over 400,000—and broadened the scope of treatment meant more people sought hospital care. Existing surgical facilities had been designed for a bed capacity of 570, but the CGH now had 952. The surgical committee suggested at least 8 major operating rooms had to be added in addition to renovating existing surgical facilities.

Psychiatric facilities prior to the C-R building consisted of only 22 beds. When these filled, as they did frequently, patients occupied beds in the emergency unit or were transferred to temporary accommodation on B west. In comparison, Edmonton General had 68 beds for psychiatric patients. It had other advantages. The Provincial Mental Institution was located in nearby Oliver allowing easy

⁷¹⁸ “Minutes of the Regular Meeting of the Calgary Hospitals Board,” 29 January 1962, 1. File 3 Box 6 CGH Fonds AHS Archives,

⁷¹⁹ “Report on Surgery,” 23 May 1962, 1. File 3, Box 6 CGH Fonds AHS Archives

relocation of patients. The CGH had to send its overflow 120 miles north to Ponoka. Prior to the C-R building psychiatric occupancy hovered around 95%. Some patients were under mandatory detention due to the Mental Disease Act (MDA), and did not count as inpatients which meant no provincial payments.⁷²⁰

The C-R building expanded provision for ‘day care’ with its capacity for occupational and diversional therapy. The programme helped keep the mentally ill out of police cells.⁷²¹ An interesting development among members of the psychiatry division was consensus that there was no need for special protective devices anywhere that psychiatric patients were housed. In September, the CHB designated 20 beds on the 3rd floor of the C-R building for minor psychiatric cases, allowing B wing to care for more serious cases.⁷²² The C-R represented a broadening of the CGH’s scope. Like its counterparts in Toronto, Winnipeg, and Vancouver it had always been an active care facility. Thus, it avoided convalescents because they occupied beds with untreatable patients, prolonging length of stay statistics, and inconvenienced or harmed others. Psychiatry helped blur the lines between convalescent, chronic, and active treatment.

In April 1965, the board met to outline a plan for future expansion. One member noted how “for the last eight or nine years, this hospital has been working under serious handicaps, caused by a previous lack of planning for hospitals.” The Foothills would have most its beds unavailable until the end of 1966. The Rockyview would not be open until 1967. Holy Cross was adding 170 beds, but it was at least two years away from completion. This reduction in alternative accommodation pressured the CGH during 1966 and 1967. Changes were needed, and they had to come by addition

⁷²⁰ “Dr. J. C. Johnston CGH to Alderman McIntosh,” 27 August 1962, 1. File 3 Box 6 CGH Fonds AHS Archives

⁷²¹ Ibid, 2.

⁷²² “Minutes of the Regular Meeting of the Calgary Hospitals Board,” 13 September 1962, 3. File 3 Box 6 CGH Fonds AHS Archives

rather than renovation to avoid further disruption.⁷²³ Mr. Hookway estimated that it would take \$2,000,000 to provide new buildings, and only after extensive research and planning were carried out.

The lack of sufficient facilities caused frustration for patients as well as administrators. Surgical facilities were so overbooked that they often waited between three to five days *after* being checked in. Patients could check themselves out on a ‘short leave,’ but they had to pay for the accommodation anyway.⁷²⁴ Medicare would have covered the stay had the patient remained in hospital. If they chose to pay for the leave pass it was effectively purchasing a placeholder in line. It led to extra costs on the part of the patient, and created unoccupied, but unusable, beds in the hospitals. Enough patients were willing that the issue was a topic at board meetings.

In 1965 the CGH hired Agnew Peckham hospital consultants, and architects Stevenson and Dewar to assist in planning for expansion, but a serious administrative issue stood in the way. In July Dr. Jas R. Francis, the western representative of the Canadian Council of Hospital Accreditation, contacted CGH executives. He alarmed administrators by stating “in comparing this hospital with what is done elsewhere, there is a lack of control of what goes on in the hospital, and a lack of control of the medical staff. The reason for failure to do what should be done is because this hospital has a democratic system.”⁷²⁵ The democratic system Dr. Francis referred to—in his words a “popularity contest”—was the practice of allowing the staff of each department to elect their own departmental head every two years. Dr. Francis suggested the term’s brevity prevented the position being taken seriously, and that staff members were unlikely to elect anyone strict. His view was that

⁷²³ “Minutes of the Meeting of the Committee of the Whole of the Board,” 8 April 1965, 1. File 3 Box 6 CGH Fonds AHS Archives

⁷²⁴ “Minutes of the Meeting of the Committee of the Whole of the Board,” 22 April 1965, 1. File 3 Box 6 CGH Fonds AHS Archives

⁷²⁵ “Minutes of the Special Meeting of the CHB,” 28 July 1965, 1. File 3 Box 6 CGH Fonds AHS Archives

department heads should be appointed to longer tenures by the executive committee based on merit and efficacy.

Dr. Howard P. Wright, Chairman of the CHB, accepted the concerns of Dr. Francis, and put forth a resolution to ensure the CGH did not lose its accreditation. As hospital management solutions went it was highly predictable; Wright established a committee and ordered a study. Dr. Wright's motion called for the formation of a committee that included Dr. Francis. It would review the medical staff and bring a report to the CHB. From there, the committee was to prepare recommendations as to which staff members should take over each department. Thus, voting would be indefinitely curtailed. Finally, the CHB would appoint new heads without term limits.⁷²⁶

Dr. Francis lauded the CHB's proposal on the grounds of patient welfare. He wrote "we are interested in patient care, but...the attitude of some members of staff is that they are going to do certain things, rules notwithstanding and see what happens."⁷²⁷ The good of the patient could be at odds with the good of the medical profession. If doctors sought only to advance their careers under lax departmental regimes, then in the long-run the patient and institution suffered. Patient welfare had long been an effective rhetorical tool; however, Dr. Francis was a practicing surgeon with special expertise in managing medical staff, making his comment at the highest level of administration. Here the idea of patient welfare helped bring about a staff change. Such infighting deepens an understanding of doctors by demonstrating their professional concerns. The administration no longer faced the interests of local doctors; national and at times international interests exerted pressure.

In January 1966 Mr. F. Hall representing the Agnew Peckham and Associates along with architects J. Stevenson and E. Raines of Stevenson and Associates presented suggestions for the

⁷²⁶ Ibid.

⁷²⁷ Ibid, 6.

future of the hospital campus. Hall unveiled schematic drawings of the proposed alterations and additions. He noted that “since the present building had been erected, the conception of hospital building has changed over radically,” and new buildings should be “capable of expansion.”⁷²⁸ Raines spoke in support of Hall’s plan; however, it would take at least nine months to produce preliminary drawings which the board wanted before it requested a provincial grant. The board was pleased with the overall scope of Hall’s work and approved in principle his plan to add a five-storey—90,000 square foot—addition south of the hospital. Some members bristled at what the project might cost. Mr. Hookway, formerly the City’s comptroller, asked if it was possible to modernize essential services, or pursue something cheaper. Members such as Mr. English and Mrs. Walker agreed the five-storey plan was expensive, but they had been impressed by the presentations. This was especially true about Hall’s pitch as he tapped into the vogue of hospital planning; versatility, flexibility, adaptability, and thwarting obsolescence. Hospital administrators were no less immune to the dream of perpetually modern facilities than architects or consultants.

By September 1966 plans had advanced appreciably. To save time, Raines drew a layout of the surgical floor that could be copied throughout the building and on any additional storeys. During the summer he visited the Swedish Medical Centre in Seattle and met with its surgical directors. Upon review, they endorsed his floor plan. Raines was optimistic that construction could begin in June 1967 so long as funding and supplies were forthcoming.⁷²⁹ The June date proved unrealistic. Raines made a final major report to the CHB in April. If the board approved, he hoped to be able to move ahead with tending and begin construction in August. The CHB remained concerned about cost. The final estimate was \$30.00 per square foot, or \$3,299,400 in total. Once the architect's fees

⁷²⁸ “Minutes of the Regular Meeting of the Calgary Hospitals Board,” 27 January 1966, 1 File 1 Box 8 CGH Fonds AHS Archives

⁷²⁹ “Minutes of the Regular Meeting of the Calgary Hospitals Board,” 20 September 1966, 1 File 1 Box 8 CGH Fonds AHS Archives. The ‘Swedish Hospital’ was founded in 1910 as a non-profit hospital.

and renovations were factored, the cost rose to \$3,788,480. Cost of renovation was estimated at \$20.00 per square foot. The fact that renovation would cost 66% per foot of what new construction served as further evidence to administrators that building from scratch was always better.⁷³⁰ Ground breaking commenced on 19 September 1967 with a small celebration that included Reverend J. J. Cunningham, Mayor John “Jack” Leslie, and Chairman Wright.⁷³¹ The celebration was a toned-down affair as delays were hard to celebrate, and September could not be disguised as June.

Teaching had long been a part of the CGH’s function, but in 1967 the CHB began regarding it principally as a teaching hospital. At a meeting of the medical executive committee in June Dr. McEwen stated that it was “correct” to describe the CGH as a teaching hospital, and reminded the board that the university was going to play a more significant role in educating doctors for general practice. Some associated with the CGH did not wish the move to be too drastic. A member of the medical advisory committee asked: “Is this hospital to be a teaching hospital within the sphere of influence of the University?” The board agreed it should be a teaching hospital, and was “willing to cooperate, but wished to maintain its autonomy as a community health centre.”⁷³² Teaching was important, but the board was not inclined to see its authority usurped by the university.

In 1969 hospital chairman S. A. English, vice-chairman M. Chorny, and alderman J. Ayer met with three planning firms. The first was Kates, Peat, Marwick and Company who impressed with their “Madison Avenue approach and the very evident fact that they had done their homework.” Meanwhile the Woods, Gordon and Company—who worked for the TGH in 1960s—struck administrators as unprepared. The final organization, Wilson and Associates, lacked enough

⁷³⁰ “Minutes of the Regular Meeting of the Calgary Hospitals Board,” 27 April 1967, 1-2. File 1 Box 8 CGH Fonds AHS Archives

⁷³¹ “Minutes of the Combined Meeting of the Medical Advisory and Medical Executive Committee,” 28 September 1967, 3. File 4 Box 6 CGH Fonds AHS Archives

⁷³² “Minutes of the Combined Meeting of the Medical Advisory and Medical Executive Committee,” 8 June 1967, 2-3. File 4 Box 6 CGH Fonds AHS Archives

experience specific to hospitals. In a colourful simile Chorny described the board's actions as that of a "young married couple running to consult a marriage counsellor before they talked between themselves." She did not deny the value of external consultants but felt as there was also value in "asking our administrators to put their heads together and bring us a report." The 1900s were the consultant's century. Their words helped shape administrative, medical, and civic thought about hospitals. For an administrator to suggest that the knowledge of these individuals was not so different from what internal employees possessed was almost revolutionary. In closing she noted "I don't believe I have to remind you that 'people' are the most important part of this hospital."⁷³³ Chorny implored the board to have confidence, and remain central in shaping the CGH's future.

The 1970s was one the CGH's busiest decades. Several buildings were added: the Gertrude M. Hall Memorial wing in 1970, the South Service Wing (F-building) in 1971, a three-storey addition to it in 1973, and the completion of a Centennial Wing (G-building) in 1977 that also provided psychiatric care. In 1979 the board embarked on an extensive expansion and renovation program from which arose the idea of two 400-bed hospitals as opposed to a single, large main building. The plan culminated in 1988 in the Peter Lougheed facility when the CGH became 'one hospital on two sites' with a combined capacity of approximately 1,000 beds.

The idea of maintaining two sites emerged as early as 1971. Consultancy literature generally warned administrators about the risks associated with hospitals becoming too large. Based on this advice hospital planners typically pursued linked facilities. Patient welfare emerged as a pivotal component in solidifying concerns over facility size. At a meeting in 1971 Dr. R. C. Selby raised the relationship between staff size and quality of patient care. He noted "when the medical staff of a hospital becomes too large, this constitutes an encumbrance to good patients care, it is difficult to

⁷³³ "Report of Vice-Chairman Concerning Meeting with Hospitals Consultants," 28 May 1969, 1. File 1 Box 8 CGH Fonds AHS Archives. A note on language – vice-chairman is preserved to be consistent with the documents, M. Chorny was a woman. Quotes earlier in the paragraph are Ibid.

control a large staff, organize it, to undertake educational activities, and maintain medical records.”⁷³⁴ Many departments were understaffed as it was. Specialist areas such as dermatology and gastroenterology struggled to attract experienced practitioners.

In 1970 the Gertrude M. Hall memorial wing opened. Hall had been the CGH director of nursing from 1952-1960.⁷³⁵ In September 1971 the CGH closed its nursing school, the oldest in Calgary, following “the nation-wide trend to place the preparation of nurses in an educational setting.”⁷³⁶ It had been in operation for 79 years and graduated over 2,940 nurses. The responsibility for training nurses now rested with the university. Thus, the boundaries between two of the defining institutions of post-Second World War Canada, namely the hospital and the university, were shifting toward increased cooperation.

Increased involvement in public health issues nudged the hospital towards a standard of patient care divorced from moral judgements. At a meeting in May 1970 the board discussed drug use. The CGH was concerned about a rumour that “emergency wards were telephoning police with every actual drug problem.” The board did not believe that the CGH had reported any patients, but it was possible other institutions had. Ambulance drivers, as civic employees, were theoretically required to report any crime they witnessed which would include drug use. Alderman Farran defended the practice on those grounds. Alderman Ayer skirted the issue asking, “if we are going through changing times, should we look at the ambulance contract and take a different attitude toward the drug user?”⁷³⁷ The board felt the effects of drugs were unclear and was reluctant to act; some staff doctors argued marijuana was less harmful than alcohol. The board ultimately settled on

⁷³⁴ “Minutes of the Meeting of the Joint Conference Committee,” 23 March 1971, 1. File 4, Box 6 CGH Fonds AHS Archives

⁷³⁵ “Copy of information sheet and questionnaire sent to Dr. Hoat and Mary Wilson,” 3 November 1983, 1-2. File 9, Box 33 CGH Fonds AHS Archives

⁷³⁶ “School of Nursing Closing,” 1972, 1. File 1, Box 29 CGH Fonds AHS Archives

⁷³⁷ “Minutes of the Regular Meeting of the Calgary Hospitals Board,” 28 May 1970, 5. File 1 Box 8 CGH Fonds AHS Archives

putting patient welfare first, and resolved board resolved that any sick person should be helped. It passed a resolution to keep a psychiatric nurse in the emergency entrance area. The board even considered providing valium to these patients, but opted not to due to concern over possible chemical complications.⁷³⁸

In 1972 the CGH hired the Stevenson, Raines, Barrett, Hutton, Seton and Partners architectural firm to oversee plans to the service wing to expand obstetrical facilities and laboratory space. Construction began on 23 November 1972 and finished 31 July 1973.⁷³⁹ At the same time plans for construction of a Centennial Wing were underway. On 4 October the Alberta Hospitals Services Commission (AHSC) wrote to the CHB to grant permission to begin construction and draw up future plans.⁷⁴⁰ Stevenson architects Hugh Seton and Dave Thompson began drafting, which now included a psychiatric wing. Floors 3-6 of the original building would receive renovation worth \$3,462,194. The intensive care unit would include an electrical vault and penthouse for a total of \$895,457. A new food service system including equipment, installation, and necessary structural alterations was estimated at \$2,313,370. The psychiatric unit—with remand and detention floors—cost \$7,304,897. A final expense of \$100,000 was added to the city budget for demolition of the Perley Wing.⁷⁴¹ The Perley found a niche as a maternity and children's facility, but by 1973 was worth less than the ground on which it stood.

The year 1974 was something of a bridge between two eras. The Perley wing—the oldest building on campus—was demolished, and the final class of nurses from the CGH School of Nursing

⁷³⁸ The relationship between what have become 'recreational' drugs is an area of medical history that requires more exploration. It is easy to forget how many drugs originated as medicine. Two Canadian histories include Marcel Martel, *Not this time: Canadians, public policy, and the marijuana question, 1961-1975* (Toronto: University of Toronto Press, 2006) and Stuart Henderson's *Making the Scene: Yorkville and Hip Toronto in the 1960s* (Toronto: University of Toronto Press, 2011) Henderson also explores drugs such as LSD.

⁷³⁹ "Minutes of Regular Meeting of the Calgary Hospitals Board," 23 November 1972, 2. File 1 Box 8 CGH Fonds AHS Archives

⁷⁴⁰ "Minutes of the Calgary Hospitals Board," 4 October 1973, 1 File 2 Box 8 CGH Fonds AHS Archives

⁷⁴¹ "Minutes of the Calgary Hospitals Board," 4 October 1973, 2 File 2 Box 8 CGH Fonds AHS Archives

graduated. Simultaneously the additions of the previous two years were completed, and construction of the Centennial Wing was imminent since it would stand partly where the Perley had. The final two relics of an older era of hospital organization had disappeared. The replacements were part of long-ranging plans. They represented notions of function that extended beyond the immediacy of a filled ward or an outraged public to a broader vision of what the administration, and to some extent the university, hoped to see from the campus going forward. CGH administrators and planners in the provincial government alike were desirous for buildings with longer life spans. They were influenced by architectural optimism that buildings could last longer thanks to design that allowed for inexpensive, though major, renovations.⁷⁴²

In April 1974, the Calgary Area Hospital Planning Council sent the CHB more bad news. The Minister of Health would be placing emphasis on “improving health care in the community in the facilities that presently exist. Therefore, it is not likely that any new facilities will be developed nor any of the existing facilities increased other than those that have already received provincial approval.”⁷⁴³ An additional important aspect of the council’s plans was it began investigating sites in Southwest Calgary near the Lake Bonavista with a mind to purchase the area for the purpose of future development. The final area of the Peter Lougheed Centre in 1988 was approximately 23 km northeast of Lake Bonavista, but this was the start of looking for property in that area.

In August 1974 with the Perley Wing demolished the Stevenson firm began evaluating builders. Cascade Builders Ltd. presented the lowest bid for construction manager of the psychiatric building. The Stevenson firm warned that over the past five years Cascade had only been involved in three large-budget projects, and they were ‘simple’ apartment or office buildings. Stevenson added that in all recent builds Cascade listed at least one professional designer as a consultant, and did not

⁷⁴² Eberhand H. Zeidler, *Healing the Hospital: McMaster Health Science Centre: Its Conception and Evolution* (Toronto: Zeidler Partnership, 1974), 2, 5-6.

⁷⁴³ “Minutes of the Calgary Hospitals Board,” 4 April 1974, 2 File 2 Box 8 CGH Fonds AHS Archives

have a registered engineer on staff. Stevenson noted “hospital construction is a field quite different in scope and complexity to the commercial apartments area, where very often the builder himself modifies design to meet economic consideration which may arise.”⁷⁴⁴ The CHB’s architectural advisors placed a premium on experience. Three members opposed Cascade in the final vote, but on 14 August in a movement seconded by Mayor Rod Sykes they got the contract.⁷⁴⁵

On 8 July 1975, the board decided on the construction contract, recommending the Poole Construction Company. The CHB had to forward plans to the city, which in turn sent them to the AHSC for approval and funding. It was a significant project, covering over 230,000 square feet, at a cost of \$15,666,282.⁷⁴⁶ The time between excavation and completion hospitals was a difficult period for administrators. On 4 March 1976, the board, in response to the “Government’s limited support for hospitals,” reduced services by closing 63 beds in the North Wing, 14 surgical beds on 1 West, 20 surgical and a further 21 psychiatric beds in the C-R building, and the diabetic day care centre. The board amalgamated the nursing units on 2 west and 2 south to take 31 beds out of service. When deciding which floors to close the board harkened to the desire for adaptability and ‘plastic space’ so important to the 1970s. “Areas of concern including occupancy rates, support services, and fear of inflexibility,” governed the decision, and the board believed it had reduced capacity as efficiently as possible.⁷⁴⁷

Late in 1977 the Centennial Wing was officially opened. CHB chairman L. W. Roberts presided over a ceremony with an opening address by Gordon T. Miniely, cabinet minister of hospitals and medical care. The ceremony included the unveiling of a mural paid for by CGH

⁷⁴⁴ “Letter from Stevenson, Raines, Barrett, Hutton, Seton, & Partners,” 4 August 1974, 2. File 2 Box 8 CGH Fonds AHS Archives

⁷⁴⁵ “Minutes of the Calgary Hospitals Board,” 14 August 1974, 2 File 2 Box 8 CGH Fonds AHS Archives

⁷⁴⁶ “Minutes of the Calgary Hospitals Board,” 8 July 1975, 3 File 2 Box 8 CGH Fonds AHS Archives

⁷⁴⁷ “Minutes of the Calgary Hospitals Board,” 4 March 1976, 3 File 2 Box 8 CGH Fonds AHS Archives. See Appendix V, Images 5.5 and 5.6. The former showing how technological innovation was changing hospital procedure and the latter for an aerial overview of the campus in 1976.

employees, dedication of a chapel by a coterie of priests, and *O Canada* performed by a soloist and pianist. The CHB produced a brief pamphlet that reiterated how its philosophy remained “a concern to give the highest calibre of care of its patients,” and that would be “actualized not only through the human concern and expertise of its staff, but also by having modern and up to date facilities.” The new Centennial Wing would “reflect this responsibility to patients, but also meet the needs of the community as well as the continuing education needs of its hospital staff and affiliated students.”⁷⁴⁸ The ceremony lasted for an hour, followed by tours. Administrators wanted the building ‘working’ as soon as possible.

By 1980 time and efficiency determined more than the brevity of public ceremonies. A regime of discipline was pervasive. Patient experiences reflected these changes. New rules dictated how many visitors could enter a room at a time. Supplemental insurance was required for private or semi-private rooms—with exceptions for pediatric, psychiatric, labour, intensive care, day surgery, and ophthalmology. Patients were forbidden from bringing medication with them. The institution’s ‘voice’ was changing too. The size of the institution and its openness to the public required a means of readily identifying patients as people and medical cases. “Upon admission you will be issued a bracelet showing you name, sex, age, hospital number, doctor, and date of admission. The bracelet is for your protection, ensuring the hospital staff treats the correct patients. Babies and mothers wear matching bracelets. This identification must not be removed until after your discharge.”⁷⁴⁹ Technological change occurred too; televisions proliferated throughout lounges and waiting rooms, patients brought battery-operated radios, and rented telephones in their rooms. The hospital grew, paradoxically, more comfortable and cold.

⁷⁴⁸ “CGH Centennial Wing, Official Opening Program,” 2 December 1977, 1. File 3 Box 40 CGH Fonds AHS Archives

⁷⁴⁹ “For your information: A Handbook to Acquaint you with the CGH Hospital Policies and Service,” 1980, 5, 7, 18-19. File 1 Box 43 CGH Fonds AHS Archives. Quote is on page 7.

The CGH campus changed significantly between 1960 and 1980. The CGH that existed at the end of the 1970s was incomplete. It made major advancements such as the 1977 Centennial Wing, and was becoming increasingly involved in medical research and education. Fed on oil revenues administrators embraced a philosophy of demolition and rebuilding. The apogee of this ethos was the CGH's fifth move to the Peter Lougheed site in 1988. The site was smaller, and a volatile oil market caused delays in construction. However, it reflected a mindset that even when major crashes—such as in 1973—took place revenues would recover and lead to new buildings. The decision to split the CGH into 'one hospital on two sites' almost hearkened back to an older pavilion style except that the distance between the two would be large enough that they could not be considered to share a campus. Instead, administrators placed convenience over efficiency when funds were plentiful. The CGH remained uniquely strange. It was an institution of central import to the city and surrounding area, but it did not achieve the emotional connection observable in cities such as Winnipeg.

Vancouver 1961-1980

The VGH saw few major building projects or institutional realignments between the years 1961 and 1980. The 1960s had its share of problems: the Heather Annex drew the ire of patients and staff alike, in 1964 the Laurel Street Pavilion—erected in 1929—was demolished, and for most of the 1970s the Centennial Pavilion was the only building consultants and architects deemed worth using. By 1966 the facility boasted 1,578 beds, but administrators still set their sights on acquiring more space for mental health care, teaching, expansion to the Centennial Pavilion, and additions for surgical day care. The lull in construction during this period clarified how important the Centennial Pavilion was to the campus. VGH administration relied on it to hold the line when issues arose, and it served as a useful symbol to remind the public of the institution's success and medical importance.

In June 1961, the medical board addressed staff and patient concerns relating to the Heather Annex. The minutes present a mixture of naked honesty and equivocation. They provide a glimpse

into the way space was experienced in different ways depending a patient's class and gender.⁷⁵⁰ One could add medical condition to that list. The board admitted that "it is recognized that the [Heather] Annex is not the most attractive hospital in many regards. It is an old building, which was cleaned up a few years ago [in 1955]." Patients were no longer sent to the facility for intravenous therapy or complicated treatments. The report noted the significant number of senile patients held there, and that it was still functional as a nursing home since building code requirements for that type of facility had lower baselines—a single storey frame building could suffice. "This is not an admission that the Hospital Annex is not a good place for this type of individual," noted the minutes.⁷⁵¹ Here space correlated with patient 'types,' shaped their clinical experience, and revealed how administrative perspectives on space were not impartial.

One of the largest initiatives of the 1960s was the modernization programme to improve utilization of the Laurel Pavilion site. Demolition was a foregone conclusion. "Without conversion, the building could not be used economically to provide present-day standards of hospital care. But conversion for any hospital services would be so costly and require so many compromises that a replacement of the building is valid." Once erected the new building would provide state-of-the-art health services for "mothers and newborns, and for the treatment of certain health problems of women."⁷⁵² The plan resulted from administrative indecision. In April 1962 voices as powerful as the chairman Dr. Gould favoured the anathema approach of renovating and repurposing old buildings over new construction. The matter was ultimately returned to the building committee, which issued a new report favouring demolition in May.⁷⁵³ The board intended to seek funds for the

⁷⁵⁰ For the best example of this approach see Annmarie Adams, *Medicine by Design: The Architect and the Modern Hospital, 1893-1943* (Minneapolis: University of Minnesota Press, 2008)

⁷⁵¹ "Minutes of the Medical Board," 19 June 1961, 4. File 1, Box 584-A-7 VGH Fonds CVA

⁷⁵² "Modernization Programme of the VGH: Utilization of the Laurel Pavilion Area," 1962, iii. File 2 Box 584-A-7 VGH Fonds CVA

⁷⁵³ "Minutes of the Medical Board," 16 April 1962, 1 File 2 Box 584-A-7 VGH Fonds CVA

project from provincial and federal grants, but those could only be acquired if the City of Vancouver relinquished its ownership of property near and adjacent to the Laurel and Willow Pavilions.

Much like their brethren in the CHB, VGH administrators stressed their intent to provide the best patient care to the citizens of Vancouver. The board argued that all administration, patients, planners, architects, and nurses suffered due to current arrangements, and that renovation would not help. “Conversion of the building to chronic care, active chronic care, psychiatry and other long-term services will over-tax the ingenuity of any planner.” Forced renovation would drive up costs by at least \$6.00 per patient day; a burden the provincial insurance service would not bear. Doctors and nurses felt hobbled in the inadequate space and that hindrance, it was alleged, would have long-term repercussions for the institution and city.⁷⁵⁴ A new building could provide facilities for maternity, reduce stress on the rest of the campus, and raise the bed count from 1,594 to 1,758. The board valued efficiency and bed capacity evenly, believing there was cooperation to be found between them.

Evaluation of space by its efficiency was not limited to medical use. Administrators dismissed the suggestion that the pavilion would be converted to non-patient services. Clerical space “must be planned to produce the most efficient and economical work-flow in the interest of useful efforts for personnel as well as from the specialized equipment that must be installed.”⁷⁵⁵ The structure required more than renovation, it needed relocation. ‘Core services’ such as the patient’s kitchen, central supply, and department of social work were in the Centennial on the other side of campus so access was limited. The placement of core services in the Centennial was by design and indispensable to the VGH’s long-term plan. Relocating them, it was claimed, would send a disruptive ripple through the entire campus. The report referred to this problem using the language of

⁷⁵⁴ “Modernization Programme of the VGH: Utilization of the Laurel Pavilion Area,” 1962, 6. File 2 Box 584-A-7 VGH Fonds CVA

⁷⁵⁵ Ibid, 8.

futuristic planning. “For reasons of economy a hospital must run as a unit...to shift central core services to the periphery would be unreasoned planning...indefensible inconvenience would be imposed on the staff by lengthened horizontal communications.”⁷⁵⁶ The current plan called for overhead, ground-level, and tunnel connections to ensure the Centennial could be easily reached from nearby buildings. Much has been made of the influence of architects, patients, administrators, politicians, and doctors in the various ways their thoughts and expectations influenced design, but buildings also had influence by virtue of their permanence.

The May report was convincing, and the board sent executive director, L. N. Hickernell to make the case to the city. In a June 1962 J. N. Robertson, public relations director for the hospital sent a blunt warning to Hickernell about what might happen if the city rejected the report. “In presenting again the Laurel Pavilion program to the city it is believed to be essential that the Hospital’s case should be established upon an existing community need for an improved standard of Obstetrical service which can be provided through the proposed building.” It went further suggesting, “In effect, the Council, by its action in respect to the necessary transfer of land and title, will be in the position of denying the community, or facilitating, a much-needed service to Mothers and Babies.”⁷⁵⁷ Here the VGH sought to leverage public opinion against the city, and force its hand. Such tactics are explained by the internal decision to destroy the Laurel Pavilion. Talks with the city hit a snag on finances. Even so city cooperated by transferring real estate needed for expansion to the VGH. Victoria pledged \$1,989,000.00 toward a new building, and Ottawa offered \$2,000 per bed. The VGH expected the city to cover the rest. Its hesitation led to a spike in costs. By March 1964 estimates had risen from \$4,000,000 to 5,800,000 of which the “city’s share” was \$2,340,000.⁷⁵⁸

⁷⁵⁶ Ibid, 9.

⁷⁵⁷ “Interoffice memo J. N. Robertson, Public Relations Director to L. N. Hickernell, Executive Director,” 26 June 1962, 1. File 2 Box 570-A-5 VGH Fonds CVA

⁷⁵⁸ “Banfield Press Statement,” 18 March 1964, 1. File 2 Box 570-A-5 VGH Fonds CVA

In the afternoon on 16 April 1964 the board announced it would move forward with plans for the Laurel Pavilion site, and awarded the demolition contract to Merchants Cartage. It promised in only a few weeks that “the staccato chatter of Jack Hammers and the crunch of the wrecker’s ball will loudly sound.”⁷⁵⁹ The board issued a press release that emphasized the necessity of demolition. The Laurel was “inflexible to change and is now obsolete. The hospital has a very real responsibility to the community in maintaining facilities adequate to the demands of the day...[that] means recognising that major changes to our physical plan are, and always will be, necessary.” Rebuilding the Laurel was “the first step to providing a much-needed new facility which will benefit thousands of patients.”⁷⁶⁰ The board’s victory cannot be removed from the physical context. The Centennial’s design required centralization.

As the Laurel Pavilion’s walls came down, the VGH began planning for a new building. A tentative design appeared in June 1964, which consisted of 200 beds for gynecology and obstetrics, 80 specifically for gynecological patients, and 20 ‘floating’ to be used for either purpose depending on demand. In addition, it was to include 140 bassinets, with 20 for intensive care, and another 20 for premature cases. The proposal called for 40% of the beds to be public (maximum four per room) 40% two-bed semi-private and 20% single-bed private. In obstetrics, each nursing unit was to contain 36-40 beds. All rooms had private toilet facilities. Some BC Hospital Insurance Service (BCHIS) research suggested sharing washrooms was less objectionable to patients than administrators might assume. However, the committee preferred obstetrical rooms to have private toilet facilities. The door to each patient room was to have a clear-glass window, though the report noted “this glass is not necessarily for corridor observation but as a safety factor for nursing staff

⁷⁵⁹ “Laurel Pavilion Coming Down,” 16 April, 1964, 1. File 2 Box 570-A-5 VGH Fonds CVA.

⁷⁶⁰ Ibid, 2.

leaving the patient's room with the infant."⁷⁶¹ The window was to prevent nurses from colliding with hallway traffic. Each nursing unit had two separating rooms for patients who had contagious infections or mental issues. In addition, each unit contained ten sitz baths—small, shallow devices of cleaning between the anus and vulva—six showers and two bathtubs. The units contained a variety of other rooms, some of obvious import such as examining rooms but also areas for medical supplies, and storing suitcases brought by patients.

Important as the wards were—they were the main reason for the new building—a host of services and spaces were needed in the new pavilion. Some of these were functional: each floor required public washrooms, waiting areas, and payphones. Other factors were medical or professional. For instance, the BCHIS favoured a 'British approach' to obstetrical suites that involved a designed delivery bed in a small room. Plans called for 7-10 labour rooms each with a private washroom. There would be four case rooms, with air conditioning and separate rooms for caesarians as well as circumcisions. Post-delivery rooms would contain 2-4 beds, and there would be a nearby suite for gynaecological operations. The University of British Columbia was promised 5,000 square feet for laboratories, staff offices, and research. Finally there were social areas. Family visiting rooms, space for the preparation of formula, and maternal instruction. Other areas straddled the social and economic sphere: a gift shop run by the women's auxiliary, a baby photo service, and beauty salon.⁷⁶² The hospital was becoming ever more integrated with the community. It was a regulated space, but also a porous one.

While the pavilion had social functions, its nurseries were an entirely different matter. Strict regulations related to these spaces. No more than 10 infants could be accommodated in the same room, and each bassinette required 25 square feet of space. There was one isolation nursery that

⁷⁶¹ "Committee Studying the Requirements for the proposed New Building for Obstetrics, Gynaecology and Newborns," 15 June 1964, 1-2. File 30, Reel 34 VGH Fonds CVA

⁷⁶² Ibid, 6,9, 10-14.

contained eight cubicles for high-risk or sick infants. A separate area housed 40 incubators for premature infants, each requiring a minimum of 36 square feet. Even air was subject to a technological regime. A forced air draft positive pressure ventilation system would perform 12 air changes per hour.⁷⁶³ Infant's physiology was an influence on design.

The architecture of the new building was informed by a high value on flexibility and efficiency. The new pavilion reflected medical need and expectation while attempting to maintain the cadence of social life. For instance, all obstetrics wards were to have a socialization area capable of accommodating approximately 50% of patients on the ward. These areas were off-limits to non-patients, and in some sense was an echo of a bygone era when the ward was as much a social as a medical experience. Efficiency dominated discussion of essential services. The plan called for single-room utility spaces if at all possible, and even then to add bed pan sinks in them to maximize use-value. Gynaecology wards were largely identical to obstetrics except that it had two examining rooms per ward rather than one.⁷⁶⁴

The 1964 annual report was an attempt to remind the public of the Laurel's importance. As of January 1965 the hospital employed more than 3,000 people and spent approximately 72%—\$12,700,000—of its annual operation budgets on salaries. Average length of stay hovered around 13.6 days. Occupancy was very high at 91.9%, leading to the accumulated 533,203 patient days. The board implored the public to consider how “new equipment, new procedures, new concepts of care have occasioned the need for more space, more material and mechanical aids, more financials support, new skills and added knowledge, all of which call for continued planning in every sphere of the hospital's operation.”⁷⁶⁵ The Laurel demolition reduced bed capacity by 135 and lowered total capacity down to 1,867. Also in 1964, an anonymous donation financed a three-bed pilot project

⁷⁶³ Ibid, 7.

⁷⁶⁴ Ibid, 3-4.

⁷⁶⁵ “Annual Report of the VGH 1964,” 1965, 1. File 4 Box 570-B-1 VGH Fonds CVA

began in the Heather Pavilion for a dialysis unit. The program flourished and by 1970 produced one of the country's first home dialysis units.

Despite the hopes of administrators for a gynaecology and obstetrics building two factors in the mid-1960s ensured it was never realized. One was of the administration's own doing, and the other resulted from the increased involvement of provincial planners. The Minister of Health, Eric Martin, corresponded with the board and ultimately approved the demolition of the Laurel. Despite this cooperation, the board was sending contradictory messages. On 23 March 1964 a confused Martin wrote VGH Chairman Walter J. McNaughtan outlining the history of the plan since 1961 when it began as a bid for renovation that turned into a rebuilding scheme. Referring to an article that had appeared in the *Vancouver Sun* about the board wishing to construct an 'active chronic unit' Martin noted: "In various correspondence with the BCHIS your hospital spoke of an 'active-chronic unit' facility. In exasperation Martin stated: "It is essential for me to have from your board a statement of precisely what type of facility your hospital proposed to construct."⁷⁶⁶ A month later the gynaecology and obstetrics plans further complicated the matter. The VGH wanted the grant money, but on its terms. The second issue was that the Greater Vancouver Regional Hospital District (GVRHD) was incorporated in 1967 as part of implementation of Medicare. It assumed responsibility for planning and construction, and voided previous negotiations.

The gynaecology and obstetrics expansion never came to pass. In 1966 the consultancy firm of Agnew, Peckham, and Associates—also employed by the CGH at this time—provided short and long-range planning reports to the board. The reports suggested a vision wrapped in the future-oriented language found in comparable reports in Toronto Winnipeg, and Calgary. Just as their

⁷⁶⁶ "Eric Martin, Minister of Health Services and Hospital Insurance to Mr. Walter J. McNaughtan, Chairman, board of Trustees VGH," 23 March 1964, 5. One of the complications was language. There was a need for both rehabilitation care and 'nursing home type care' which was referred to by different names—such as custodial nursing care, continuing treatment care, and extended care—throughout the country according to Martin. Whatever the name, patients were not expected to recover but required nursing attention and occasional medical care as well.

administrative brethren the VGH was deluged in the language of futuristic hospitals. “When the master plan will have been completed, you will have a magnificent, closely integrated and efficient hospital second to none on the continent. Your Consultants have been greatly impressed with the tremendous amount of in work being done in the hospital despite the handicap of several obsolete units.”⁷⁶⁷ What followed were 300 pages that explained the survey, and provided a logistical vision for the future of the hospital campus. The proposal focused on the Centennial Pavilion which it described as “the most recent and satisfactory of the entire hospital.” It lamented the cut-backs during construction as original plans had 18 floors and greater room depth.⁷⁶⁸

The survey provided a three-stage ‘master plan’ that revolved around using “the one modern building—the Centennial Pavilion—as a focus point with a broad base at tunnel, ground, and first floor levels extending to the west, north and later the east and northeast, connecting it with two more patient towers and a service tower.”⁷⁶⁹ Stage I would add an emergency rehab and physical medicine facility west of the Centennial Pavilion. Stage II addressed the east wing surgical suite, ten floors of nursing units (926 beds) doctors’s facilities, medical records and library as well as women’s auxiliary space. This would also include a north wing for laboratories and dietary department rooms, mechanical facilities, and space for teaching. Stage III added more floors to the towers, or another tower if funds permitted. The report railed against the pavilion layout of the campus as it slowed patient movement dramatically. To direct a patient from emergency to the adult outpatient department required walking the distance of two city blocks.⁷⁷⁰

⁷⁶⁷ “Harvey Agnew to Mr. Ross Wilson, Chairman Board of Governors VGH,” 24 June 1966, 1. File 1 Box 585-D-3 VGH Fonds CVA

⁷⁶⁸ “Present and Long Range Program of Development for the VGH: Agnew, Peckham and Associates Hospital Consultants,” 1966, 33. File 1 Box 585-D-3 VGH Fonds CVA

⁷⁶⁹ Ibid, 12.

⁷⁷⁰ Ibid, 43.

Affirmation of the hospital as a community institution was an important objective for consultants. “There is not a widespread recognition that the function of a hospital, a general hospital in particular, should be much broader than they have been in the past. In the evolution of hospitals, it has at last become apparent that the hospital cannot limit its responsibility to those patients who may be within its walls.”⁷⁷¹ Thanks to more reliable funding from Ottawa, hospitals had the potential to extend services beyond urgent needs and provide diagnostic and treatment services to the general public as well as inpatients. The buzzword of the 1960s for this approach was ‘community health care.’ It broke from the tradition of outpatient clinics by attempting to provide more consistent care.⁷⁷² The long-range plan suggested that the hospital could provide care without admitting a patient. This notion dovetailed nicely with the other argument put forward in the report that hospitals should be reducing intake of inpatients to those in urgent need.

The Agnew report proclaimed several of the older pavilions—Willow, Fairview, and Heather built in 1906 and 1929—“functionally obsolete.” Consultants understood the political difficulty in demolishing relatively new buildings. The older pavilions were expendable by virtue of their age, but others such as the North Wing, erected in 1951, posed a problem. “This is such a recently erected building that we are reluctant to suggest that it, too, should be used for a purpose other than patient’s care. However, we cannot see any long range planning in this location and believe that it must have been located here because beds were urgently needed.” Positioning was a problem but it was also architecturally abhorrent: “it continued the old style hospital bed facilities using centralized washrooms, the narrow room depth, and limited nursing service facilities. There are no up-patient

⁷⁷¹ Ibid, 59.

⁷⁷² Ibid, 59, 69.

lounges nor student instruction areas.”⁷⁷³ Up-patient, those who could easily leave their beds, constituted a new constituent for consultants to consider.

The Agnew report signalled a return to the utilitarian ethos not seen in hospital buildings booms during the 1920s and 1950s. Buildings were better if rectangular and modular. “The interesting and aesthetic plain shape of X’s and Y’s and circles have an appeal but are not functionally satisfactory. Both expansion and flexibility of such structures are difficult and sometimes impossible.” The future lay in “vertical expansion and horizontal expansion.”⁷⁷⁴ Demolition was the current necessity, but looking ahead planners and architects considered addition and internal adjustment. Hospitals would add more floors as new technology required. Architects sought a cost-effective way to achieve this without sacrificing the existing structure.

By 1970 there had been no substantive building progress. In its annual report the VGH tried to curry public favour, juxtaposing the “measure of dedication, the sheer hard work, the degree of tension and anxiety that surrounds and accompanies the endeavours of those who skillfully comfort and heal the desperately ill and injured,” with the desired state of patients. The latter included “violently disturbed psychiatric patient[s] bent upon destroying all animate or inanimate things that can be reached, a near-dead derelict from skid-row, a heart surgery or what have you.”⁷⁷⁵ The report dredged up ‘deranged’ patients to reinforce how important the VGH was for community safety, and how important it was to have the funds to expand capacity. It also suggested the advent of Medicare increased the need for modern buildings. The reference to ‘skid-row derelicts’ implied that *all* people now poured into the hospital, and revealed the persistent importance of class after federal hospital insurance formally removed the categories of public and private.

⁷⁷³ Ibid, 36-37. First quote on 36, following one on 37.

⁷⁷⁴ Ibid, 306.

⁷⁷⁵ “Annual Report of the VGH 1969,” 1970, 4. File 4 Box 570-B-1 VGH Fonds CVA

In 1971 the board finally had good news to report. The GVRHD had approved its request for expansion, and the VGH could issue a contract for a 201-bed extended care unit, which would be the first building approved on VGH grounds since 1959. On 7 December 1970, the province granted permission to commence planning for another major project that would look at emergency and ambulatory care. However, public relations comments remained as reminders that the board remained self-conscious about its seemingly superior prowess in drafting plans rather than completing them. “The general public seems to expected ‘them’ (the health field) to provide service. It is increasingly expecting the provision of a high level of health care service as a right to an ever growing population. It does not seem to want to face the responsibility of planning the resources and supplying the funds...”⁷⁷⁶ Planning had come to rival ‘modern’ as the holiest word of hospital administration. Through planning the board hoped to keep pace with advancement, and remain within the constricted budget of a public institution with high expectations.

In December 1972, the extended care unit—the Banfield Pavilion—came into service. Winter openings were not as attractive as spring ones. Publicity was relatively muted until the week of 13 May 1973 when the VGH reintroduced the building to the public with a string of hospital tours to coincide with National Health Week. It was a three-storey building, on the outskirts of the campus at 11th Avenue and Ash Street; it remains in service as an assisted living facility albeit heavily renovated and sporting an additional floor.⁷⁷⁷ In 1973 it had 201 beds. Banfield differed from other buildings on campus in several important ways. For one it had its own ‘area administrator.’ It still relied upon the main campus for logistics such as food services and maintenance, but maintained its own nursing staff and had more autonomy within its walls.⁷⁷⁸ In order to be admitted a patient required a physician recommendation. Wards were limited to five beds. Each floor had four wings

⁷⁷⁶ “Annual Report of the VGH 1970,” 1971, 6. File 7 Box 570-B-1 VGH Fonds CVA

⁷⁷⁷ See Appendix, figures 5.1, 5.2, 5.3.

⁷⁷⁸ “News Release – VGH Hospital Week,” 9 May 1973, 2. File 8, Box 570-A-5 VGH Fonds CVA

which radiated from a central hub where patients took meals, participated in group activities, and received physical therapy. The Banfield boasted the largest square footage per patient among units of this type in the province. Its expanded size resulted from an effort to accommodate more educators. No longer were elderly patients unhelpful in the quest for medical knowledge, and buildings to care for them soon followed.

Three projects occupied the VGH between 1975 and 1980: constructing an additional storey on the Centennial Pavilion, adding a new surgical day care unit, and deciding what to do with the land freed by the Laurel demolition. The most straightforward of these was the additional storey. It was a rare moment where ideals of architectural flexibility were borne out in practice. The building had been designed to bear the weight of extra storeys. The building committee declared the project substantially completed on 26 May 1975. It was not yet functional, but had much bigger problems on the agenda, and took victories where it could.⁷⁷⁹

What to do with the Laurel site and the expansion of same-day surgical facilities was part of a broad expansion project known as the 5-year plan estimated to cost \$106,000,000 between 1975 and 1979. In March 1975 \$1,640,000 had been approved for constructing the surgical day care facility within a one-year time frame. Reports in October came back \$200,000 above budget and the process slowed for re-evaluation. A decision about the former Laurel Pavilion finally crystalized in July 1975 as the ‘New Emergency Department,’ or ‘Laurel Street Project.’ The GVRHD approved the project in principle. When discussions began in January 1975 there was a split in opinion among the building committee. Some members favoured an emergency building, but others argued for general consolidation.⁷⁸⁰ The result, a gargantuan project intended to be the cornerstone in a

⁷⁷⁹ “Minutes of the Planning and Building Committee,” 21 October 1975, 1. File 115 Reel 10 VGH Fonds CVA

⁷⁸⁰ “Minutes of the Planning and Building Committee,” 16 January 1975, 3-4. File 115 Reel 10 VGH Fonds CVA

consolidation of all existing hospital buildings apart from the Centennial Pavilion, addressed both. A large section of Laurel Street had been closed and would be covered by a new building.⁷⁸¹

In 1976 the VGH presented its project goals. The new building would “improve hospital services, create a major emergency facility within greater Vancouver, centralize existing and new hospital facilities, establish a simplified flow and control of traffic, and allow for systemic expansion of hospital services within a long range plan.”⁷⁸² The VGH consisted of 1,516,843 square feet, covering 33.23 acres. More than any other hospital in this study, the VGH embraced the pavilion style popular at the turn of the 20th century. It suffered as layouts trended in a different direction. The board lamented how decentralization had caused expenses to spiral, and saw the Laurel project as a chance to put things right. This could not be achieved without careful consideration. Thus, the planning report culminated in a call for more planning. Beneath the report bubbled two overriding factors: the rising cost of providing medical service and construction, and the “social evolution” whereby health insurance imposed pressure upon medical infrastructure. Health care coverage contributed to the public demand for sophisticated surgical and therapeutic techniques.⁷⁸³ The surgical day care unit began construction on 5 April 1976. It was scheduled for completion in January 1977.⁷⁸⁴ The announcement was somewhat hollow given the same report also indicated that the Laurel project would only have a budget of \$10,000,000.

By 1978 construction had not begun. A variety of consultants had come and gone between 1975 and 1978. One example, H. A. Simon International, was hired to oversee the construction project expected it would be completed no earlier than 1985, and provided the board with such unsettling commentary as “Since we do not have a full understanding of the architect's and detail

⁷⁸¹ “Minutes of the Planning and Building Committee,” 12 August 1975, File 115 Reel 10 VGH Fonds CVA

⁷⁸² “VGH Facility Planning,” 1976, 5. File 4 Box 570-B-3 VGH Fonds CVA

⁷⁸³ *Ibid*, 56.

⁷⁸⁴ “Executive Director’s Report to the Board of Trustees,” April 1976, 7. File 6 Box 569-G-3 VGH Fonds CVA

firms's involvement a detailed scheduled of engineering and construction is difficult to estimate.”⁷⁸⁵

It was this sort of uncertainty that frustrated administrators and doctors. Dr. F. P. Patterson of the Department of Surgery at UBC wrote in 1978 that “A number of us are quite concerned about the Master Plan possibly because of the haste and worry that, though the planner may be very efficient at planning it is not our view that they necessarily understand that we really to have a proper functioning department.”⁷⁸⁶ The 1970s had become a decade of planning with little action.

The Laurel project continued on into the 1990s. In June 1982 the first phase of the project, the largest emergency trauma centre in the province, was completed. It was 32,000 square feet and included an area with separate ambulance entrances depending on whether the patient required observation before admittance, a psychiatric unit, diagnostic unit, and consulting area for teaching. Additionally, it included a separate building for cardiac care with 26 beds and ultrasound diagnostic service. The second phase added a 14-storey building with five floors for administration, and nine for 26 bed nursing units, which amounted to an additional 500 beds. The Laurel project was more than an increase to accommodation or research and teaching, it was a remaking of the campus. Upon completion of the second phase all building with the exception of the Centennial Pavilion and power plant were slated for demolition to make room for a ‘park’ containing tennis courts, walking paths, and a duck pond.⁷⁸⁷ Administration did not expect completion of the plan until the 1990s, but it retained the core objective of centralizing services in modern buildings.

Growth in provincial influence over planning contributed to the stagnation of the 1970s, but so did the type of construction required. Some projects including renovations, demolitions, and additions did take place. Even the decrepit Willow Pavilion received \$500,000 for enhancement in

⁷⁸⁵ “H. A. Simmons International to VGH,” 21 November 1977, 1. File 95 Reel 17 VGH Fonds CV

⁷⁸⁶ “F. P. Patterson, Department of Surgery UBC to Dr. R. W. Lauener, Clinical Associate Dean VGH,” 21 April 1978, 1. File 118 Reel 21 VGH Fonds CVA

⁷⁸⁷ Peter Walton, *The VGH Story: A History of the Vancouver General Hospital, A Century of Caring* (Vancouver: Vancouver General Hospital Public Relations Department, 1988), 2, 4-6.

1977. The VGH in the late 20th century was the subject of numerous planning inquiries, and it had access to funding. However, not enough for a solution to address the main problem as articulated by consultants and administrators which was an antiquated pavilion-style campus. The language of advanced building was an important tool. An article in the *Vancouver Sun* conveyed the board's message 'Present Wards Labelled Obsolete.'⁷⁸⁸ What the board wanted—a hospital of the future—did not finish its first phase until 1982, and its second until after 1990.

Conclusion

Roy Porter's synthesis of the history of medicine, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (1997), accorded much value to medicine without lionizing the profession. Instead it reminded historians that longer life also meant more sickness, injury, and engagement with the medical system. Western medicine had never been able to cope with so many ailments, and yet the 20th century saw several moments of medical impotency such as the 1918-1919 influenza epidemic, Ebola, AIDS, and Marburg fever.⁷⁸⁹ Even in a time of great medical success the patient remains central and health foremost an experience. Medicine, practiced in the hospital or elsewhere, has not *solved* illness, injury, disease, age, or death. The general hospitals—or medical centres—of the 1960s and 1970s were technologically and scientifically sophisticated institutions, but they were by no means complete.

The socialization of hospital and health insurance between 1957 and 1966 affected a cultural change in Canada that contributed greatly to moving hospitals further along a course of social integration. Citizens continued to insist on better facilities and services. The public could also think of health care as something within their reach, and thus worthy of research and the better training of doctors and nurses. In turn the hospital and university became twin institutions financed by the

⁷⁸⁸ "Patient Wards Labelled Obsolete," *Vancouver Sun*. 3, May 1973, 22.

⁷⁸⁹ Roy Porter, *The Greatest Benefit To Mankind: A Medical History of Humanity* (New York: W. W. Norton and Company, 1997), 710.

public purse. As detailed in the introduction, the implantation of federal Medicare did not dramatically alter the existing marketplace for care so much as it provided a culmination to a long, local, and piecemeal process.⁷⁹⁰ Turning the economic and administrative power of the federal state toward the provision of health care led to each province finalizing a permanent and universal system. New provincial departments wrestled with the autonomy of municipal general hospitals and were empowered to approve plans for expansion and renovation. The hospitals that existed prior to 1957 charged for services, but had always operated to some extent as a charity. Patients were expected to contribute if they could, but health care was not withheld. Patients employed agency in shirking these payments, but many also contributed by volunteering, fundraising, and voting for by-laws to finance expansion.

The word ‘modern’ had long been central to the rhetoric of hospital administrators, consultants, and architects. Between 1960 and 1980 the word privacy joined it. The Woods Report of the 1960s noted that, “Each human being has a right to privacy; no less in hospital than at home; no less when he is sick than when he is well.” And further that, “A doctor and his patient can communicate best under conditions of privacy, absence of distraction, and minimal personal embarrassment...A nurse can provide the best immediate care for her patient if neither the nurse or the patient are distracted by other patients/nurses.”⁷⁹¹ Privacy had appeared in trustee minutes and architectural reports before. However, the emphasis had not typically been on the patient’s emotional experience during treatment, nor did it have any language that used a word like ‘right.’ In the Woods Report concerns for privacy helped uproot one of the oldest hospital conventions, which was segregation of wards by gender. The report noted that if administrators stopped taking patient sex

⁷⁹⁰ Carr and Beamish, *Manitoba Medicine: A Brief History*, 130, 135.

⁷⁹¹ “Toronto General Hospital: Planning Report. Volume 1 Summary Programme: Prepared by Woods, Gordon & Co. Planning Consultants and Mathers and Haldenby Architects,” 1964, 31. File 2.25.1 Box TG 84 TGH Fonds UHN Archives.

into consideration they could allocate beds more efficiently. The gender segregation stemmed from social rather than medical impulses to begin with. By the 1960s even the design process was becoming clinical.

As hospitals became further entrenched in the social landscape the loftiness of its perch began to raise expectations for staff conduct in increasingly minute ways. Spatial organization contributed directly to this phenomenon. Where once patients saw the doctor rarely—and on his terms—spaces were becoming more mixed and far larger numbers of people entered the hospital and used non-medical facilities therein such as shops and restaurants. A meeting of the VGH medical board in 1961 resolved to “take immediate action on the problem of the wearing and disposal of face masks...the medical board strongly condemns the wearing of face masks in the manner described in the areas named.”⁷⁹² Dr. Hardyment had raised the issue, indicating he ‘deplored’ how doctors would leave face masks hanging around their necks, both on the wards and in cafeterias and urged the board to take steps towards ‘discipline’ the medical staff who did so. The optics did not match up with what the hospital wanted to present. The doctors looked casual, perhaps even cavalier about hygiene. Further, the masks were a reminder of contagions and sickness of which a hospital needed no more.⁷⁹³ Areas such as cafeterias were places of social congregation where patients or their families could catch a glimpse of doctors and form impressions.

The 1960s and 1970s were home to a paradox of administrative preferences for bed usage. On one hand, there was a developing ideal that other than post-operative recovery or severe illnesses patients should be ushered home at the first opportunity. However, there was also a movement to expand the types of facilities associated with hospitals to include acute beds, and for educational purposes an increased interest in these patients. The bent of hospital construction had long been

⁷⁹² “Minutes of the Medical Board,” 19 June 1961, 10. File 1, Box 584-A-7 VGH Fonds CVA

⁷⁹³ “Dr. A. F. Hardyment Senior, Department of Paediatrics to Dr. C. E. G. Gould Chief of Staff,” 1 June 1961 File 1 Box 584-A-7 VGH Fonds CVA

towards active treatment facilities. But there was growing appreciation for chronic beds as well, and administrators began delegating some space for rehabilitation as a core component of health care just as surgery or active therapeutics were.

Between 1960 and 1980 challenges to construction derived chiefly from political and legal developments which placed provincial oversight on planning and financing. Boards found the methods and conventions of their professional sphere changing. Planning now involved the costly production of encyclopedic texts spanning several years and often decades. The consultants, too, had changed. They were professionals who commanded respect and held much sway with the provincially-constituted committees that came to control funding and planning for general hospitals. More capital than ever was becoming available for healthcare facilities, but it came with added scrutiny. The model could not easily be rejected. Modern hospitals required too much forethought and equipment—and indeed sought to please too many parties—to find enough finances from benevolent citizens.⁷⁹⁴ The boards of general hospitals in Toronto, Winnipeg, Calgary, and Vancouver dialogued with municipal and provincial governments for most of their history; however, the reduction in autonomy of the 1960s was staggering. By the 1970s these hospitals were in thrall to the province and to some extent the university. Now branded as medical centres these institutions shifted from relatively independent sites of healing to a cog in a state apparatus responsible for health care.

⁷⁹⁴ Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (Baltimore: Johns Hopkins University Press, 1999), 267-269.

Conclusion – Still Standing: General Hospitals and Society

During the 19th and 20th centuries hospitals moved from marginal charitable services to the locus of successful surgery, clinical education, and medical research. Hospitals also participated in a broader cultural change that saw medicine rise remarkably in public esteem. By the 1950s, readily accessible medical care was so central to Canadians's expectations that the federal government enacted a national insurance program despite lacking the constitutional authority or responsibility to do so. Decades before this political recognition of health care, civic perceptions of the hospital had been evolving. Alert to new opportunities, several emergent professions responded. Architects and administrative consultants grew increasingly interested in hospitals in the 20th century, chasing after the dreams—and funds—of trustee boards that space could be more efficient, longer-lasting, and medically useful. However, it was the general public that experienced the most significant change in attitude. Concomitant with a process occurring in Europe and the United States citizens from across the class spectrum began entering general hospitals in large numbers.⁷⁹⁵ The conflux of effective surgery, educational necessity, and public acceptance in the early 20th century relocated hospitals from the medical marketplace's periphery to its centre.

Canadian provinces and territories held the legal responsibility to maintain hospitals for the sick and mentally ill. The federal government was responsible for quarantine and marine hospitals, and for First Nations health needs through an 1867 treaty.⁷⁹⁶ In practice municipalities took up the lion's share of responsibility for financing and managing these institutions. Municipalities and charitable organizations across 19th century Canada set up general hospitals—Montreal in 1820,

⁷⁹⁵ Roy Porter, *The Greatest Benefit To Mankind: A Medical History of Humanity* (New York: W. W. Norton and Company, 1997), 380-381. Michael Bliss, *The Making of Modern Medicine: Turning Points in the Treatment of Disease* (Toronto: University of Toronto Press, 2011), 44-48.

⁷⁹⁶ Maureen K. Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s* (Toronto: University of Toronto Press, 2016), 177-182. Lux's history focuses on the 'medicine chest' clause in 'Treaty Six' and the resulting federal efforts—disciplinary and inadequate—to provide health care for First Nations.

Toronto in 1829, Hamilton 1854, Winnipeg in 1872, Victoria 1876, Vancouver in 1886, Calgary in 1890, Edmonton in 1895, Regina in 1901, and Halifax in 1909 as examples—in response to a lack of health care. Provinces maintained separate hospitals for the mentally ill. Such facilities were often inadequate, and any overflow was foisted upon general hospitals. Downloading care for the mentally ill had economic motivations, as it ran counter to medical conventions that preferred to treat the mind and body in separate facilities.⁷⁹⁷ Cities typically lacked the funds to establish hospitals entirely on their own, thus most arose from a conflux of private charitable donations and the acquisition of private medical ventures. A melting pot of provincial, municipal, and private funds paid the salaries of the first nurses who worked these sites, purchased medical supplies, food, and maintained the buildings as much as possible. There was a fair number of donations in kind as well, including domestic items like irons and cooking pots, and major assets such as buildings or land. Fledgling hospital administrators—who ranged from private groups of concerned citizens to municipal health or hospital boards—depended on charity and community support to run their hospitals.

There was no common impulse that led to hospital establishment and construction in Canada; however, some general issues were common. The most obvious, and pressing, was a general shortage of health care. Citizens of frontier cities that grew up along expanding rail lines often had no recourse other than CPR medical facilities. In other cases government agencies, such as the NWMP established temporary hospitals that attracted civilians and troopers alike. Neither organization had the budget or inclination to provide medical charity to non-employees. The sick and injured imposed on these institutions for care, and were often unable to pay. The first public general hospitals in Calgary and Vancouver were repurposed single-constituent institutions belonging to the NWMP and CPR respectively. In Toronto and Winnipeg, general hospitals owed their genesis to

⁷⁹⁷ David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950* (Montreal: McGill-Queen's University Press, 2002), 57. Harvery G. Simmons, *From Asylum to Welfare* (Downsview: National Institute on Mental Retardation, 1982), 174.

charitable impulses; one sought to care for veterans while the other addressed waves of epidemic disease.

The surgical and medical scope of the early general hospitals was not large. They were not yet technological marvels. Often these institutions were basic affairs consisting of a handful of beds, a nurse, and perhaps a cook or laundress. Often a physician was not even on staff, rather one would visit once or twice a day to check with patients and advise on treatment. The initial host of options was limited as much by space as by staff. Surgeries were minor, and usually these facilities dealt with victims of accidents or those struck with illnesses such as typhoid. The general hospital grew with the city. As the population increased there were more patients, and eventually more doctors. Universities and medical schools were natural allies since hospitals could provide an unmatched source of clinical material for education and later research.⁷⁹⁸

Canadian hospitals appearing in the late-19th century were largely spared a drawn-out debate and professional schism over aseptic and antiseptic procedures. Jim Connor argues in his history of the TGH that the use of carbolic acid was so widely accepted that the medical staff implemented it without issue. British and American hospitals were sights of controversy over ‘Listerism,’ and the effects of incorporating its tenets into hospital management.⁷⁹⁹ The late-comer status of some Canadian hospitals, especially in the prairies, allowed for the leapfrogging of a major episode in hospital history. One of the earlier incarnations of the CGH, for example, had a bowl of carbolic acid placed on a stand near the main entrance so that anyone who entered or left would pass it by and wash their hands.

⁷⁹⁸ Morris J. Vogel, *The Invention of the Modern Hospital: Boston 1870-1930* (Chicago: University of Chicago Press, 1980), 2-3.

⁷⁹⁹ J. T. H. Connor, *Doing Good: The Life of Toronto's General Hospital* (Toronto: University of Toronto Press, 2000), 129.

The experiences of patients in general wards—especially in the early decades of the 20th century—were often highly structured. Rules shaped experience, but also had a practical purpose. The institutions were cash-strapped and understaffed. Medical treatments of disease and injury had improved since the days of the custodial hospital, but there were still limits. Patients constituted both the purpose for the hospital’s existence and one of the most significant threats to its ability to function. If patients spread illness, aggravated an injury, hurt one another, or if word got out that an institution supported through donations and taxes became a venue for unscrupulous activities the enterprise was jeopardized.

As a settler colony, medicine travelled through imperial channels.⁸⁰⁰ Geoffrey Bilson argued that pre-confederation medical boards emphasized the colonial nature of British North America by exempting graduates of universities in the British Empire from licensing exams, and allowing anyone with a commission from the military medical services to practice. This observation was echoed by historians of colonial era medicine who noted how settler colonies attempted to recreate European society.⁸⁰¹ In 1839 the Privy Council, responding to lobbying from the Royal College of Surgeons, nullified an Act to create a ‘College of Physicians and Surgeons of Upper Canada.’ The Royal College viewed the establishment of an independent professional body as an unwelcome step toward self-regulation. The move ensured that for the next three decades Canadian medical knowledge derived mainly from British sources. In October 1867, the Canadian Medical Association (CMA) formed in Toronto, signalling a shift from the predominance of British to American

⁸⁰⁰ Relatively little literature examines Canada as a ‘settler colony’ in a medical context. Of equal import are the imperial aspects of western medicine on First Nations; of which there has been more written. See Lux, *Separate Beds: A History of Indian Hospitals in Canada*, 93. Mary-ellen Kelm *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-50* (Vancouver: University of British Columbia Press, 1998), J. R. Miller *Shingwauk’s Vision: A History of Native Residential Schools* (Toronto: University of Toronto Press, 1996)

⁸⁰¹ Michael Worboys, “Colonial and Imperial Medicine,” in Deborah Brunton ed. *Medicine Transformed: Health, Disease and Society in Europe 1800-1930* (Manchester: University of Manchester Press, 2004), 212.

influence.⁸⁰² A good example of this continental alignment is Abraham Flexner's 1910 report. The Flexner report sought to define "the relation of professional education in medicine to the general system of education." It was an American document with minor Canadian content.⁸⁰³ Nonetheless it influenced Canadian medical schools for decades. Over the course of the 20th century the influences on professional medicine in Canada became increasingly American.

Hospital insurance was important to many patients throughout the 20th century, and the HIDS Act marked a crucial moment. Jim Connor outlined the legislation's *effects* on general hospitals as the start of direct state involvement in running this institution, the destruction of a lingering 19th-century patient classification scheme—"pauper" "deserving" "indigent" ceased being relevant categories—and the transformation of general hospitals into "middle-class egalitarian institutions." By virtue of state payment all patients became available to medical students. There was also a shift toward curative rather than preventative treatments.⁸⁰⁴ The most significant change for patients was their full availability to educators. Throughout the 1960s and 1970s administrative boards and building committees experienced delay and frustration when navigating this new bureaucratic terrain.

In the early 20th century, hospitals began accepting more class-diverse patients, but they were far from egalitarian institutions. No longer did they primarily house paupers; however, a patient's experience once in the hospital varied depending on their ability to pay. For instance, in 1907 the WGH established a second operating theatre exclusively for paying patients. The addition coincided with renovations to the existing operating room that added a swinging instrument tray and tilting

⁸⁰² Geoffrey Bilson, "Public Health and the Medical Profession in Nineteenth-Century Canada," in Roy Macleod and Milton Lewis eds. *Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London: Routledge, 1988), 158, 167-168, 173.

⁸⁰³ Abraham Flexner, *Medical Education in the United States and Canada: A Report to The Carnegie Foundation for the Advancement of Teaching*, (New York: The Carnegie Foundation for the Advancement of Teaching, 1910), viii.

⁸⁰⁴ Connor, *Doing Good: The Life of Toronto's General Hospital*, 240-241.

wash basins. Despite architectural similarity between the operating rooms the patient's surgical experiences were different. For example, the hospital only provided rubber gloves for surgeons in the paid operating room. The staff differed also. The private theatre had an extra graduate nurse and a senior assistant on hand for all operations, and an anaesthetist whenever possible. In the public operating room there was provision only for a table upon which 'anaesthetic apparatus' such as chloroform, ether, and inhalers could be placed rather than consistently monitored.⁸⁰⁵

The types of rooms available to those with means differed in terms of medical treatment and social experience. For patients who entered public—sometimes referred to as general—wards they were surrounded by fellow sufferers of the same sex. Patients could hear the conversations of those around them, see who received visitors, recognize neighbours or coworkers, or even establish friendships. In the first half of the 20th century hospital stays were more often measured in weeks than days. The social effect was twofold; patients had meaningful interaction with each other on the ward, and communities were disrupted by the lengthy removal of individuals. Consequently, administrators faced pressure from friends and family to visit, and visitation became part of ward routine.⁸⁰⁶ This differed for private ward patients who faced laxer regulations. Public wards operated under a litany of rules that included prohibitions on swearing, wandering, gambling, and any other forms of disruptive interaction. Private patients were excused from most restrictions.

Health care was a concern for all cities, especially the metropolises of Vancouver, Toronto, Winnipeg, and Calgary. Some common themes stand out, but before turning to these, it is important to emphasize the differences because local variation is a substantial merit of a comparative study. The locales were distinctive, and regional context shaped the initial physical space and the longer arc

⁸⁰⁵ "Minutes of the House Committee," 18 March 1907, 1. File 1, Box 18 WGH Fonds PMA.

⁸⁰⁶ Graham Mooney and Jonathan Reinartz, "Hospital and Asylum Visiting in Historical Perspective: Themes and Issues," in Graham Mooney and Jonathan Reinartz eds., *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (New York: Editions Rodopi B. V., 2009) 7-10.

of their history. The TGH's relationship with the University of Toronto allowed it to become a frontrunner in North American medical research.⁸⁰⁷ Its access to donors such as Flavelle and Eaton mattered too.⁸⁰⁸ All case study hospitals had a charitable genesis and relied on donation from time to time. Yet in Toronto the source of donation came frequently from a richer clientele than elsewhere. Of the four, Winnipeg is perhaps the best example of a community-built edifice. The first WGH was ephemeral. It came into existence during an epidemic and was not intended to remain afterwards. A group of citizens pressed on with makeshift buildings and fundraising drives to keep it open.

The administrative history of the CGH is unusual. It originated with the NWMP before passing briefly into civilian hands only to become an organ of the municipality in 1914. As a result, the CGH operated in a more subordinate manner with its local government. It was an arrangement that allowed for some positive outcomes such as the erection of new wards during the Depression. The municipal connection also tied the CGH's post-war development to the cadence of the provincial oil economy. The VGH's story is one of plodding advancement until the 1960s. The VGH made use of consultants very early in its history, and established a pattern of growing its campus through a varied pavilion style of establishing annexes. The world wars elevated the social significance of general hospitals across the country, but of the four case studies the VGH profited the most in terms of buildings. The VGH was quick to incorporate vacated buildings into its campus.

As the reputation and clientele of hospitals changed so too did the reputation of those who worked there. During the 20th century the role and image of nurses shifted from an ambivalent position in social consciousness to a respected profession, the practice of which was fused to the

⁸⁰⁷ Michael Bliss, *The Discovery of Insulin* (Toronto: McClelland and Stewart Limited, 1982), 8.

⁸⁰⁸ Michael Bliss, *A Canadian Millionaire: The Life and Business Times of Sir Joseph Flavelle, Bart. 1858-1939* (Toronto: Macmillan of Canada, 1978), 204-206. Joy L. Santink, *Timothy Eaton and the Rise of his Department Store* (Toronto: University of Toronto Press, 1990), 160-162.

modern hospital.⁸⁰⁹ In July 1916 the WGH hired two ‘women anesthetists.’ The board suspended them—with pay—soon after because Dr. Ross was ill and could not supervise them during surgery. Among the minutes accompanying this decision the board kept a clipping from a Pennsylvania newspaper addressing the legality of nurses administering anesthetic. It read, “The nurse may not assume the place of the physician and practice medicine and surgery, but she assists him in his practice, and in some respects serves as eyes, hands, and feet for the physician—she is a human instrument, used and employed by the physician in the treatment and cure of disease.”⁸¹⁰ Some hospital administrators such as Charles Clarke of the TGH sought to rehabilitate nurses’s image as a means of boosting the hospital. In his 1913 history, he wrote “The women who acted as nurses were, too often, crude, uneducated, and, not unfrequently, alcoholic in their habits...” and that “the pay was a mere pittance, the work so repulsive and hopeless that there was little to attract a different class.”⁸¹¹ Clarke did not spare the 19th century nurse negative comments, but sought to show the public these woman, like his hospital, were changing.

Progressive change was long in coming for nurses, whose identity as determined by their male superiors remained tethered to notions of domesticity, femininity, and fragility. In 1957 an injured Jack Hutchinson—fullback for the Winnipeg Blue Bombers—was photographed in bed at the WGH surrounded by teammates and staff nurse Maureen Finn. The photo appeared in the *Winnipeg Free Press* with caption quoting Hutchinson as jokingly stating “Sick? Yeah, we’re dying. Bring us more nurses like this one.” The report noted “you couldn’t really believe them – but then again – you couldn’t blame them. Not with pretty general hospital nurse Maureen Finn standing

⁸⁰⁹ Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*. (Toronto: Oxford University Press, 1996), 34.

⁸¹⁰ “Statement of William H. Keller, First Deputy Attorney-General of Pennsylvania in “Minutes of the House Committee,” 1 August 1916, 1. File 1, Box 18 WGH Fonds PMA.

⁸¹¹ Clarke, *A History of the Toronto General Hospital*, 91

by.”⁸¹² Finn was a trained, medical professional but the *Free Press* reduced her to a feminine caricature. The photo juxtaposed her with Hutchinson whose physique conformed to an unambiguous image of muscular masculinity. Despite the deeply-engrained sexism in this aspect of hospital culture, nurses of the later-20th century were highly skilled medical operatives. Most had university educations, and laboratory experience. In some ways, the nurse-doctor relationship in the early 20th century echoed the medieval schism between physicians and surgeons; one was work of the hand the other of the mind and the hierarchy was clear. Doctor and administrative discourses during the first half of the 20th century treated nurses as useful functionaries but little more.

Nurses Alumnae organizations have played a crucial role as community organizers, fundraisers, and chroniclers of institutional histories. Nurses had long been an organized and self-aware group at the institutional level, though this solidarity did not reflect as strongly on the national labour stage.⁸¹³ Alumnae associations for all the case study hospitals kept historical records of the institutions they worked at and helped shape—this dissertation could not have been written without them. These organisations reveal an internal perspective of how nurses saw themselves, wished to remember their past, and to what extent viewed themselves as agents. A CGH nurses’s alumnae bulletin from October 1972 described its annual homecoming banquet which was set to the theme ‘the march of time.’ Members came from as far away as Texas and Alaska. Nurse Eleanor Tregilus put together an exhibition showing changes in nurse’s uniforms between 1898 and 1972; from caps and aprons to modern “miniskirts and pant suits.”⁸¹⁴ Her exhibit displayed—cheekily—an important level of self-awareness.

⁸¹² “News Clipping, 1957-1959. Image from *Winnipeg Free Press*, 14 November 1957” Box 35 WGH Fonds PMA. Also see appendix 6.1

⁸¹³ McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*.

⁸¹⁴ “Nurses’s Alumnae Bullet,” October 1972, 2. [Unnumbered Box and File] CGH Fonds AHS Archives. Along with fellow nurses Evelyn Hardwick and Eileen Jameson, Tregilus published a history of the CGH in 1975.

Discussion of space had powerful rhetorical value for hospital administrators; but it could cut both ways. One of the most powerful public relations tools administrators possessed was description. To describe a building was to define identity, purpose, and occupant. As the public information relating to the VGH Centennial Pavilion in 1959 demonstrated, this could amount to an attempt to dazzle the public. It was an old practice. Even a casual glance at 19th century hospitals—at least those designed and built as such—reveal architecturally imposing buildings.⁸¹⁵ The elaborate cornices, pointed roofs, chimneys, and grand entrances, often ascended by a flight of stairs, differed markedly from the plain, utilitarian exteriors of so many post-1945 hospitals. The public could be awed in other ways, of course. What had been lost in aesthetic or architectural majesty was replaced by technological sophistication and feats of engineering. The size, scope, and technological prowess of hospitals in the second half of the 20th century became the focus of an administrator's public outreach. New technologies like magnetic resonance imaging (MRI), and computerized axial tomography (CAT) scans replaced older virtues like calmness and domesticity. Hospitals inspired hope for boundless expansion of treatment.

For citizens, the press, and at times elected officials the most natural corollary to hospitals was hotels. After all, both institutions provided beds, food, and comfort. Hotel comparisons occurred throughout the 20th century and tended to reflect larger social or economic context. When length of stay was long, and the hospital had not entirely shed its reputation as a storage house for the sick, comparisons with hotels were sometimes welcomed. The public—including those with means—did not mind staying in such places. In 1919 the WGH implored the public to consider how “the average daily register of patients is considerably larger than the average daily complement of guests at both of Winnipeg's big hotels.” In an attempt to explain why its costs were so high administrators were

⁸¹⁵ John D. Thompson and Grace Goldin, *The Hospital: A Social and Architectural History* (New Haven: Yale University Press, 1975), 23.

even blunter, “primarily the hospital is nothing more or less than a hotel for sick people.”⁸¹⁶ In 1925 the VGH annual report lamented that “hospitals have not only to pay like hotels for labour, food, linen, and housekeeping supplies, but in addition to maintain expensive undertakings such as X-ray departments, surgical operating rooms, emergency departments,” concluding that it was “called upon to supply skilled service in a hundred and one directions.”⁸¹⁷ In one of the first reports from the TGH’s private patient pavilion in 1931 the chief dietician noted: “just a few days ago one of our patients who is at home in the hotels of the world, told us that this was the finest food service he ever had.”⁸¹⁸ In the early 1900s general hospitals lacked a strong identity. Administrators evoked hotels to contextualize their institutions.

The hotel comparison appeared in internal discussions as well. In a 1937 memo describing the experience of TGH internes Dr. Stephens brought up hotels. Rather than comparing the fact each institution provided beds he raised a legal issue. “While the hospitals do not wish the financial end to appear paramount, admission of a private patient is a business proposition like that of a hotel except that the hospital has not the legal protection of the ‘Innkeepers Act,’ which makes it a criminal procedure to obtain credit by false pretenses.”⁸¹⁹ Patients routinely promised credit for semi-private or private accommodation only to later default; something punishable by law if done to a hotel. Legally, hospitals were not within the same constellation of enterprises that required protection from defaulting clients. Hotels also accepted superficial similarities between themselves and hospitals. In 1944, J. Barnes business manager of the CGH received a request from the proprietor of the

⁸¹⁶ “The Hospital Appeal - \$200,000” November 1919, 5-6. File 1, Box 7 WGH Fonds PMA. Above quote on pg. 5.

⁸¹⁷ “Twenty-Fourth Annual Report of the VGH,” 1925, 30. Box 3 VGH Fonds CVA.

⁸¹⁸ “Report of the Chief Dietitian of the TGH for the year ending 31 December 1931,” 2. File TG 2.6.30 Box 18 TGH Fonds UHN Archives

⁸¹⁹ “Internes Life – By Dr. Stephens,” 4 February 1937, 3. Folder 1 Box 10 TGH Fonds UHN Archives. Interestingly Dr. Stephens notes that in New York state it was a felony for a patient to receive free medical treatment if it could be shown they were able to pay.

McNamara Hotel in Peace River to provide a reference for a former CGH cook.⁸²⁰ While administrators made rhetorical use of the comparison—or grew frustrated by them—there is evidence that employees moved between the two industries. Whatever social differences existed, there is evidence that experience gained working in one setting was transferrable to the other.

By the 1960s lingering hotel comparisons served only to frustrate hospital administrators. A 1965 issue of the WGH's staff and patient newsletter, *The Generator*, addressed the comparison. An issue arose over a large carpet installed in the main entrance. The newsletter author noted, "No; we haven't got more money than we know what to do with. No; we are not trying to compete with hotel lobbies. No; it did not cost a small fortune to purchase it."⁸²¹ Administrators wanted to use the carpet to trap dust, snow, dirt, and water so that detritus was not tracked into the hospital, down its halls, and into the wards. The article admitted it was expensive, and that the purchasing agent was cognisant of how pleasing to the eye it was. The newsletter promised such a carpet would save hundreds of hours of labour, which a hotel could also appreciate. The way the newsletter responded though—that the hospital was not attempting to compete with hotels—demonstrated that for the moment at least administrators disliked comparison of their institutions with profit-seeking enterprises. The newsletter dipped back into somewhat utilitarian rhetoric to justify the carpet.

One identifiable characteristic of general hospitals prior to the 1950s that administrators emphasised was their role in 'active treatment.' Patients who suffered from chronic conditions, mental illness, or anything the medical establishment deemed untreatable were unwelcome. From an administrative perspective, these patients did nothing for the institution other than occupy beds, prolong wait times, and lower ward morale. For fledgling general hospitals, active treatment held the promise of legitimacy through efficacy. In an environment of limited funds admitting untreatable

⁸²⁰ "Joe Jensen to J. Barnes," 5 August 1944, 1. File 2 Box 11. CGH Fonds AHS Archives.

⁸²¹ "Carpets," *The Generator*, 25 January 1965, 2. File 1 Box 8 WGH Fonds HSCAM

patients bordered on irresponsibility. By the early 1900s general hospitals issued public annual reports which contained statistics such as average length of stay and treatment rates. Transparency elevated the standing of general hospitals. It could also embarrass administrators. Public response to statistics became a new consideration for administrators when outlining patient policies.

Administrative preference for active treatment did not survive the 20th century. In part this was the result of the expansion of hospitals; however, developments in medical practice also broadened the range of what could be treated. Changes in the direction of education and research found ways to realize value in different types of patients. In February 1962, the CGH added an eight-storey Convalescent-Rehabilitation (C-R) Wing. A *Calgary Herald* report promised the public it would “provide proper facilities to meet an urgent need for a vital stage in a combined unit of progressive patient care during convalescent and active rehabilitation.”⁸²² The new building offered services such as hydrotherapy, therapeutic gymnastics, speech therapy, and pre and post-natal physiotherapy. The range and specialization of these services spoke to the maturation and expansion of medical practice in general and hospitals in particular. These techniques were being pioneered at university hospitals, and were breaking through into general care.⁸²³ Earlier incarnations of the CGH—or any of the other three case study hospitals—did not embrace convalescence. Rather, administrators saw it as unavoidable. The goalposts had moved, and now medicine had to do more than stitch patients up and send them home. It had to see them return to work and as far as possible to resume a ‘normal’ life.

In addition to medical care, hospitals expanded the range of social services on offer in the second half of the 20th century. In their account of hospital architecture, Stephen Verderber and

⁸²² “Convalescent Wing At General To Open,” *The Calgary Herald*, 3 February 1962, 26

⁸²³ Walter H. Johns *A History of the University of Alberta* (Edmonton: University of Alberta Press, 1989), 254. Elise A. Corbet, *Frontiers of Medicine: A History of Medical Education and Research at the University of Alberta* (Edmonton: University of Alberta Press, 1990).

David Fine argue persuasively that hospitals ceased being exclusively medical spaces. Rather, these facilities served an array of functions from medical, to economic, to social, and even political.⁸²⁴ In the 19th and early 20th century administrators and architects emphasised adding wards and operating rooms when designing new buildings. The auxiliary services included in this model were pragmatic: power houses, laundry facilities, kitchens, nurses's residences, and tunnels. After the Second World War, more functions crept onto medical campuses. By the 1960s beauty salons, barber shops, cafes, smoke stands, gift shops, food courts, and waiting rooms equipped with television sets became part of the architectural landscape. The expansion of hospitals into education drew in non-patients. The presence of medical students on campus ensured libraries remained. The clerical staff members who organized medical records, drafted schedules, and ordered supplies mattered too. The doctors, students, nurses, visitors, maintenance workers, clerical staff, shopkeepers, and outpatients began to outnumber patients. This was a process that was as much enabled by changing uses of space as it was a cause.

If the 19th century was an age of efficiency and discipline, the 20th was that of the social, welfare state. In the 19th century hospitals were overcrowded, pestilent, and feared. In so far as there was a management paradigm it was the utilitarian search for waste, including squandered space or aging structures that could be put to another purpose. The 20th century witnessed a shift in attitudes about space. Administrators, doctors, and architects began considering how space could be organized to promote the dignity, welfare, comfort, and social standing of patients. These views differed from the focus of the medical community or treasurer. Hospital historian Jim Connor argued that by the end of the 20th century the TGH—likely other institutions too—had lost the human touch.⁸²⁵ Connor's point aligned with the reality that Ottawa's eagerness to spend on hospitals waned after the

⁸²⁴ Stephen Verderber and David J. Fine *Healthcare Architecture in an era of Radical Transformation* (New Haven: Yale University Press, 2000), 28.

⁸²⁵ Connor, *Doing Good: The Life of Toronto's General Hospital*, 243.

economy began to slow in the 1970s. Emphasis on efficiency crept back in the language of consultants and architects, but the design process remained aware of the patient.

The idea of cultivating, maintaining, and improving ‘national health’ was a central aspect of the nascent Canadian welfare state. As Maureen Lux reminds historians this reorganization of daily life was not perfectly universal or egalitarian. There were casualties and segregation. First Nations were especially affected by this.⁸²⁶ On a more mundane level, the development of the welfare state would naturally interface with hospitals by—in theory—reducing the number of indigent patients. The influx of federal money after the Second World War influenced the size and shape of general hospital campuses, and administrative thought. Previous chapters noted the optimism of boards that a new age of better funding would follow the Second World War. To some extent this was correct; however, it was also short-lived. The 1948 National Health Grants Program (NHGP) dramatically increased hospital accommodation across the country by providing \$30 million in annual grants for construction and research.⁸²⁷ In 1945 there were approximately 1,102 hospitals in Canada with a rated bed capacity of 111,000. By 1959 there were 1,481 hospitals with a rated bed capacity of 186,000.⁸²⁸ In the 1960s the NHGP provided less funding for the construction of new general hospitals. Instead, its budget and development agenda focused on adding beds to existing facilities.

By the 1960s and 1970s the mission of general hospitals was no longer exclusively medical.

A 1969 CGH operations manual offered an explanation:

In essential terms, a hospital is a place where one goes for care when sick or injured. But it is much more than that. It is an institution unto itself, borrowing motives and methods from many fields, but characteristics of none but its own. It is not primarily a charitable institution. It is not essentially a business operation. It is not basically a public utility. Since a hospital is no longer a charitable institution because of social, economic, and scientific changes, it is a new concept

⁸²⁶ Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s*, 46.

⁸²⁷ G. Harvey Agnew *Canadian Hospitals, 1920-1970 A Dramatic Half Century* (Toronto: University of Toronto Press, 1974), 205.

⁸²⁸ Aleck Ostry, *Changes and Continuity in Canada's Health Care System* (Ottawa: CHA Press, 2006), 180-181. Note that the number of hospitals is inclusive; that means general hospitals, mental hospitals, tuberculosis hospitals, etc.

motivated like a charity, operated like a business regulated like a profession and governed like nothing else in society.⁸²⁹

The social status of general hospitals in the 1970s was almost the opposite of 1870. To be sure, it retained many of the old, fundamental aspects such as charity and health care. However, the ‘venture’ of a hospital had drawn many hands and interests under its aegis over the course the 20th century. It was a unique institution that mattered to civilians in ways that ranged from employment to the preservations of life. The fact society had come to embrace general hospitals more completely was not without drawbacks. Real limits to medical efficacy remained in terms of cost and scope of care. Medical research leapt ahead in the 20th century, but progress had limits. Administrators began the task of managing public expectations that increasingly saw hospital medicine as a panacea.

As the scope of health institutions grew so too did the responsibilities and competencies of professional consultants. Architectural and management consultants interfaced with hospital administrators for most of the 20th century.⁸³⁰ Initially these firms were fairly limited in what they could provide, as much by constrained economic resources on the part of hospitals, as by the ongoing development of their profession. As hospitals became more complex so did management research and professional literature. There may have been some hubris between 1920 and 1960 on the part of hospital specialists, especially during periods of booming construction. But by the 1960s, the complexities of health facilities appeared more and more daunting, and firms sought to specialise, a process observable in professional identities and the multi-volume hospital-planning reports in the second half of the 20th century.⁸³¹

⁸²⁹ “CGH Manual,” 1969, 3. File 1, Box 35 CGH Fonds AHS Archives

⁸³⁰ David Rosner, “Doing Well or Doing Good: The Ambivalent Focus of Hospital Administration,” in *The American General Hospital: Communities and Social Contexts*, ed. Diana Elizabeth Long and Janet Golden (Ithaca: Cornell University Press, 1989). Agnew *Canadian Hospitals, 1920-1970 A Dramatic Half Century*.

⁸³¹ Though there are many viable examples, one that fits especially well with the emphasis on rhetoric in this chapter is Jacquie L’Etang, *Public Relations in Britain: A History of Professional Practice in the 20th Century* (London: Routledge, 2004). For a more theoretical piece examining the changing world of public, private, and professional relations as well as

As much as hospitals depended upon citizens, architects, and professional consultants they also worked closely with universities. These relationships did not always begin well; the TGH and University of Toronto were on particularly shaky terms in the early 1900s. In 1942 when the WGH entered in a health centre with the University of Winnipeg it was careful to ensure the institutions were not merged. The initial synergy between general hospitals and universities was the number of patients collected in one space. Such conditions enabled efficient clinical education, while also providing opportunities for doctors to hone their skills and enhance their reputation. As universities embraced clinical testing and research and as medical practice moved into the wards, the two institutions became natural allies.⁸³² The training of nurses in this way was equally important, however, general hospitals were more inclined to run an in-house training school for these individuals. In the latter-half of the 20th century nursing schools left the medical campuses for the university. The relationship between patients and education was generally defined by the type of ward they could afford. Private patients chose their own physician and did not have to be seen by students, whereas the general wards had low daily rates precisely because they had no such exemption. Medicare ended this division by granting student access to all hospitalized individuals.

The history of hospitals has evolved into a history of professionals and patients. But as parts of the city landscape and civic pride, the buildings themselves have mattered too. In the fall of 1920 Mark Irish, Chairman of the TGH property committee, planned for the demolition of the Gerrard Street hospital. An unremarkable event on the surface, it demonstrated how buildings came to hold communal meanings, and how ideas, emotions, and myths could be transplanted through physical artefacts. Irish wrote city council stating that the TGH wanted to sell the Gerrard lot with the

the power dynamics between them see Jurgen Habermas, *The Structural Transformation of the Public Sphere: An Inquiry into a Category of Bourgeois Society* (Cambridge: Polity Press, 1989).

⁸³² Edward Shorter, *Partnership for Excellence: Medicine at the University of Toronto and Academic Hospitals* (Toronto: University of Toronto Press, 2013).

condition that the buildings be demolished. He described the entrance, above which hung a carved stone bearing the inscription ‘I was ill and Ye visited Me,’ as well as several “rather fine carved figures.” Irish noted that the stone had no commercial value, and that removing it “without injury and placed on the property of the New General” would require a minimal amount of labour and not imperil the sale. That said he confessed “It is of so much sentimental consequence that I am unable to sacrifice it.”⁸³³ It was not the last time in the TGH’s history that a piece of the Old General would surface to take on sentimental prominence. In 1960 an elderly man contacted the TGH and offered the return of a stone angel he had acquired while purchasing brick rubble from the 1920 demolition site. The angel had sat in his garage for years, and he wanted to return it to the TGH.⁸³⁴ The inscription and the angel addressed the image of the hospital, rather than the experiential side that patients endured. They each made sentimental, positive, and hopeful statements, and conveyed the social importance of visitation. Those who saw them could imagine themselves performing a selfless act and associate that feeling with the institution.

The eminent medical historian Charles Rosenberg described the 1900s as the century when “the hospital became medicalized, and medicine became hospitalized.”⁸³⁵ It was a fitting statement, though limited in its scope. In the 20th century the hospital came to hold a position of social prominence equally important to the one it ascended to in professional, scientific medicine. In Canada, this process occurred rapidly at the end of the 19th century as what had been frontier outposts grew into large, urban centres. In parts of the country that were more developed such as Ontario and Quebec this process occurred earlier. This was especially the case since these regions

⁸³³ “Mark Irish, Chairman of the Property Committee TGH to F. B. Poucher Manager, Real Estate National Trust Co.,” 5 October 1920, 2. File 1.4.2 Box 5 TGH Fonds UHN Archives

⁸³⁴ “Memo: Dr. Doyle to Dr. Sharpe Re: Keystone – Old TGH,” 19 September 1960, 1. File 2.2.122, Box TG 0009 TG 41. TGH Fonds UHN Archives

⁸³⁵ Charles E. Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System* (New York: Basic Books, 1987), 189.

were more closely connected with the United States and its professional networks. On the prairies and west coast civilians rallied to address their health care needs. Part of this process was wresting medical infrastructure from the hands of private enterprise or the government. It also required compromises. Doctors, architects, and politicians lent time and expertise—not always with compensation—to see that general hospitals were realized in emerging metropolises.

In 1880 general hospitals were latent forms of the institutions that existed by 1980. Much has been made in this dissertation about the physical changes: campuses moved from a few wings or pavilions to interconnected complexes covering acres, beds proliferated from single digits to hundreds and thousands, and the range of medical specialisation and treatment surpassed all expectations. However, these comprise only one portion of the change important to the social history of general hospitals in Canada. The advent of Medicare affected the delivery of health care and services. Throughout the 1960s and 1970s a proliferation of group health societies, minor treatment facilities, and semi-private institutions for the mentally ill, chemically-addicted, or chronically ill (aged) occurred. These formed a substructure to medical delivery and affected the form, function, and reputation of general hospitals in the latter third of the 20th century.⁸³⁶

The evolution of the social status of general hospitals was as dramatic as that of their architectural exteriors and interiors. The movement of these facilities from a peripheral station to a central one happened in several arenas during the same several decades: social, medical, educational, and political. With so many interests rooted in general hospitals, the physical space invariably reflected the motives and desires of interested parties. So varied and many were these interests, however, that no singular entity could claim sole credit. The general hospitals of 20th century Canada

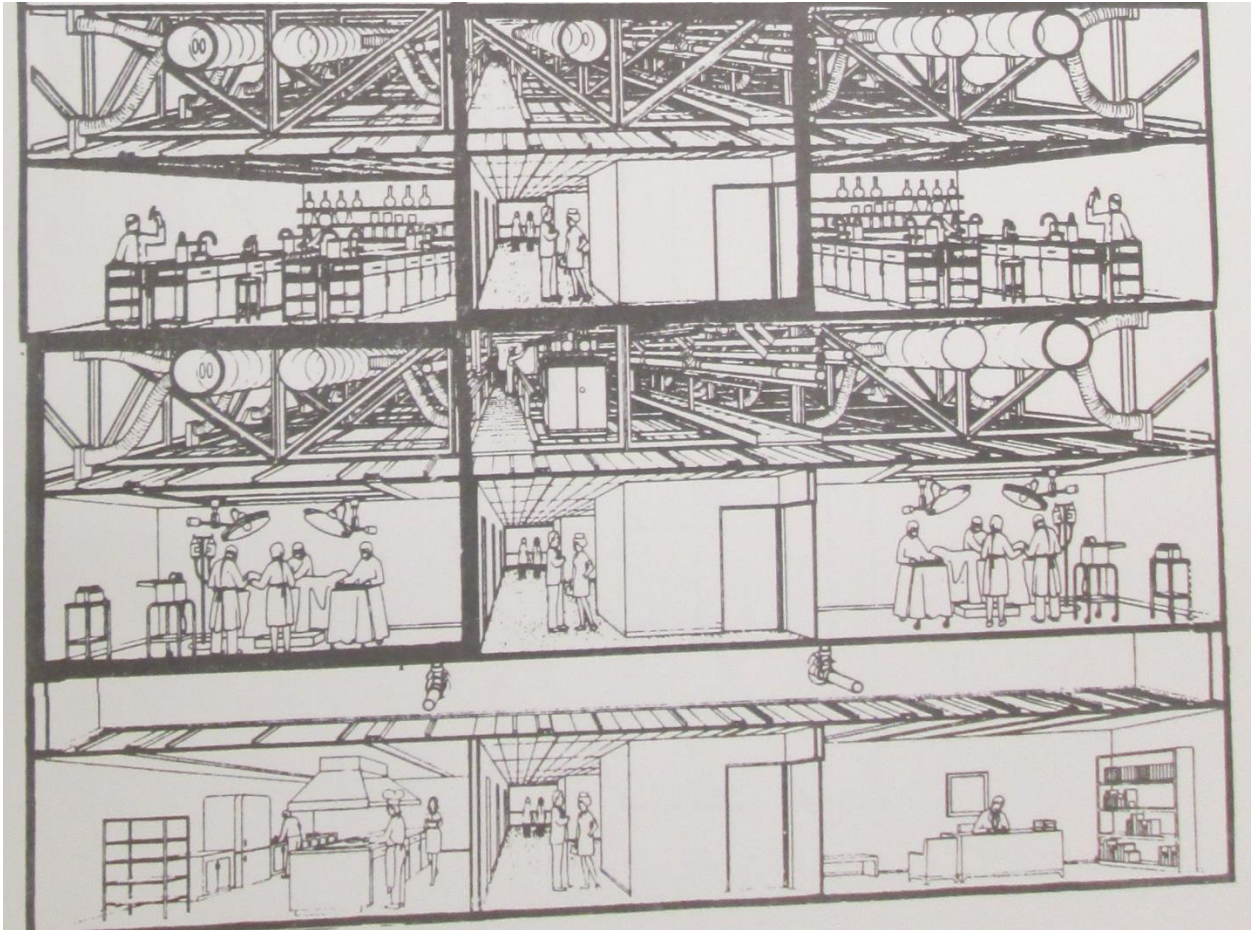
⁸³⁶ Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (New York: Oxford University Press, 1999), 681-685.

were fundamentally community institutions that reflected the needs of professionalizing medicine and public expectation.

APPENDCES

Appendix I

1.1

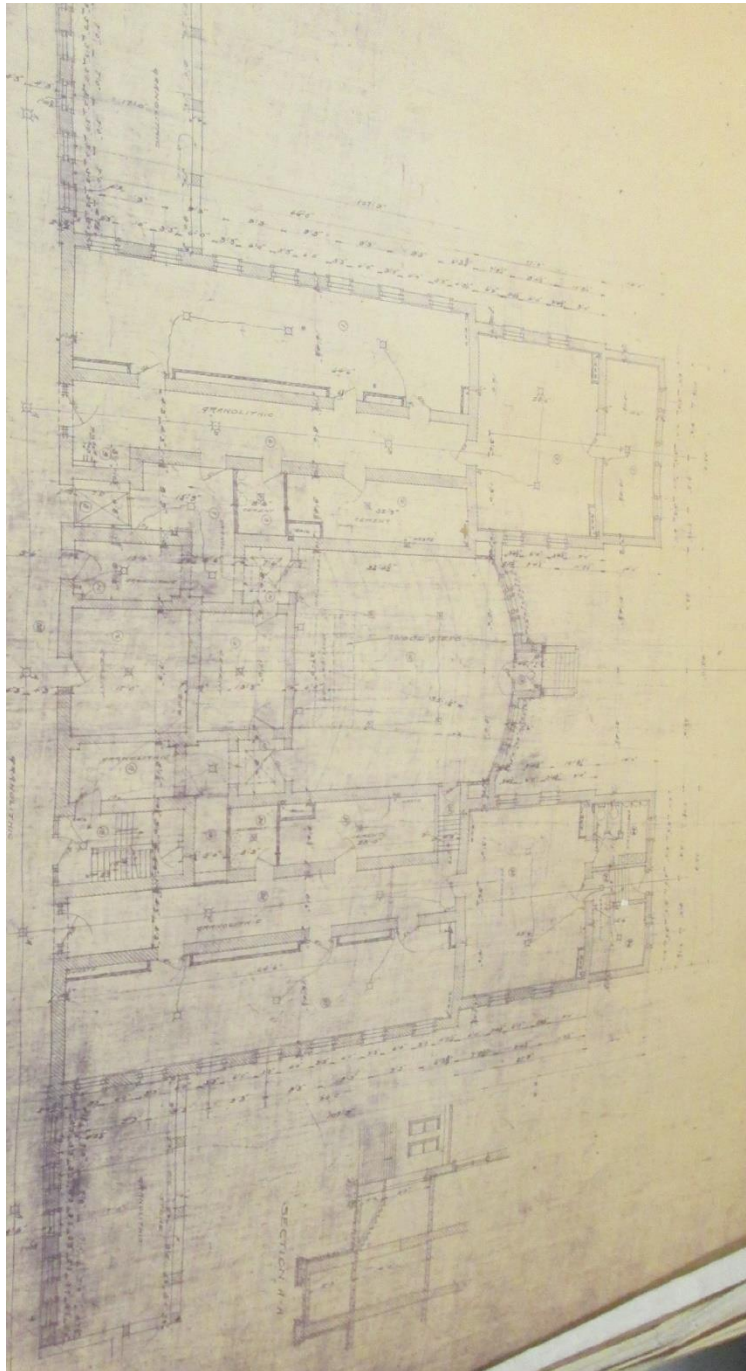


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⁸³⁷ “VGH Facility Planning, 1976,” 46. File 4 Box 570-B-3 VGH Fonds CVA. Photo courtesy of Vancouver Coastal Health Authority. Example of interstitial space prepared by consultants for the VGH. The bottom middle cell on all floors is a hallway; the first and third cells change. On the lowest floor in this example there is a kitchen on the left and office on the right. Note how in the interstitial space above there is basically no infrastructure. Above are two operating rooms, and above them more complicated ventilation apparatus. On the floor above are two labs and again above them is advanced ventilation equipment. In theory the interstitial spaces could be easily entered to modify these systems at far less cost than in a traditional building.

Appendix II

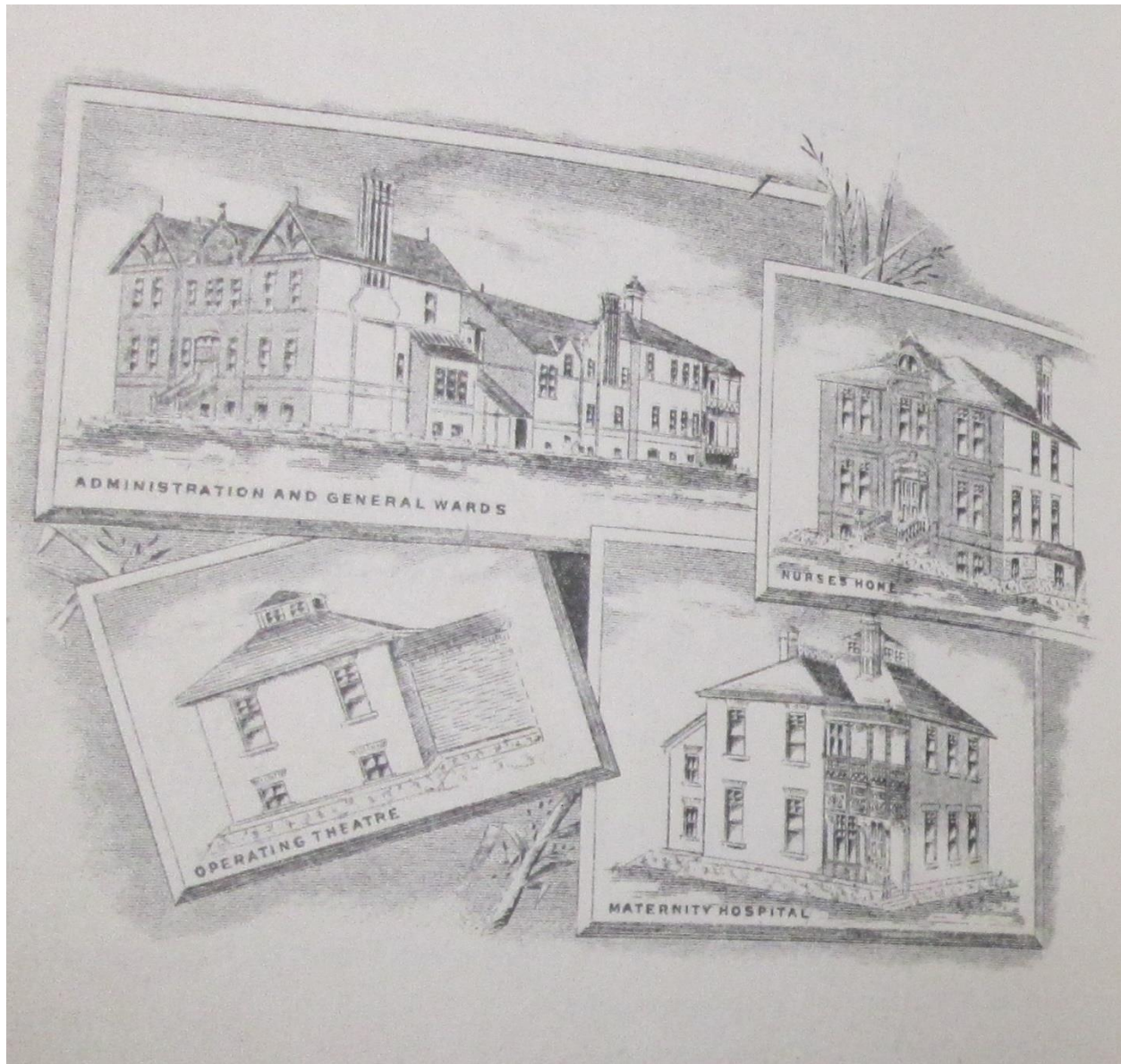
2.1



838

⁸³⁸ Toronto General Hospital, Administration, Basement Plan B, Sheet No. 3, issued September 1910 [architectural drawing], Toronto General Hospital fonds, Plans and Architectural Drawings, TG 33.0.1, University Health Network Archives, Toronto. Credit: Darling & Pearson Architects. On the left side note the small 'quarantine' area. This is a partial drawing due to size limitations, the building extends further back. On the right is an exterior representation of the entranceway.

2.2



839

⁸³⁹ “WGH Annual Report for the year 1889,” File 7 Box 9 WGH Fonds HSCAM. Various rendering of the building then in use. The operating theatre was attached to the main building by a covered hallways but also set purposefully aside as to be isolated to some extent.

2.3



840

⁸⁴⁰ “WGH Annual Report for the year 1906,” File 23 Box 9 WGH Fonds HSCAM. Overlay of existing campus with numbered areas. Produced for the annual report to show the new Nurses’ home in relation to other structures.

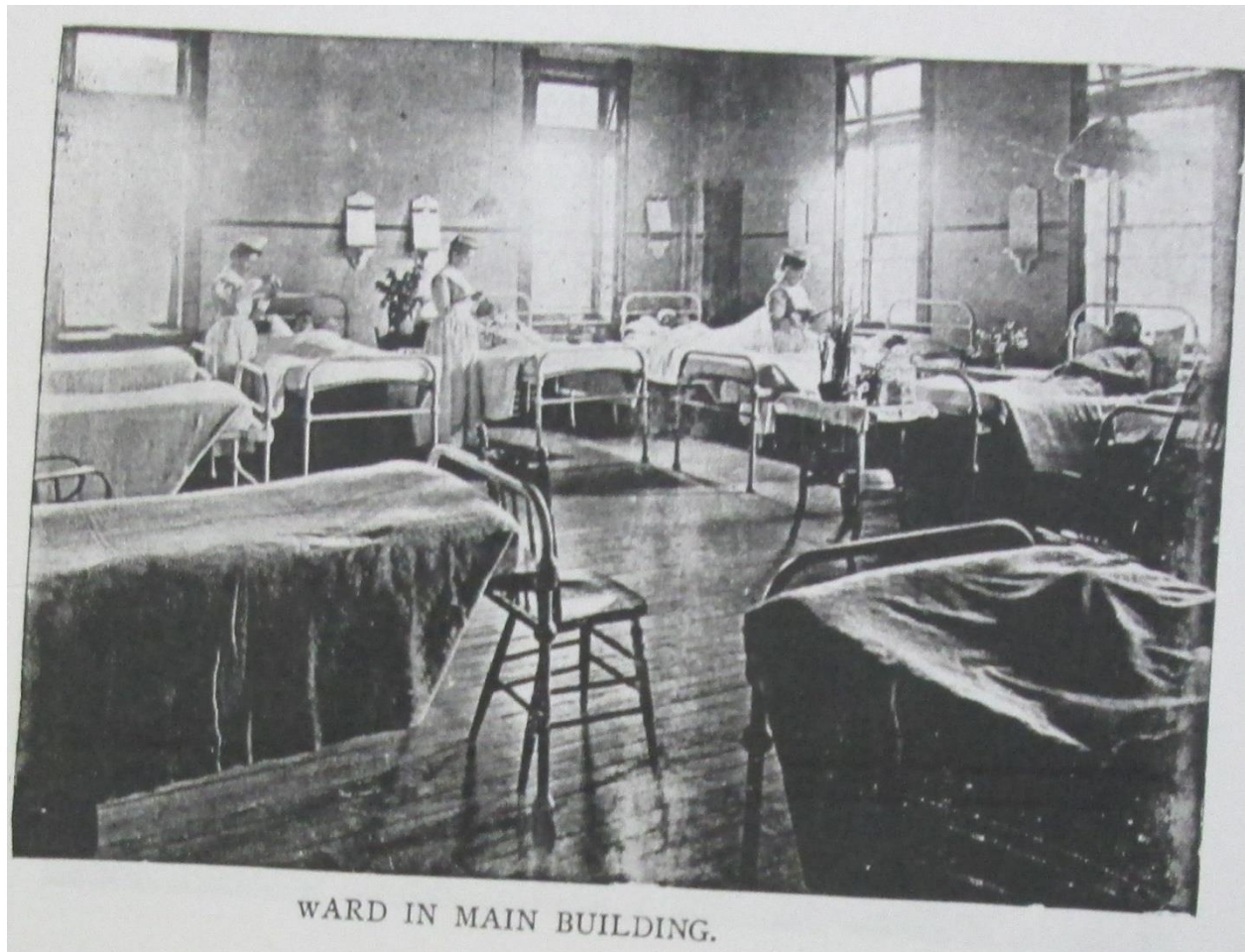
2.4



841

⁸⁴¹ "CGH Annual Report, 1905." Box 12, File 2. CGH Fonds AHS Archives. Image showing exterior of main building (CGH I Cottage Hospital 1895), Maternity Hospital 1900, and Isolation Unit 1905; left to right.

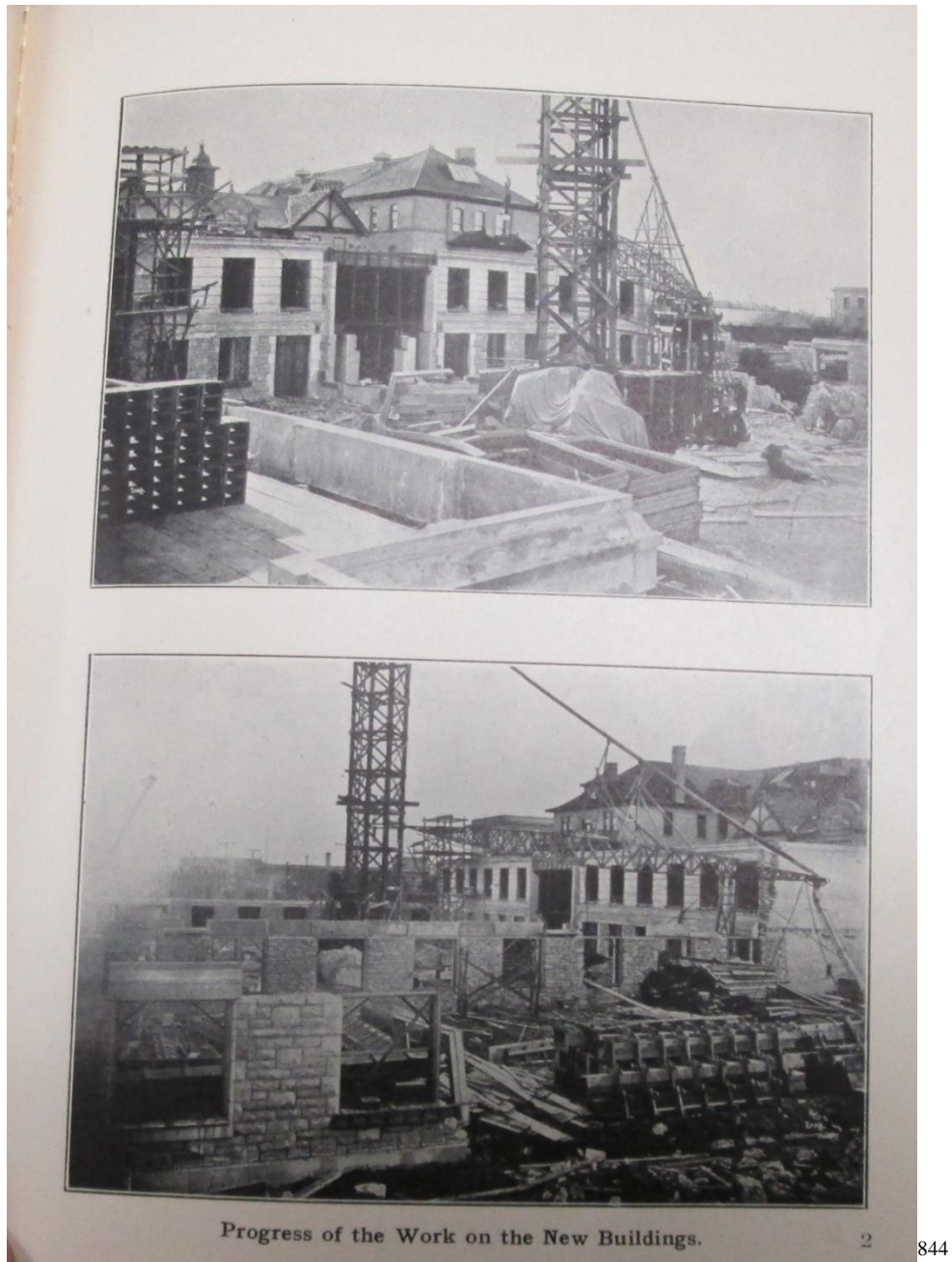
2.5



842

⁸⁴² Ibid. Image showing public ward in main building. Patients and nurses visible.

3.2



⁸⁴⁴ "WGH Annual Report, 1911." Box 9, File 28. WGH Fonds HSCAM. Images showing construction progress on the East and Central wings. Public distribution of these types of photos both reaffirmed that the project 'truly happening' and also allowed the board to present images of progress.

3.3



845

⁸⁴⁵ "WGH From the Air, 1929." Box 17, File 4 WGH Fonds HSCAM Archives. Images taken from the Nurses' Alumnae Journal depicting the campus from the air. The decision for this sort of sketch reinforces awareness of, and desire to express, the size of the campus.

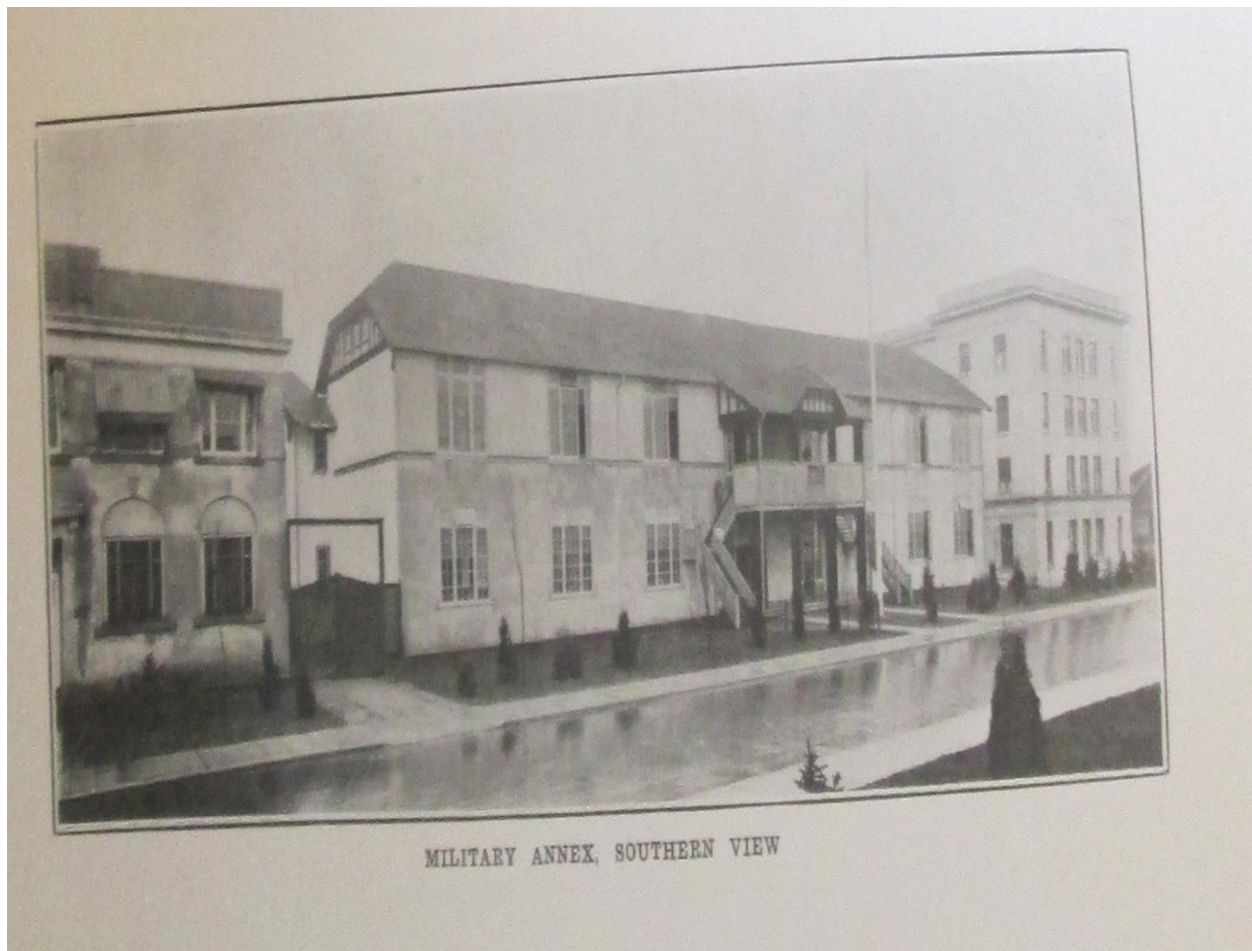
3.4



846

⁸⁴⁶ “CGH Annual Report, 1913.” Box 12, File 5. CGH Fonds AHS Archives. Image depicting the main building. (CGH III ‘Old General’)

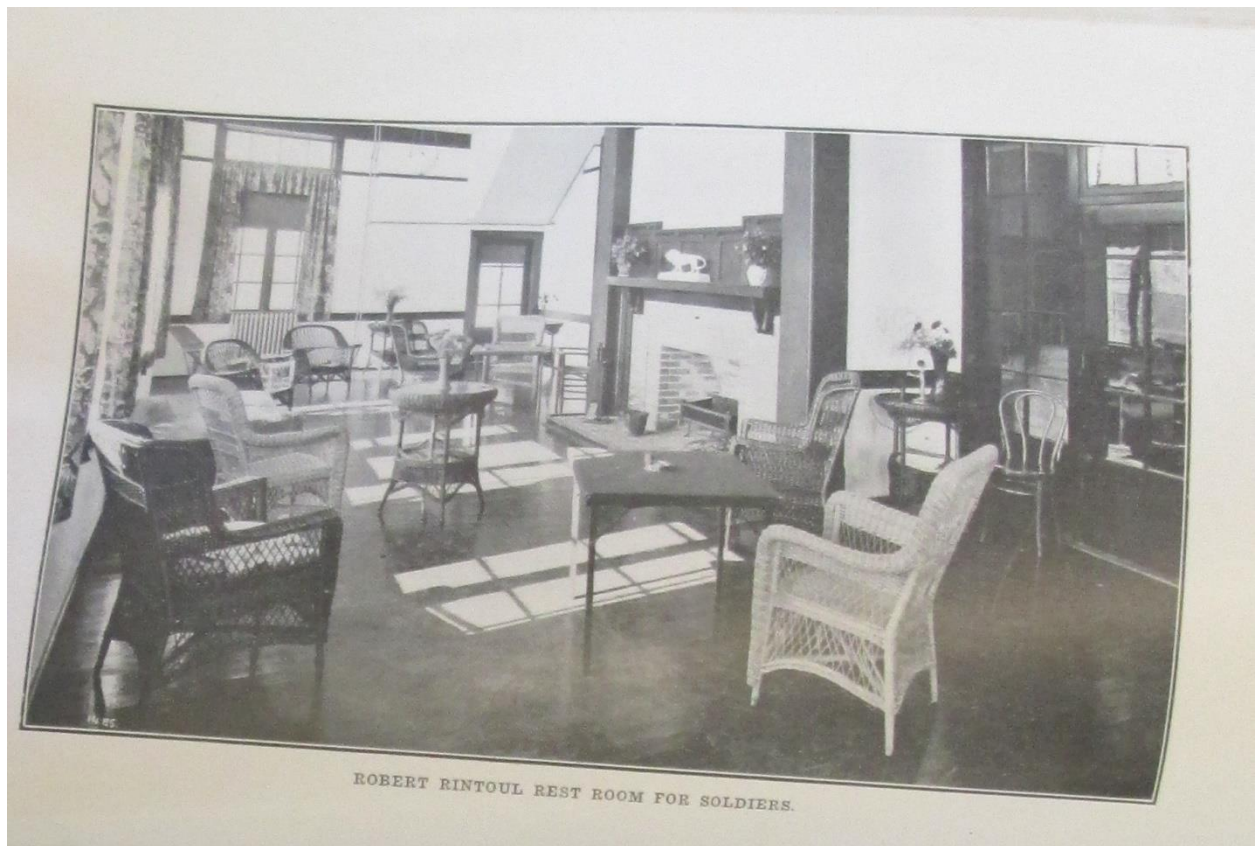
3.5



847

⁸⁴⁷ "VGH Annual Report, 1917." Box WX 2 DC 2.2 V2, VGH Fonds CVA. Image depicting exterior of the military annex – warehouse design, two storeys.

3.6

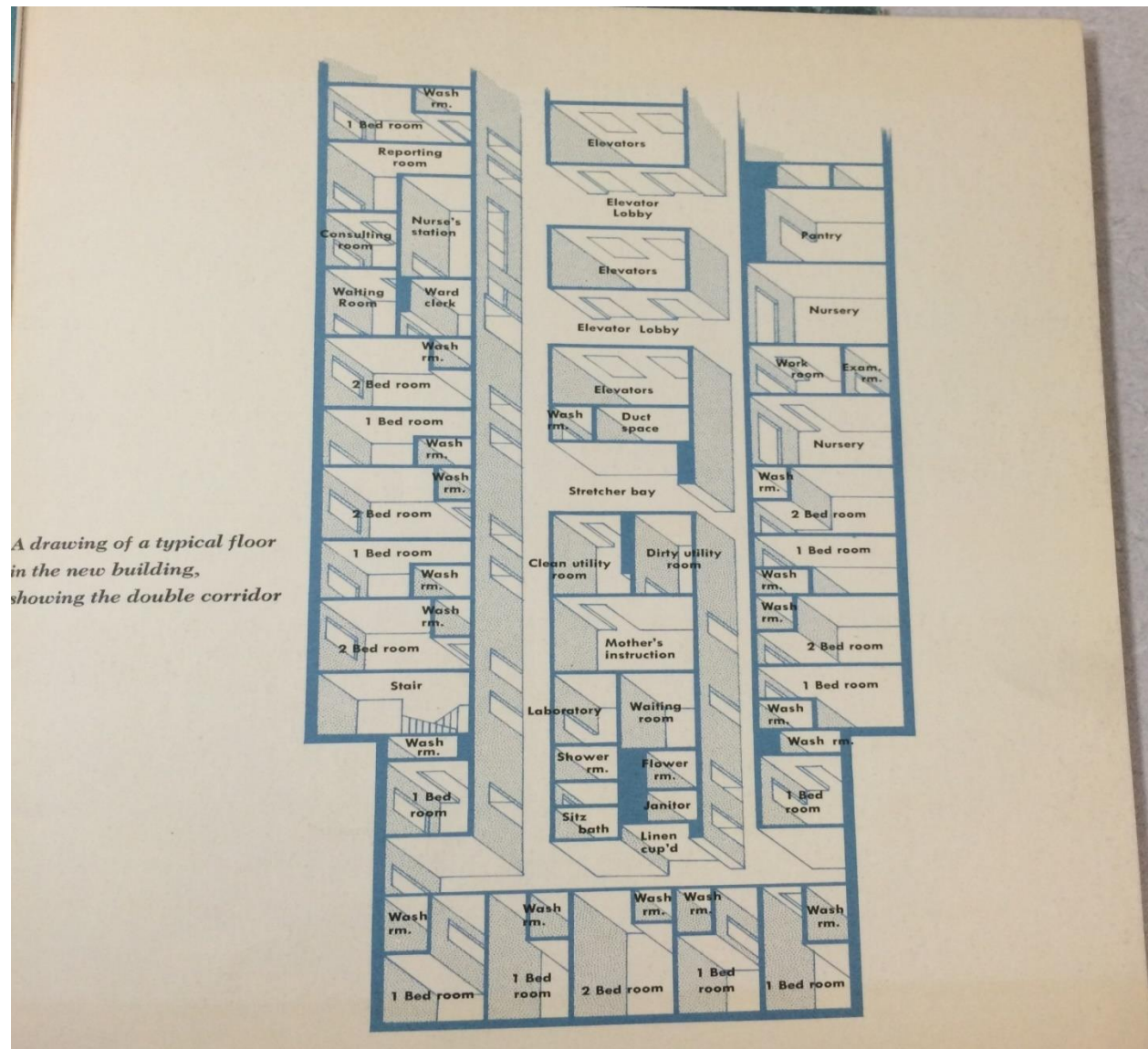


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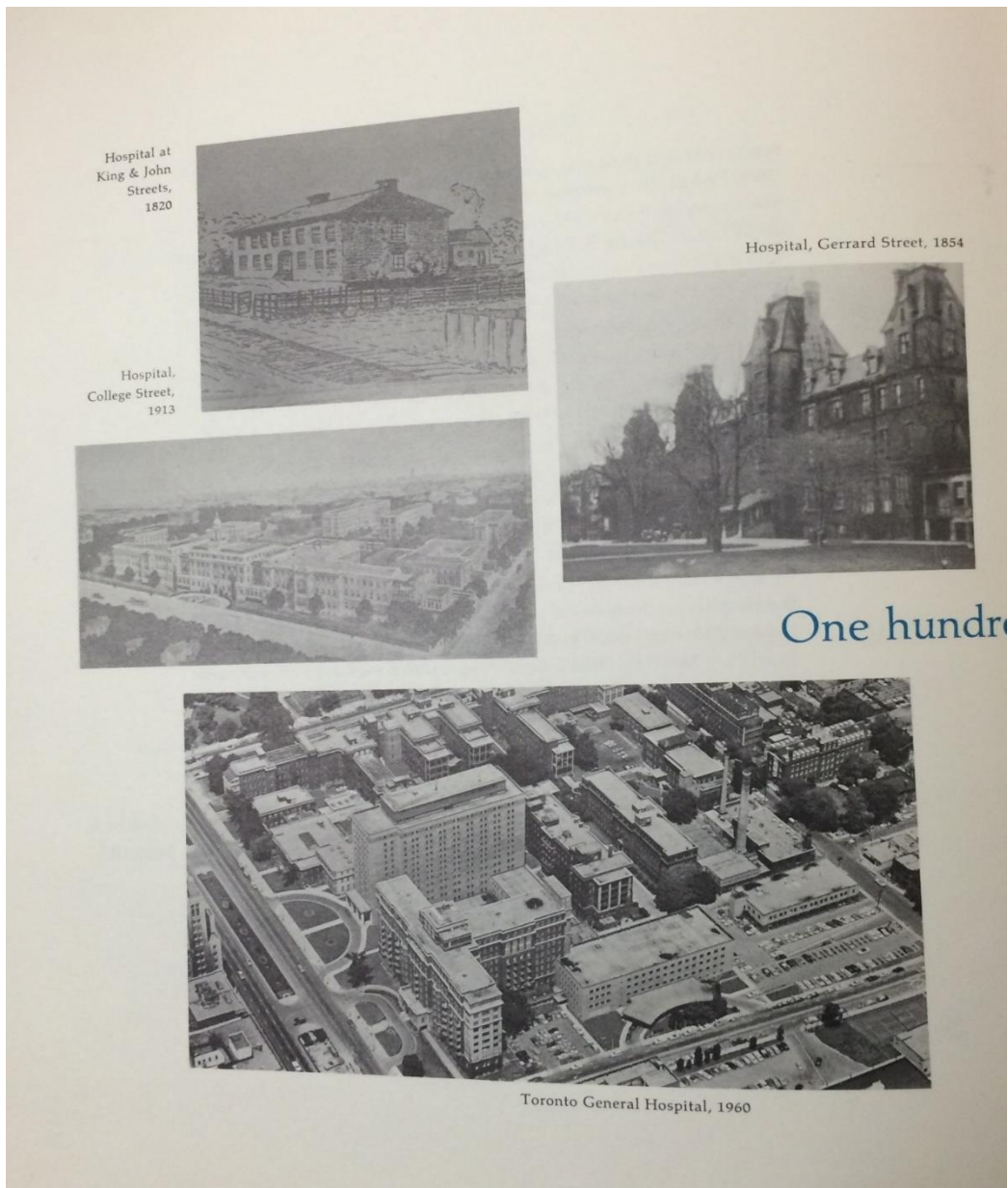
⁸⁴⁸ "VGH Annual Report, 1918." Box WX 2 DC 2.2 V2, VGH Fonds CVA. Image showing interior of the Military Annex. Specifically the Robert Rintoul Rest Room for Soldiers.

Appendix IV

4.1



4.2



849

⁸⁴⁹ One hundred and forty years of service, unpaginated, 1960 [photograph], in Toronto General Hospital Report for 1960, Toronto General Hospital fonds, Board of Trustees records, Annual Reports, TG 1.2.17, University Health Network Archives, Toronto. Image of campus from the air. Sketches of older buildings included.

4.3



⁸⁵⁰ “WGH Annual Report, 1956.” Box 11, File 8 WGH Fonds HSCAM. Image of North Wing nearing completion. Intended to spring opening in 1958; would add 324 private and semi-private beds.

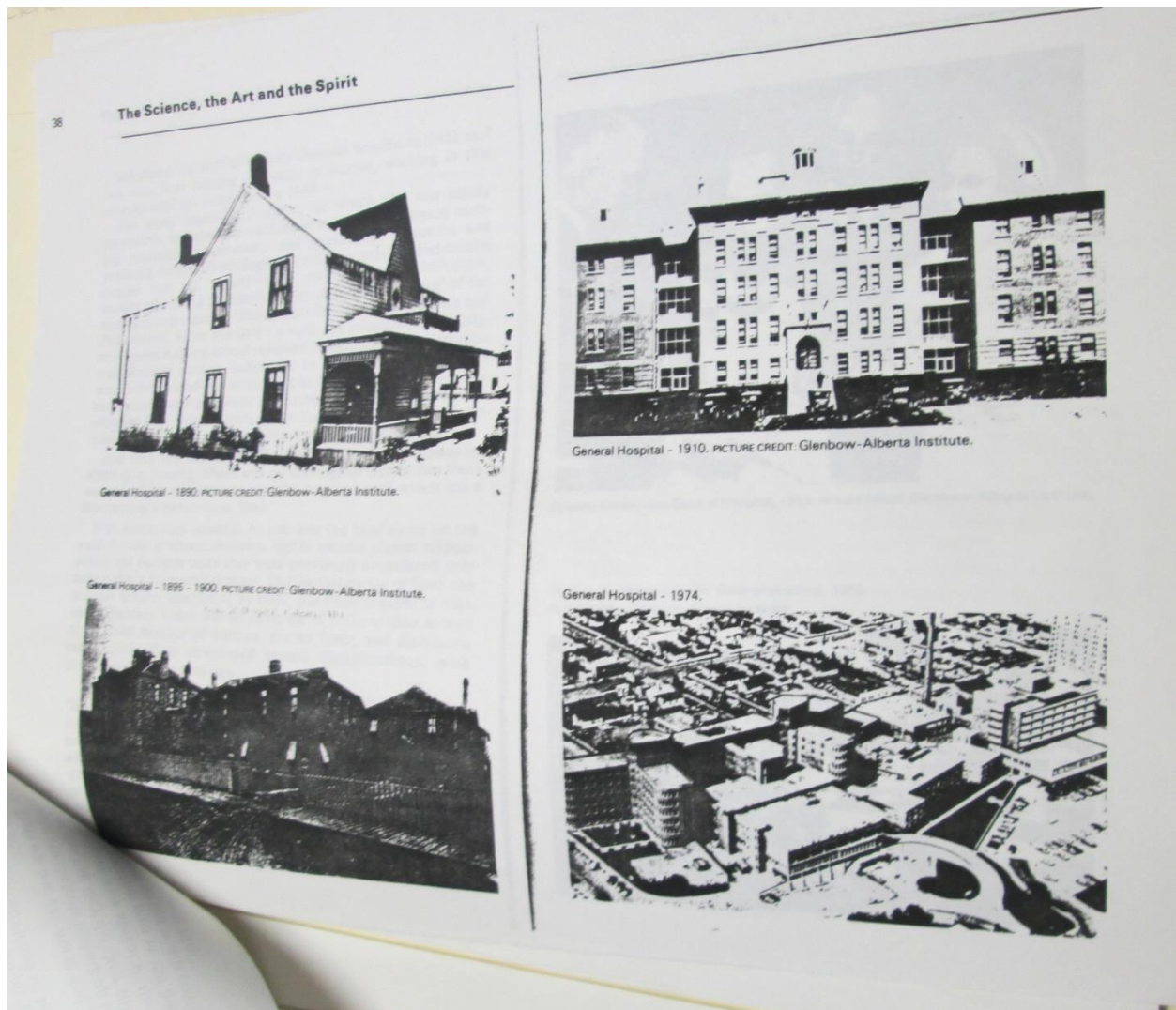
4.4



851

⁸⁵¹ "WGH Annual Report, 1958." Box 11, File 10 WGH Fonds HSCAM. Image of operating room in the new North Wing; note it is a room now, not a theatre.

4.5



852

⁸⁵² "CGH Through the Years," Box 33, File 15. CGH Fonds AHS Archives. Photo courtesy of the Alberta Health Services Archive. Image depicts all four 'phases' of the CGH.

4.6



853

⁸⁵³ Ibid. Photo courtesy of the Alberta Health Services Archive. Aerial depiction of CGH campus c. 1950.

4.7

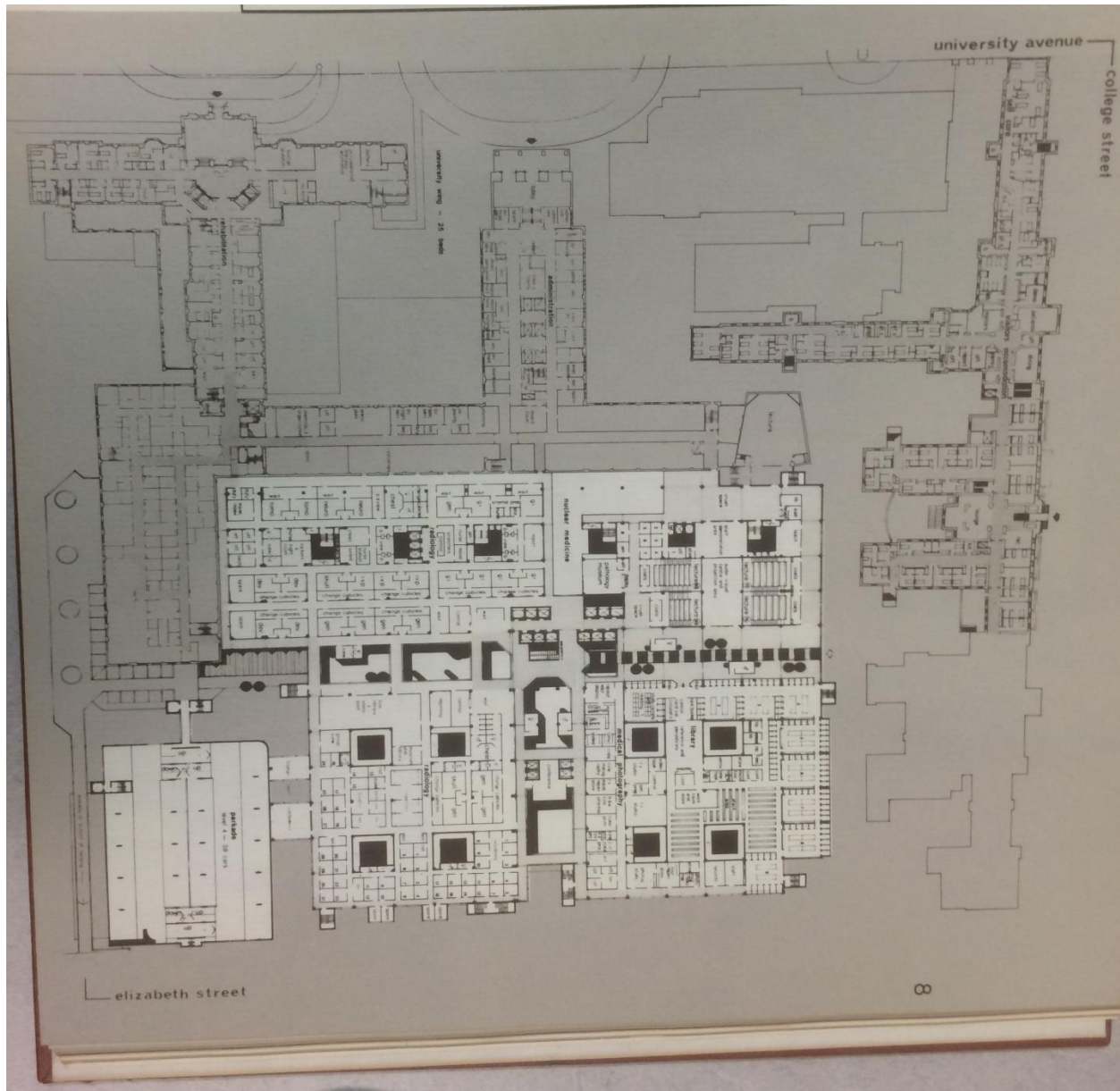


854

⁸⁵⁴ “Exterior of Centennial Building, 1959.” Box 535-D-3, File 3, CGH Fonds CVA. Photo courtesy of Vancouver Coastal Health Authority.

Appendix V

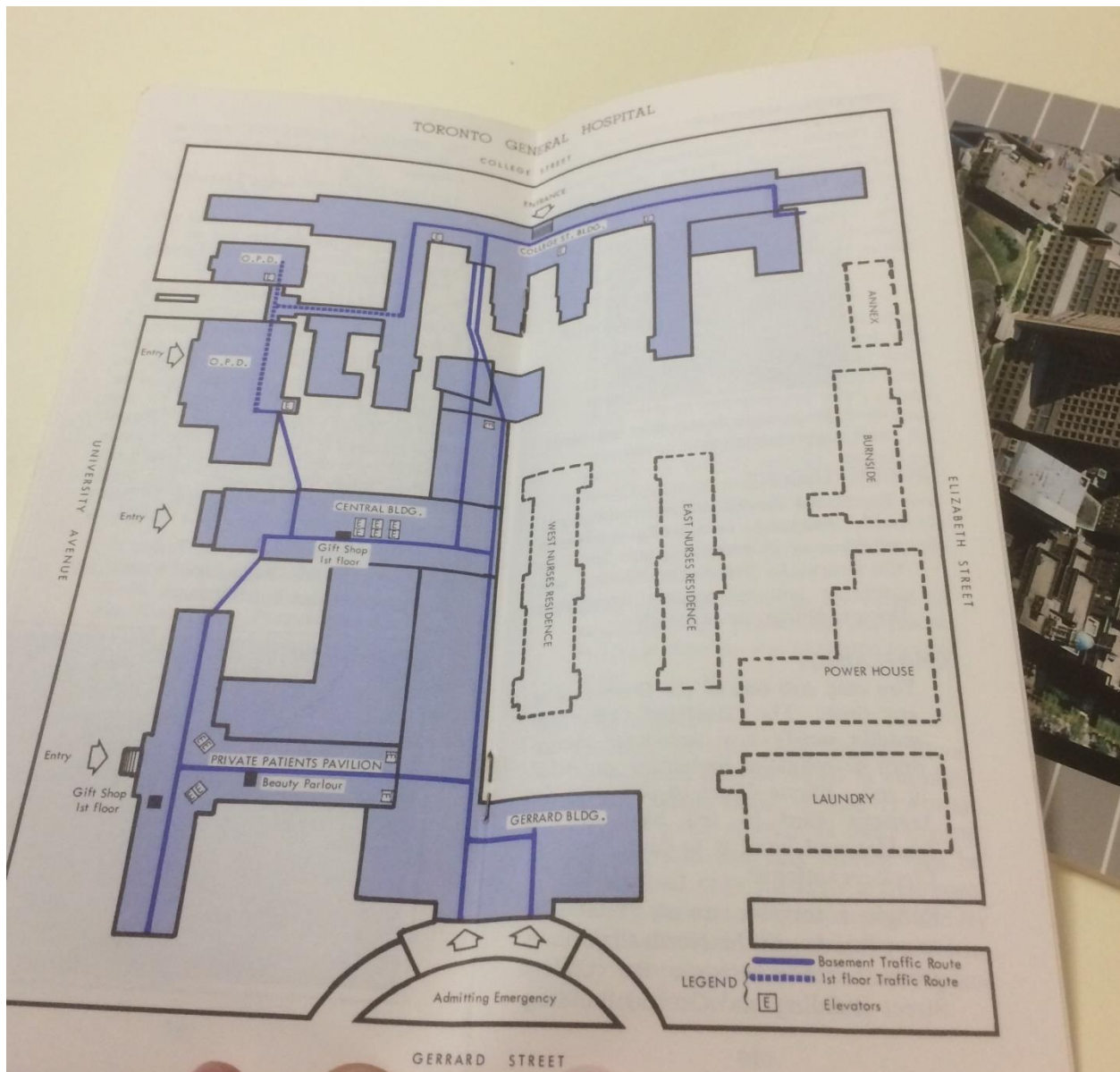
5.1



855

⁸⁵⁵ Floor 1, Toronto General Hospital, 1968 [architectural drawing], in Mathers and Haldenby Architects and Woods, Gordon and Co. Planning Consultants, Toronto General Hospital Planning Report, v.2, 1968, Chapter 8.4 Floor Plans, Elevations and Sections, Toronto General Hospital fonds, Office of the President records, TG 2.25.2, University Health Network Archives, Toronto. Image from the Woods Report showing the building as a concept and then several floors artificially spaced out. The idea was to conceptualise the whole building as one unit or interconnected entity rather than discrete floor with their own functions.

5.2



856

⁸⁵⁶ “Overview of TGH, 1966” Box TG 80, File TG 25.3.7. Image from a pamphlet meant to promote the new buildings to the general public. A useful contrast with the Woods Report to show the differences in detail with what was public and what was not.

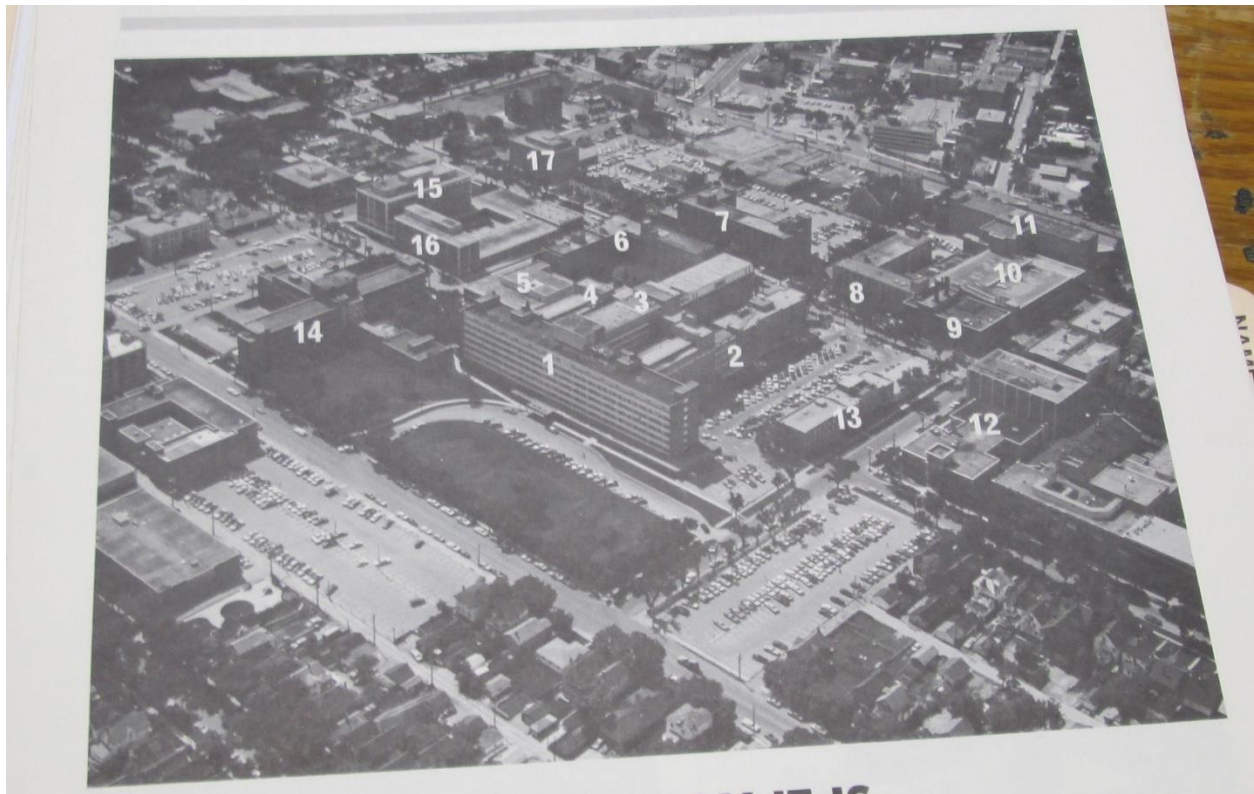
5.3



857

⁸⁵⁷ "WGH Annual Report, 1960." Box 11 File 12, WGH Fonds HSCAM. Service Wing under construction.

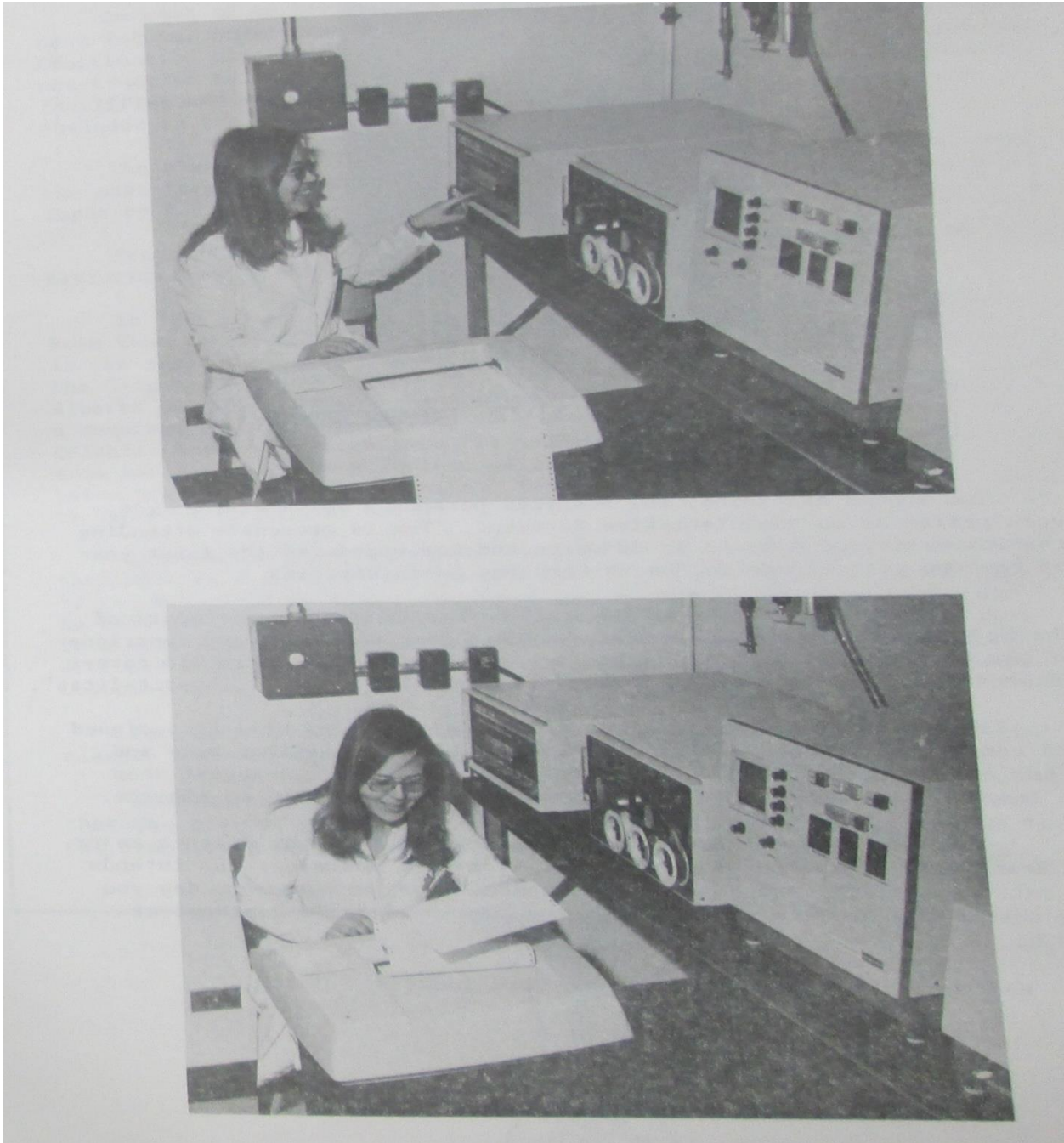
5.4



858

⁸⁵⁸ “The Way it is,” Box 8, File 7 WGH Fonds HSCAM. Image from the internal newsletter—*The Generator*—offering an aerial photo of WGH campus with numbered buildings. 1. ‘A and D’ wings, 2. ‘E and F’ 3. ‘G and H’ 4. ‘C’ Wing 5. The Cancer Treatment and Research Foundation 6. The Nurses’s Old Residence 7. The School of Nursing 8. Interns Residence and Lennox Bell House 9. The Power House 10. The Laundry and Parkade 11. The Women’s Pavilion 12. The Medical College 13. The Psychiatric Institute 14. The Children’s Hospital 15. The Rehabilitation Hospital 16. The D. A. Stewart Centre 17. The Manitoba Clinic

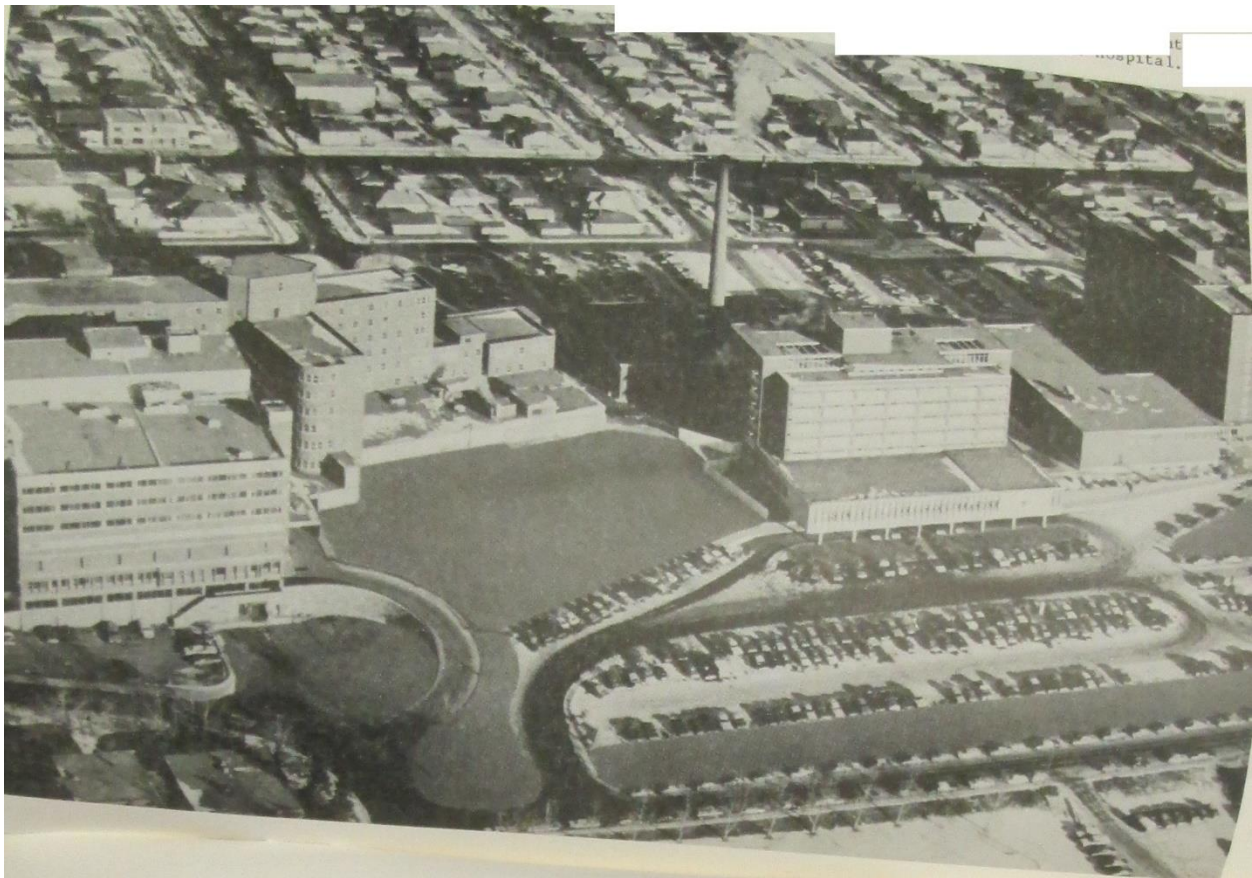
5.5



859

⁸⁵⁹ “Sounds Off!” Box 50, File 2 CGH Fonds AHS Archives. Photo courtesy of the Alberta Health Services Archive. Image showing technician using a ‘GEMSAEC Fast Analyzer.’ A recently-acquired machine used for analysing chemical tests. An example of faster technology foreshadowing computation.

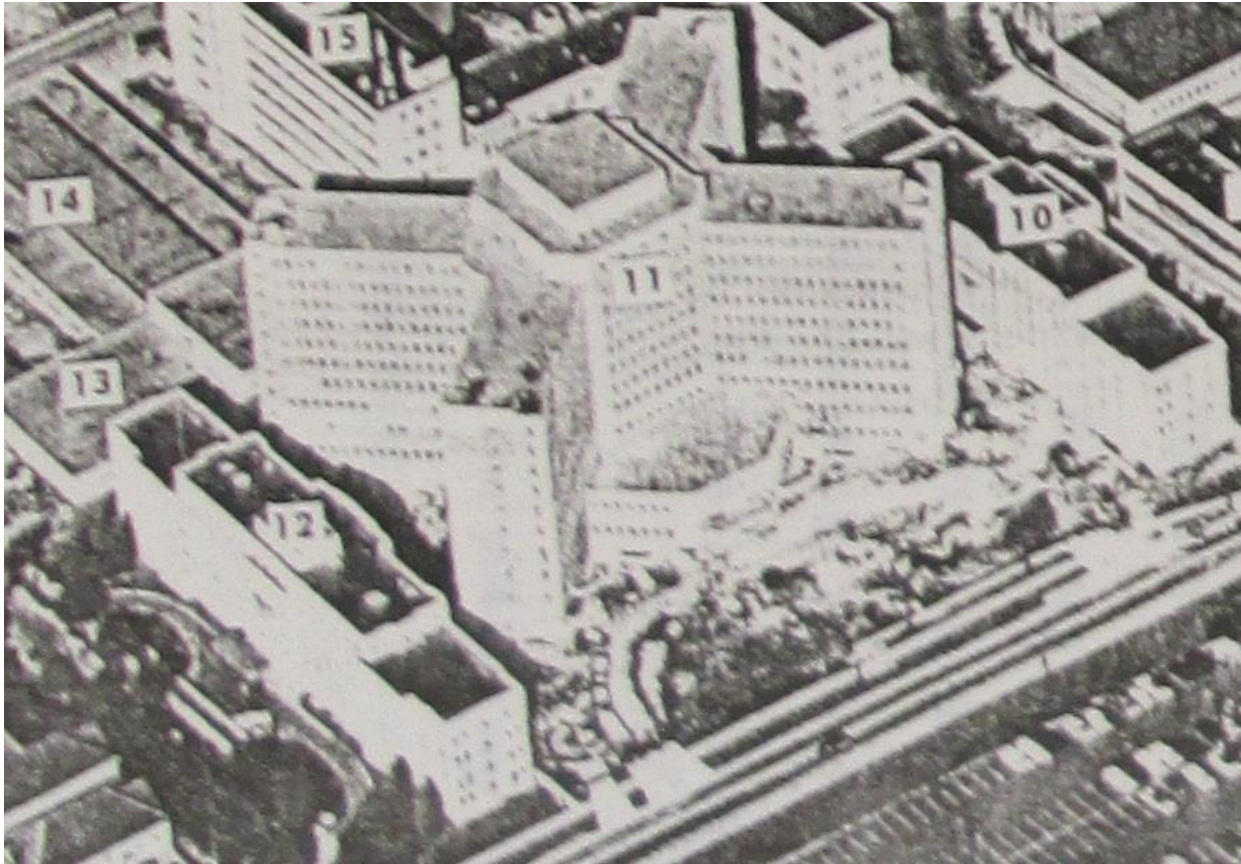
5.6



860

⁸⁶⁰ “CGH From The Air, 1976” Box 50, File 2 CGH Fonds, AHS Archives. Photo courtesy of the Alberta Health Services Archive. Aerial Photograph showing the campus, and its relation to nearby residential areas.

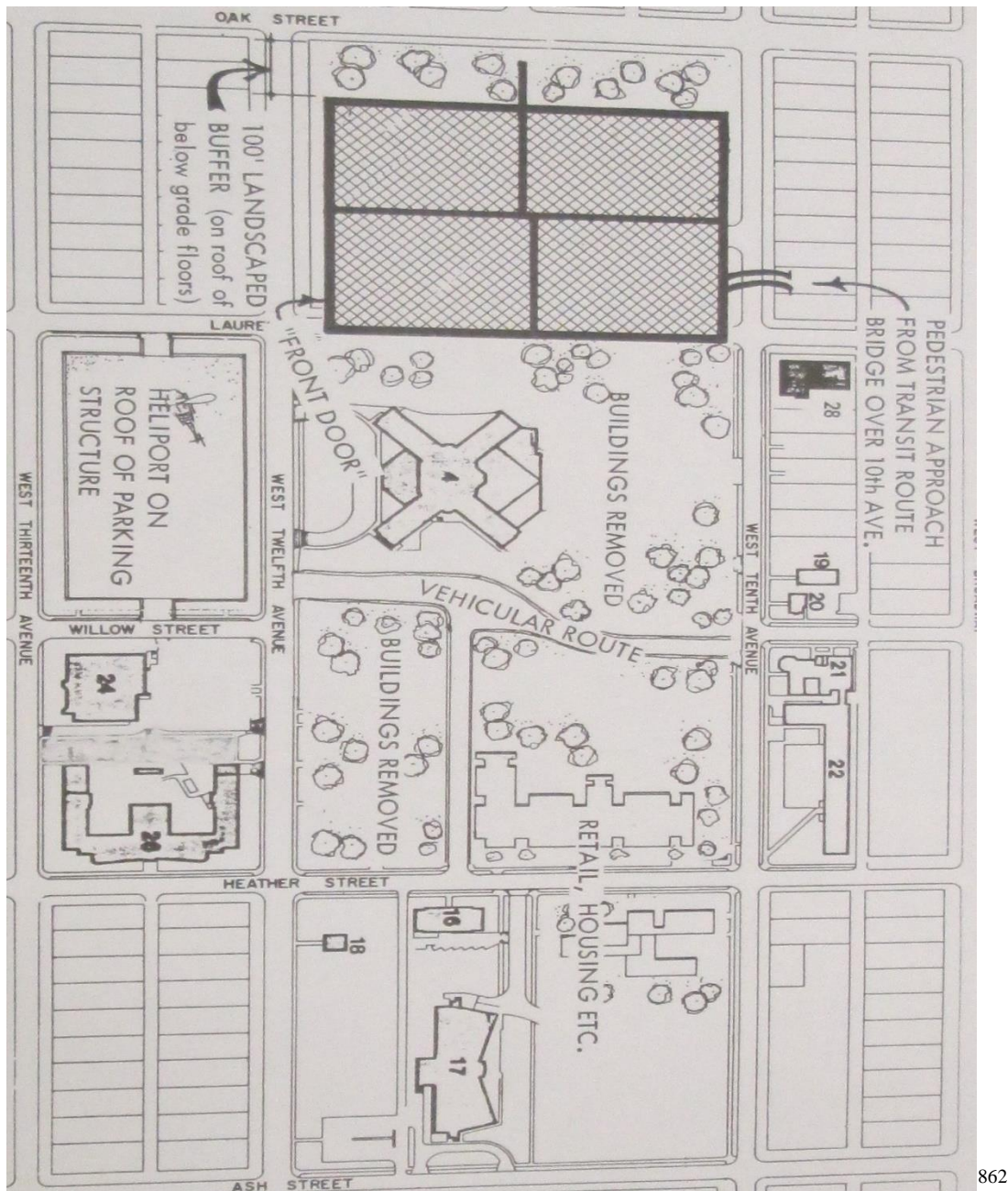
5.7



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⁸⁶¹ “The Vancouver General Hospital: The Heart of British Columbia’s Medical Centre,” File 7, Box 570-A-5, VGH Fonds CVA. Photo courtesy of Vancouver Coastal Health Authority. Ariel view of the VGH c. 1959. Willow is labeled 10, and Laurel—still standing—it labelled 12. This image shows the Laurel and its proximity to the Centennial building. Also note its similarity in design with the Willow.

5.8



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⁸⁶² “VGH Facility Planning,” 1976, 67. File 4, Box 570-B-3 VGH Fonds CVA. Photo courtesy of Vancouver Coastal Health Authority. Building Numbered 17 is the Banfield Pavilion. The Open grid area to the West of the Centennial Building (Numbered 4) is the eventual site of the Emergency Trauma Centre that opened in 1982. Note the Laurel and Willow Pavilions do not appear in this drawing though the Willow is still standing. The original (1940) Willow Pavilion building is no longer called that, but it remains on the campus. The new ‘Willow Pavilion’ is located within the complexes added after 1982.



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Appendix VI

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⁸⁶⁴ *Winnipeg Free Press* 4 November 1957, Box 35, File 1, WGH Fonds PMA. Image courtesy of the *Winnipeg Free Press*.

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