The Country Doctor in British Columbia: 1887-1975. An Historical Profile*

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The characteristics currently deplored in North American rural practice — high average age of practitioners together with lack of access to improvements in medical science and technology, leading to excessive conservatism; and isolation of patient and practitioner from hospital and other health care facilities — are nothing new in British Columbia. They are not simply a recent product of increasing materialism and declining idealism among young practitioners, or of progressively deepening neglect of the outbacks by urbanized society, but have characterized rural practice there for most of the past century. High quality rural practice depends, above all, upon the wealth and stability of rural communities.[1] Both these qualities have been only intermittently and uncertainly available in rural British Columbia and in other extractive-industry areas on this continent and in the Western world generally.

The model of the country doctor which most people on this continent have in mind and which most laymen in country districts today still hope for is that made famous by Arthur Hertzler in *The Horse and Buggy Doctor*.[2] It concerns a young man from a rural background, trained in a good second-rank medical school, who establishes himself in a substantial agricultural community where the social structure is stable and the population growing steadily. His practice grows, and he decides to stay and grow old with the community. That practice consists largely of primary care, notably patching up farm injuries and treating illnesses, including the epidemic diseases of the period; of family practice, especially obstetrics and pediatrics; and, increasingly, as he grows old with the community

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1 Erwin H. Ackerknecht, *A Short History of Medicine* (New York, 1955, 1965), p. 218.

2 New York, 1938.

and his practice comes increasingly to concentrate on his contemporaries, of palliative geriatrics. He becomes Good Old Doc, a respected and, above all, a *stable* figure in the community. Such a model applied in large areas of the United States between the 1880s and 1920s, in developed agricultural areas of Southern Ontario and Quebec and, with some variations, in parts of the prairie provinces before the Second World War. No doubt equivalents can be found in the developed agricultural communities of other countries of the Western world.

Did it apply in British Columbia? The evidence suggests generally not. The principal evidence which is used in this paper is drawn from the *Medical Register of British Columbia* at approximately five-year intervals from the beginning of the *Register* in 1887 to 1975. The *Register* provides, directly or indirectly, the following information:

1. The name of the practitioner;
2. The name of the community in which he is currently practising, from which, by comparing the entry in the current year with those in previous years, we may learn
3. The number of years the practitioner has practised in the community;
4. The institution of, and
5. The date of the practitioner's medical qualifications, from which we may reckon
6. The years since the practitioner's qualification, and, approximately
7. The practitioner's age.

The most significant information for our purposes — the average time since qualification (suggesting average age) and the average time in practice in a particular community — has been plotted on graphs, for rural British Columbia as a whole and for the various rural districts: Vancouver Island and the Gulf Islands, Lower Mainland, Cariboo, Okanagan, Boundary, Kootenays, Nechako-Skeena, Mainland Coast and the North, as well as for the city of Vancouver as a comparison. Proportions of medical qualifications by country of origin — Canada, United States, Great Britain and Other; and, within Canada, by institution — have also been determined for rural British Columbia as a whole.

The term "rural practice" is difficult to define. A common mistake is to regard "rural" in this context as non-metropolitan, but this does not take into consideration the relatively high degree of sophistication in medical practice and health care in non-metropolitan towns, some of which have well-equipped hospitals and a variety of specialist practitioners and tend, especially in recent years, to draw a concentration of medical talent

to them at the expense of medical practice in truly rural communities. A distinction must therefore be made between *rural* practice and *small town* practice. As particular communities become urbanized, it is necessary for our purposes to remove them and their practitioners from the sum of rural practice. In some instances communities, having become urbanized, become rural once more with the failure of their principal extractive industry and the departure of a large part of their population. These must be restored once more to the sample. Until the 1930s the progress of most country towns in British Columbia was steadily toward urban status, but medical practice in them was still predominantly with a population resident and employed in the countryside, who were visited in the countryside regularly by the doctor. By the 1930s, however, most of the non-metropolitan towns of the Interior, the Coast and Vancouver Island were becoming entities socially distinct from their hinterlands and medical practice in them became urbanized. Such towns and their medical practitioners are eliminated from the series. Thereafter, as the series progresses, various other towns are eliminated as they and their medical practices become urbanized. On the other hand, additions of communities are made as they revert to rural status, especially since 1945. Perhaps the most nearly objective criteria of rural practice are that the bulk of the practice should be with people in the countryside, not in the town, and that the community should not have specialist practitioners or sophisticated hospital facilities readily available.

In one important respect practice in rural communities in British Columbia from the earliest days was not cast in the Hertzler image at all. The typical rural doctor in British Columbia in the early days was not the *country* doctor, but the *company* doctor. The companies engaged in extractive industries — fishing, lumbering, mining — and in railway building provided limited medical care through doctors paid either on contract or by individual contributions to an organized fund. The rural practitioner from the coming of the railway in the 1880s until after the First World War was most often a middle-aged or elderly company doctor or former company doctor — providing primary care. This included repairing industrial accidents and coping with epidemic diseases, such as typhoid (brought in by the railway workers in 1884 and endemic in the valleys of the interior of British Columbia until just before the Second World War).

Only with the development of permanent settlements as the yield of the extractive industry persisted did the practice expand to include family and extended care medicine. The company doctors continued to pro-

vide a significant proportion of rural practitioners, at least until the Second World War. But as the history of the Kootenay boom demonstrated, the future of extractive-industry communities and practice in them was uncertain. Young men like Peter McLennan, coming into the transitory boom towns, soon realized that the community was growing old faster than they were.[3] Ore veins or timber stands petered out, population moved on, and so did the young practitioners, leaving their middle-aged and elderly colleagues — men who were frequently burdened with local financial responsibilities, who were alcoholics or otherwise incompetent, or were just too old or to tired to move. Thus the age distribution among rural practitioners, even in these early days when pioneer doctoring was supposedly the role of the young, was increasingly trending upward. The trend was further accentuated by the migration into rural British Columbia, especially in the decade immediately before the First World War, of middle-aged general practitioners from Great Britain. Frequently they came as participants and victims in some development scheme designed to part Englishmen from their money, such as Edgewood in the Arrow Lakes or dozens of schemes in the Cariboo and along the rights-of-way of the new railways. Some came to the Gulf Islands and southern Vancouver Island to retire. Many more, no doubt, came in search of a new beginning.

Here it is necessary to comment on the significance for the quality of health care in a rural community of a steadily rising average age. In any average group of doctors, the variation in the date of their initial qualification may be forty to fifty years. Indeed, if the claims to active practice of all the registrants in the Gulf Islands in some decades of this century are to be taken seriously, in *that* locality the variation may be as great as sixty years. A physician sixty years away from his initial training is very elderly. Is he, by reason of his age, incapable of carrying on practice adequately in a rural community? A recent analysis of rural health care in Missouri accurately describes the situation:

> An elderly practitioner who has spent much of his career in a rural area will not have had much opportunity to keep abreast of current developments in medicine, and though he may compensate for this to some degree by greater experience and expertise in primary care in particular, in the long run the quality of care provided by him will probably be less than that provided by a practitioner who has more recent training.

[3] B.C. Medical Library, M/S of P. A. McLennan, M.D., "Memories," an address to the Annual Meeting of the Vancouver Medical Association, 4 May 1943. Cf. Table and Graph No. 4. Medical Practitioners in Rural Kootenay, 1887-1975.

And, further, they make a most important particular point:

> Any negative disparities in health care in this respect attributable to elderly practitioners are likely to fall most heavily on old patients, since elderly practitioners have a disproportionately large number of elderly patients.[4]

Even elderly practitioners rarely stayed in dying communities if there was an opportunity to move to something better. Thus in the thirty years before the First World War there was a rapid turnover of doctors in most genuinely rural practices.[5] To the tendency of young doctors to move upward and outward to the cities or, at least, to prosperous country towns, was added the tendency of the older doctors who were left to move to a better or at least less disadvantageous rural community than the one they were in. Though the average number of years spent by practitioners in rural communities rose, it did not rise nearly so steeply as did the average age of those practitioners.

These points can be demonstrated by the accompanying graphs. Ordinarily among a group of physicians practising in a stable or stably-growing community, there should be regular simultaneous fluctuations in both the average time since qualification and the average time in a locality. Such fluctuations, from peak to peak or trough to trough, should be of about thirty years' duration. The curves should peak and be followed by a sharp decline as retiring physicians are, in the aggregate, replaced by young physicians. The young doctor may not directly take over the retiring doctor's practice, but his presence substantially replaces that of the retiree. The situation in Vancouver and in the relatively stable agriculturally based communities of the Okanagan Valley[6] illustrates this stable pattern, which is also that in rural practice on the Hertzler model. The secular trend of both curves is upward in any case as the communities become mature and as the population in general grows older.

The different situation for the rural communities in British Columbia taken together is illustrated in Graph 3.[7] Both sets of average statistics for rural B.C. increased fairly steadily, with the exception of the decade of

[4] Edward Hassinger, Billy Y. L. Hu, Donald V. Hastings and Robert L. McNamara, "Changes in the number and location of health practitioners in a twenty-county rural area of Missouri," *Public Health Reports* (1975), 90:317.

[5] Cf. Tables and Graphs 2-4.

[6] Graph 1. Vancouver: Average years since qualification and average years in location of medical practitioners, 1887-1975; Graph 2. Okanagan District: Average years since qualification and average years in location of medical practitioners, 1887-1975.

[7] Graph 3. All rural districts in British Columbia: Average years since qualification and average years in location of medical practitioners, 1887-1975.

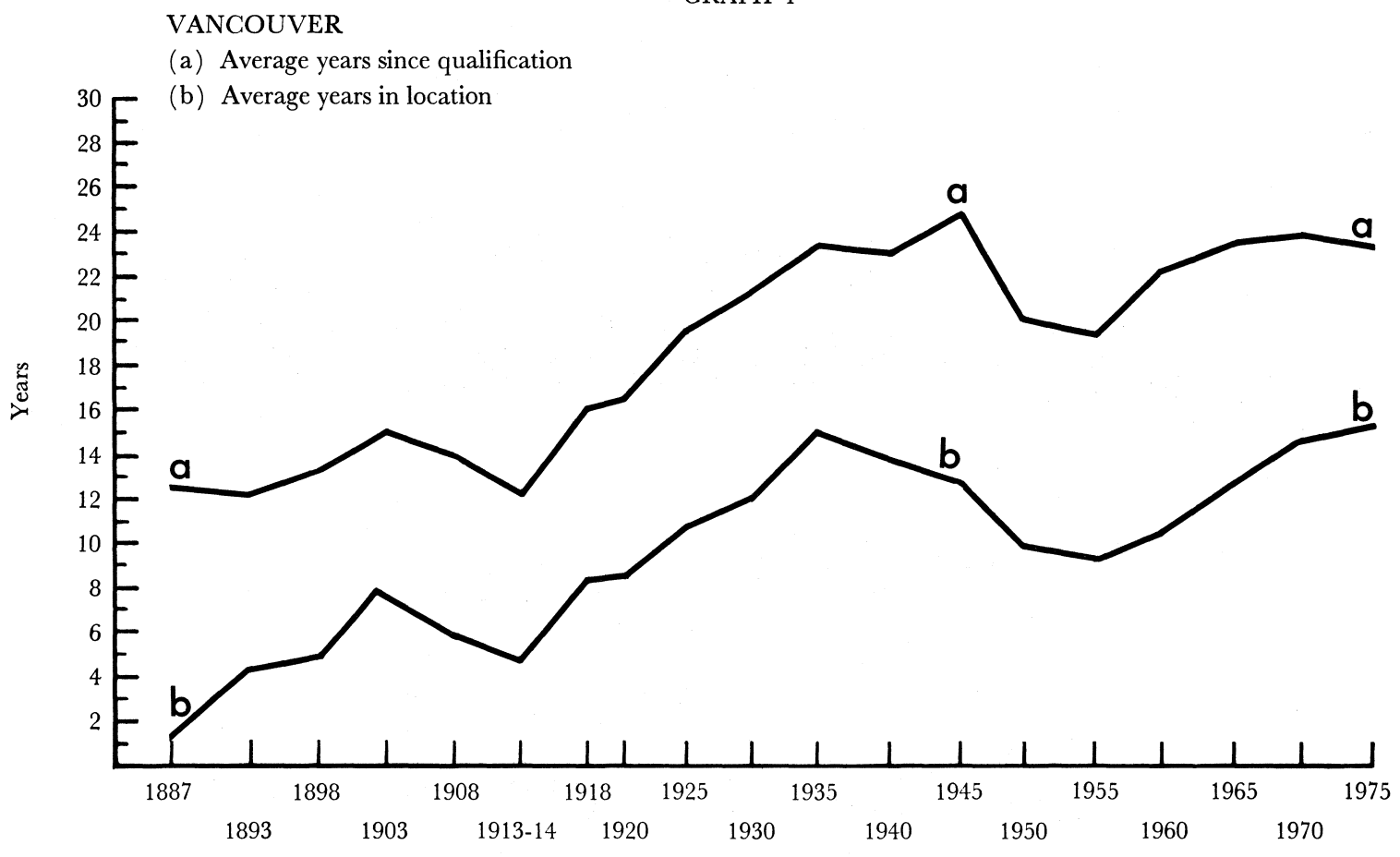
the 1930s, until the end of the Second World War, and declined sharply until the late 1950s, when they increased once more; whereas for Vancouver and the Okanagan there was an increase until about 1905, a sharp decline until about 1914, a steady rise until the Second World War, a steep drop until about 1955, and another steady rise once more.

The influence of both world wars should be noted. We should expect them to increase the average age and years in location of practitioners by the departure of young doctors to war, leaving old ones to maintain health care in both metropolis and rural areas until the end of the hostilities, at which time there should be a sharp drop in both statistics as young men come home to replace their elders. In the First World War, in both metropolitan and rural practice, the statistics went up. This may have been influenced in the case of Vancouver somewhat by the war service of the young, but in rural areas the average age was already high by reason of the departure of the young and the recruiting of middle-aged replacements. Thus there was no post-war decline in the figures when the young returned, and few returned in any case to rural practices. The circumstances influencing the fluctuation of these figures during the Second World War were somewhat different. In the Second, by contrast with the First World War, there were many more young physicians who either went to the war and returned or who, qualified before or during the war, and hitherto resident outside the province, decided to settle in British Columbia at the war's end. It should also be noted that a whole generation of elderly doctors in rural communities, who might have been expected to retire at about the beginning of the Second World War, stayed on in their practices until the war was over. The result was a steep rise in both statistics, peaking in 1945, and a subsequent sharp decline, much more pronounced in rural British Columbia than in Vancouver.

In the interwar years, and especially in the 1930s, the stability of doctors in their rural practices reached something of a plateau.[8] Company doctors were now giving way to established entrepreneurs in relatively successful practices. The remarkable young medical missionaries on the coast at the beginning of the century were now established middle-aged legends, assisted by numerous young doctors eager to have the experience of frontier medicine under the direction of a master. In the solid communities of Vancouver Island, the Lower Mainland, the Okanagan, the

[8] Cf. Ralph C. Parker, Richard Rix and Thomas Tuxill, "Social and demographic factors affecting physician population in Upstate New York," *New York State Journal of Medicine* (1969), 59:706, on tendency of rural areas to hold physicians during periods of economic depression.

GRAPH 1


VANCOUVER
(a) Average years since qualification
(b) Average years in location
Years
30
28
26
24
22
20
18
16
14
12
10
8
6
4
2
a
a
a
b
b
b
1887
1893
1898
1903
1908
1913-14
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1925
1930
1935
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1945
1950
1955
1960
1965
1970
1975

TABLE 1

Medical Practitioners in Vancouver, 1887-1975

Average Years in Community; Average Years Since Qualification and Total Number of Practitioners

Date	*Number of Practitioners*	*Average Years in Community*	*Average Years Since Qualification*
1887	6	.75	12.5
1893	21	4.52	12.29
1898	31	5.55	13.5
1903	44	8.03	14.98
1908	100	6.09	14.04
1913	211	5.56	12.33
1918	259	8.62	16.23
1920	274	8.84	16.68
1925	285	11.12	19.74
1930	343	12.27	21.04
1935	345	15.04	23.69
1940	380	14.92	23.52
1945	415	14.54	24.75
1950	654	10.34	20.38
1955	826	9.84	20.06
1960	954	10.65	19.58
1965	1,053	12.92	22.08
1970	1,289	14.58	23.67
1975	1,471	15.72	24.02

TABLE 1A

Medical Practitioners in Vancouver, 1887-1975

Distribution (%) of Medical Qualifications by Country

Date	*Number of Practitioners*	*Distribution (%) of Medical Qualifications by Country*			
		Canada	*U.S.*	*G.B.*	*Other*
1887	6	67		33	
1893	21	71		29	
1898	31	77	3	19	
1903	44	80	9	11	
1908	100	77	11	12	
1913	211	79	13	8	.7
1918	259	79	12	8	.6
1920	274	80	14	6	.5
1925	285	81	14	5	
1930	343	84	12	4	.4
1935	345	85	11	3	.5
1940	380	87	9	3	.3
1945	415	89	6	2	2
1950	654	89	4	3	3
1955	826	86	4	6	4
1960	954	81	3	10	6
1965	1,053	78	2	12	8
1970	1,289	73	1.5	16	9
1975	1,471	69	1.5	18	11

GRAPH 2

OKANAGAN

(a) Average years since qualification

(b) Average years in location

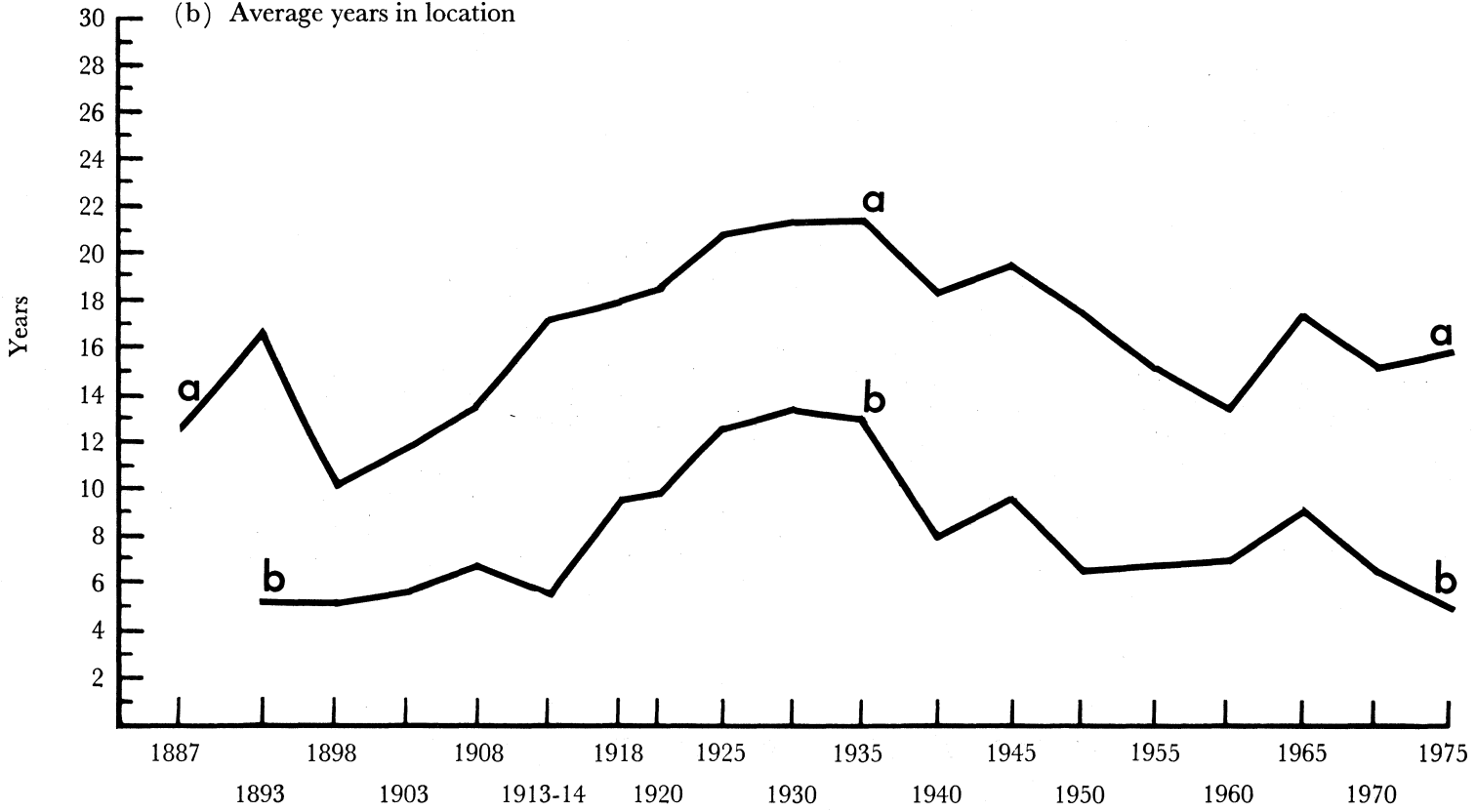


TABLE 2

Medical Practitioners in Rural Okanagan & South Thompson, 1887-1975

Average Years in Community; Average Years Since Qualification and Total Number of Practitioners

Date	*Number of Practitioners*	*Average Years in Community*	*Average Years Since Qualification*
1887	5		12.4
1893	5	4.8	16.4
1898	17	4.76	9.4
1903	18	5.75	11.39
1908	28	6.48	13.64
1913	39	5.3	17.08
1918	44	9.28	18
1920	43	9.85	18.53
1925	38	12.32	20.58
1930	38	13.46	21.42
1935	42	13.33	21.40
1940	14	7.96	18.43
1945	9	9.39	19.11
1950	14	6.5	17.5
1955	23	6.8	14.83
1960	35	6.84	13.11
1965	38	8.57	17.03
1970	56	6.46	14.61
1975	81	5.33	15.69

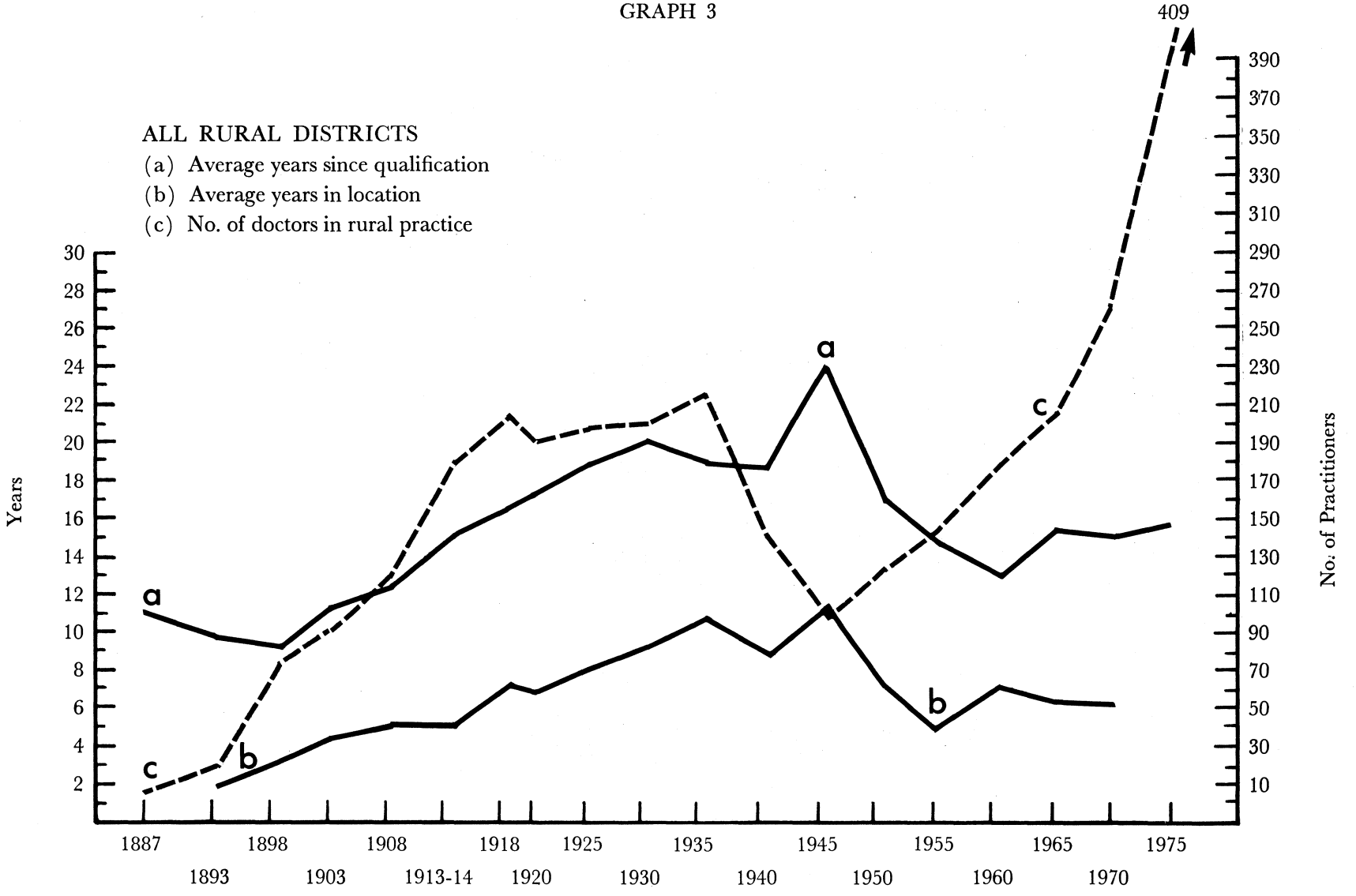
TABLE 2A

Medical Practitioners in Rural Okanagan & South Thompson, 1887-1975

Distribution (%) of Medical Qualifications by Country

Date	*Number of Practitioners*	*Distribution (%) of Medical Qualifications by Country*			
		Canada	*U.S.*	*G.B.*	*Other*
1887	5	80			20
1893	5	60		20	20
1898	17	64	12	12	12
1903	18	67	5	22	5
1908	28	79	7	7	7
1913	39	67	2	26	5
1918	44	70	2	23	4
1920	43	74	2	23	
1925	38	89	3	8	
1930	38	92		8	
1935	42	95	2.5	2.5	
1940	14	93		7	
1945	9	100			
1950	14	100			
1955	23	78		18	4
1960	35	77		20	3
1965	38	74		26	
1970	56	75	2	18	5
1975	81	79	2	12	6

GRAPH 3


409
ALL RURAL DISTRICTS
(a) Average years since qualification
(b) Average years in location
(c) No. of doctors in rural practice
Years
No. of Practitioners
30
28
26
24
22
20
18
16
14
12
10
8
6
4
2
390
370
350
330
310
290
270
250
230
210
190
170
150
130
110
90
70
50
30
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a
b
c
1887
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1970
1975

TABLE 3

Medical Practitioners in Rural British Columbia, 1887-1975

Average Years in Community; Average Years Since Qualification and Total Number of Practitioners

Date	*Number of Practitioners*	*Average Years in Community*	*Average Years Since Qualification*
1887	16		11
1893	32	2.19	10.16
1898	86	3.08	9.86
1903	103	4.83	11.4
1908	133	5.5	12.5
1913	192	5.42	15.01
1918	220	7.98	16.6
1920	200	7.51	17.75
1925	205	8.17	19.7
1930	212	9.61	20.89
1935	228	10.89	20.14
1940	152	9.04	19.88
1945	109	11.62	24.19
1950	140	7.37	17.12
1955	159	5.38	14.23
1960	190	6.64	13.42
1965	220	7.61	15.95
1970	301	6.42	15.39
1975	439	6.31	16.06

TABLE 3A

Medical Practitioners in Rural British Columbia, 1887-1975

Distribution (%) of Medical Qualifications by Country

Date	*Number of Practitioners*	*Distribution (%) of Medical Qualifications by Country*			
		Canada	*U.S.*	*G.B.*	*Other*
1887	16	56	12.5	25	6.25
1893	32	37.5	15.6	40.6	6.25
1898	86	59.3	14	24.4	2.33
1903	103	71.8	8.7	19.4	1
1908	133	75	10.5	13	1.5
1913	192	71	5	22	2
1918	220	73.6	5	20	1
1920	200	75.5	4.5	19.5	.5
1925	205	80	4	15	
1930	212	84	3	12	
1935	228	91	2	6.5	.5
1940	152	95	.5	5	
1945	109	92	3	5	.5
1950	140	93	1	5	.8
1955	159	82	3	8	8
1960	190	83	2	11	4
1965	220	80	1	12	7
1970	301	69	3	20	9
1975	439	67	4	21	9

GRAPH 4

KOOTENAY

(a) Average years since qualification

(b) Average years in location

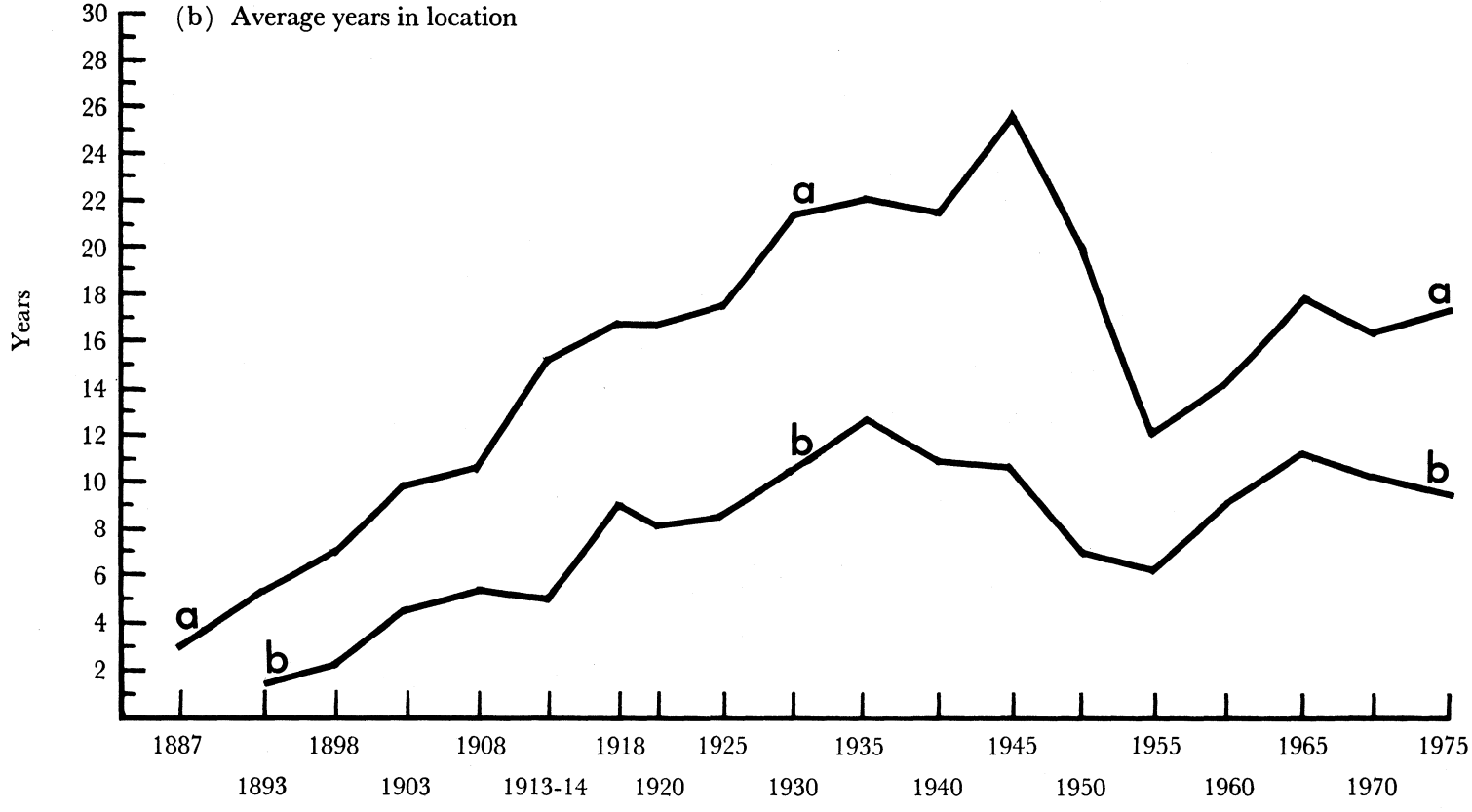

TABLE 4

Medical Practitioners in Rural Kootenay, 1887-1975

Average Years in Community; Average Years Since Qualification and Total Number of Practitioners

Date	*Number of Practitioners*	*Average Years in Community*	*Average Years Since Qualification*
1887	3		3
1893	10	1	5.3
1898	20	2.45	7.65
1903	30	4.78	10.1
1908	33	5.73	10.7
1913	35	5.39	15.97
1918	45	9.23	17.29
1920	45	8.26	17.38
1925	34	8.79	17.83
1930	37	10.58	21.89
1935	38	12.75	22.26
1940	11	11.14	22
1945	10	10.85	25.7
1950	16	7.69	20.13
1955	15	6.33	11.67
1960	18	9.39	14.22
1965	21	11.26	18.43
1970	28	10.16	16.77
1975	43	9.92	17.79

TABLE 4A

Medical Practitioners in Rural Kootenay, 1887-1975

Distribution (%) of Medical Qualifications by Country

Date	*Number of Practitioners*	*Distribution (%) of Medical Qualifications by Country*			
		Canada	*U.S.*	*G.B.*	*Other*
1887	3	67	33		
1893	10	30	30	40	
1898	20	50	25	25	
1903	30	80	17	3	
1908	33	77	19	3	
1913	35	69	14	17	
1918	45	71	16	13	
1920	45	82	7	11	
1925	34	85	3	12	
1930	37	81	5	14	
1935	38	89	2.5	5	2.5
1940	11	100			
1945	10	90	10		
1950	16	94	6		
1955	15	80	7		13
1960	18	83	11		6
1965	21	95	5		
1970	28	75	7	11	7
1975	43	60	5	16	19

GRAPH 5

Medical Degrees in Rural British Columbia:
Country of Origin: Percentage

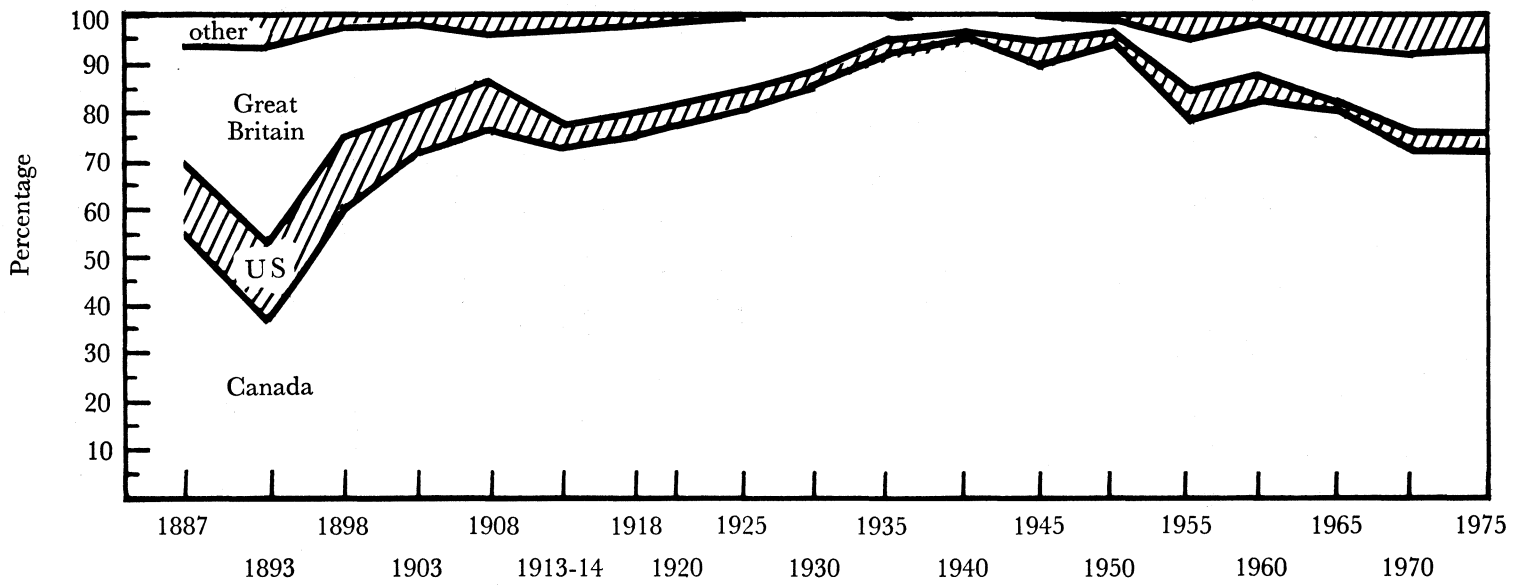

TABLE 5

Canadian Degrees — (a) Percent of Canadian Total; (b) Percent of Total

		McG.	Vict.	Trin.	Tor.	RMC		West.	Man.	Bpr.	Dal.	Tor. MC	CP & S NWT	Alta.	Lav.	UBC	OTT.	Sask.	Can.	U.S.	G.B.	O.	Total
						Que.	King.																
1887	(a)	33.3	33.3	11	22																		9
	(b)	19	19	6	13														56	12.5	25	6.25	16
1893	(a)	25	33	25		8	8																12
	(b)	9	13	9		3	3												37.5	15.6	40.6	6.25	32
1898	(a)	43	12	12	14	8	2	2	8														51
	(b)	26	7	7	8	5	1	1	5										59.3	14	24.4	2.33	86
1903	(a)	51	7	11	8	7		3	9	3	1												74
	(b)	37	5	8	6	5		2	7	2	1								71.8	8.74	18.4	1	103
1908	(a)	48	4	6	11	11		3	10	3	3												99
	(b)	36	3	5	8	8		2	8	2	2								75	10.5	13	1.5	133
1913-14	(a)	42	3	6	18	11		4	10	2	4	<1											136
	(b)	30	2	4	13	8		3	7	2	3	<1							71	5	22	2	191
1918	(a)	43	1	4	21	11		4	11	1	3	<1											162
	(b)	32	<1	3	15	8		3	8	1	2	<1							73.6	5	20	1	220
1920	(a)	46	<1	5	21	12		4	8	<1	3												151
	(b)	35	.5	3.5	16	9		3	6	.5	2.5								75.5	4.5	19.5	.5	200
1925	(a)	47	<1	5	21	10		2	10	1	1		<1	<1									165
	(b)	38	.5	4	17	8		2	8	1	1		.5	.5					80	4	15		205
1930	(a)	41	.5	4	23	9		2	15	1.5	1.5		.5	2	.5								179
	(b)	34	.5	3	20	8		1.5	12	1	2		.5	1.5	.5				84	3	12		212
1935	(a)	34		3	26	6		3	16	1	2			8	.5								208
	(b)	31		<3	24	6		<3	14	<1	<2			7	< .5				91	2	6.5	.5	228
1940	(a)	26		1.5	26	3		6	27	1.5	1.5			8									144
	(b)	24		1.5	25	<3		5	26	<1.5	<1.5			7					95	1	5		152
1945	(a)	30			22	11		3	24					10									100
	(b)	28			20	10		<3	23					9					92	3	5	1	109
1950	(a)	22			18	12		2	25		<2			18	<1								130
	(b)	20			16	11		<2	24		<2			17	<1				93	1	5	1	140
1955	(a)	23			20	14		3	17		<2			15	<1	5	<1						130
	(b)	19			16	11		<3	14		<2			12	<1	4	<1		82	3	8	8	159
1960-61	(a)	13			13	7		2	18		4			20		20		<1					157
	(b)	11			11	6		<2	15		<4			17		17		<1	83	4	11	5	190
1965-66	(a)	10			13	7		4	18		6			22		16	<1	3					176
	(b)	8			10	6		3	14		5			18		13	<1	2	80	1	12	7	220
1970	(a)	7			11	10		6	14		5			16		24	<1	7					207
	(b)	5			8	7		4	9		3			11		16	<1	5	69	3	20	9	301
1975	(a)	9			12	9		3	13		3			20		24	<1	5					294
	(b)	6			8	6		2	9		2			13		16	<1	3	67	4	21	9	439

Nechako-Skeena and the Kootenays, the incidence of urban practice was growing,[9] while the work of the Provincial Health Officers and researchers attached to the local hospitals was gradually bringing under control the annual epidemics of typhoid, diphtheria and scarlet fever. In the late twenties and early thirties the Canadian Medical Association, with the help of Sun Life of Canada, were conducting annual travelling seminars in these communities, designed to bring practitioners up to date with the latest improvements in clinical and scientific medicine.[10] Gradually, too, especially in the 1930s, the impact of workmen's compensation legislation on occupational medicine was being felt in the company towns. Despite the depression it is probable that in this period health care in the truly rural districts in terms of direct and expert personal service to the patient by the doctor was at a higher level than it had been before or than it would be for many years to come. Only in the Cariboo and the far north of the province was medical practice still dominated by elderly practitioners migrating almost annually from one moribund community to another.

One of the reasons for the relative excellence of doctor care during these years was the accessibility of the doctor — not merely as a matter of the patient being able to visit the doctor, but, more important, of the doctor being able and willing to visit the patient. Much of this has to do with the attitudes of mind in the community and among rural practitioners. One of the glib answers given in the last few decades to the problem of the shortage of physicians in rural communities has been: "You can always move the patient to the doctor."[11] This solution takes no account of attitudes in country districts whose inhabitants expect, quite as much as their city brethren, to be able to call on the services of a doctor for constant medical *care* in the full sense of those words; not to have to appear to be going as a supplicant, in emergencies or even in *extremis*, to a grand practitioner in a distant, and hence alien, community.[12] If people in such communities are given a choice, they will generally choose

[9] Note the drop in numbers of practitioners practising in circumstances defined as rural, as their communities became urbanized in the late 1930s (Tables 2, 3 and 4).

[10] "Diary of Dr. A. Gibson," Bulletin of the *Vancouver Medical Association* (September-October 1932), 8/12, 9/1.

[11] For example: "Efficiency of medical practice has increased because of improvements in communication and transportation, so that scattered distribution of physicians in rural areas is less [*sic*] necessary, and presumably a physician can be in contact with more [*sic*] patients in a day" (Parker, Rix and Tuxwill, *op. cit.*, 707).

[12] Cf. editorial, "Managing a chronic problem: the rural physician shortage," *Annals of Internal Medicine* (June 1980), 92/6:853.

the presence of a doctor — the palpable image of the healer — in their midst in preference to access to modern medical facilities and highly qualified medical personnel in another community. The onset of publicly supported medicine has, if anything, strengthened the demand for *local* care on the ground that the inhabitants, as taxpayers, are paying for the service anyway.

In the 1930s such care was available within the limits of existing transportation facilities, and these had been improved greatly from what they had been in the 1880s. In the early days inadequacy of transport had determined that all but the most desperate cases, and a good many of those as well, would be treated by the resident rural physician, usually in the patient's home. Medical transportation in most cases concerned moving the doctor to the patient. Along the coast most inlets were accessible to steamers. They were supplemented by canoe and gas-boat, in the use of which Drs. Large, Kergin and Darby became legendary heroes. Lake and river navigation was similarly employed, but also limited in scope. Communities near the railway could count on moving both patients and doctors, especially on the main lines of the CPR and Canadian Northern where the service was regular and reliable. Where it was not — as on the other railways — doctors, patients and frequently both travelled by gas-speeder, especially in the winter months. Beyond the rail lines, for most of this period, movement was by horseback or, on passable country roads, by horse and buggy. In various parts of southern British Columbia the automobile — or at least the Model-T Ford — was introduced in small numbers among doctors in the 1920s, but roads were mostly very bad outside the Lower Mainland and southern Vancouver Island and almost non-existent in the northern two-thirds of the province. The result was that the automobile was used primarily by the small-town doctor rather than the rural doctor before 1939. The Second World War in this, as in so many other aspects, profoundly changed the life of non-metropolitan British Columbia. Four developments, in particular, altered the access of rural patients to health care: the building of paved, all-weather roads to most substantial communities in the interior of the province; the growth of air travel, and the concomitant decline of coastal steamer traffic and of railway services throughout the province. The result was that there was now undoubtedly quick, efficient transportation to metropolitan centres or to the centres of population in rural areas — the country, towns on an emergency basis. But regular communication with the small and isolated medically underprivileged communities was, if anything, worse than it had been in the 1930s. It was not available as a matter of course or

within the economic reach of patients to provide the regular and easy interchange with their doctors necessary in clinical medicine.

For nearly fifteen years after the Second World War the average age and average years in locality fell steadily in the rural areas as substantial numbers of newly qualified doctors went to practise in expanding communities all over the outbacks of British Columbia. In general it could be said that this was an effect of the secular increase in the prosperity of British Columbia during these years. But it also represented, in many cases, an access of idealism and identification with rural communities and their values, as exemplified in the Hertzler model. It has been noted by several medical sociologists that early identification of physicians with rural communities when they were children is a much more important factor in determining their choice to move to country practices than is anything in their professional training or indoctrination.[13] Between the 1920s and 1960s an increasing proportion of young physicians going into rural practices came from rural communities.

This early identification in many cases also determined the choice of medical school. In rural communities, where the only university-educated person was likely to be the doctor, what more natural than that the clever and ambitious youth would wish to emulate the doctor, even to going to the same medical school and securing recommendations from the doctor to that end? In a community with several doctors it was usually the case that the senior doctor invited to join him as juniors, when the practice expanded, recent graduates from his own university. Thus, for example, Kamloops was a Trinity and Toronto town, Kelowna was a Queen's town, and this concentration of graduates further influenced the choice of the aspiring medical student. Undoubtedly the greatest beneficiary of this "return business" was McGill. Early in the history of the medical profession in the province, the predominance of McGill graduates in rural practice was established. This arose partly from the fact that it was then the largest and best established medical school in the country, but more immediately from its association with the CPR, the dominant company in the early development of the Company Province, and from the early educational link of the two-year McGill arts colleges in Vancouver and Victoria. To most people in country districts before the Second World War, McGill was not only the best-known Canadian university, but frequently the only one they had ever heard of. For most of the

[13] Parker, Rix and Tuxwill, *op. cit.*, p. 710; E. W. Hessinger, L. S. Gill, D. J. Hobbs and R. Hageman, *A Restudy of Physicians in Twenty Rural Counties* (Hyatsville, Md., 1979), p. 121.

years from 1898 to 1935 McGill accounted for nearly half the Canadian medical degrees in rural British Columbia and much more than a third of all medical degrees. By the 1920s most of this consisted of "return business" of young graduates originally resident in rural British Columbia returning to a rural practice. One has the impression that in most of these years the McGill deans of medicine must have been pushing half of each newly qualified group of interns from the Royal Victoria Hospital or the Montreal General onto the CPR day-coaches headed for the mountain valleys of British Columbia. By the time of the depression of the 1930s, McGill's dominance was being replaced, first by Manitoba (which accounted for about a quarter of all medical degrees among rural physicians in the 1940s), by Alberta (about a fifth in the 1960s), and by the University of British Columbia (about a sixth in the 1960s and 1970s).[14] But that was a matter of economic convenience rather than indoctrination. In any case, until the early 1960s, young practitioners in rural communities were largely people whose roots were in the outbacks.

By the early 1960s, however, rural practice in British Columbia was being overtaken by a phenomenon already widespread in other rural parts of North America: a substantially increasing percentage of graduating physicians going to rural areas and of young physicians already established in rural areas (rising from about 8 percent in 1945 to about 17 percent in 1960) were going into group practice and into specializations.[15] This meant that these physicians necessarily gravitated to the centres of population in rural areas — the country towns, where group practices and the facilities for specialization, including well-equipped hospitals, were located.[16]

In some rural communities in North America these young physicians who moved into town were not replaced; practices were carried on, if at all, by their elders who were left behind, thus increasing the average age of rural practitioners.[17] But in the case of British Columbia, the young rural physicians were increasingly replaced in the 1960s and 1970s by physicians who had emigrated from Great Britain or third-world countries. For most of the past century, the predominance of Canadian doctors in the rural communities has been overwhelming. Only in the 1890s,

[14] Table 5.

[15] *Medical Register of British Columbia, 1945, 1950, 1955, 1960* — Lists of Specialists; cf. Parker, Rix and Tuxwill, *op. cit.*, p. 706.

[16] Parker, Rix and Tuxwill, *op. cit.*, p. 708; Hassinger, Hu, Hastings and McNamara, *op. cit.*, pp. 317, 318.

[17] Hassinger, Hu, Hastings and McNamara, *op. cit.*, pp. 317-18.

for a brief period, did holders of British qualifications predominate. From 1900 holders of Canadian medical degrees accounted for from 70 percent (in 1903) to 95 percent (in 1940) of all rural practitioners. In the late 1960s, however, this figure fell to 67 percent, while those for British and third-world degrees rose from 5 to 20 percent and 5 to 10 percent respectively.[18] Such immigrant doctors were, on the average, ten years further from their degrees and were much more inclined to move frequently from rural community to rural community than the Canadian doctors whom they replaced. Thus the circumstances dominating rural practice in the decade before the First World War were repeated in the 1970s.

To sum up, the conventional picture of the rural practitioner permanently established and developing a stable practice in a stable community has never applied in most of rural British Columbia, and probably not in rural communities based on extractive industries. The explanation lies not in any especial or growing lack of idealism on the part of young physicians or a deliberate abandonment of the outbacks by metropolitan society (though the preoccupation with solving the problems of rural practice by moving patients to the city suggests at least a lack of imagination on the part of decision-makers and planners). It lies rather in the economic and social instability of the rural communities. Even in periods when there is a good deal of idealistic fervour for rural practice, as in the fifteen years after the Second World War, their desire to engage in professionally rewarding modern practice with modern facilities draws the young physicians away from the isolated rural districts to the country towns. In these circumstances the task of providing day-to-day *medical care* in the true sense of the words has, over the century, been left not always, but too frequently, to the elderly, the underqualified, the economically disadvantaged, the recently immigrated or the incompetent — most of whom, in any case, are likely to be transient. Too rarely it has been left to the bright young physician in the process of becoming the Good Old Doc, of Hertzler's famous image.

[18] Tables 2a-4a and Graph 5. Very few holders of American medical degrees went to rural communities. Their proportion of the total fell from one-eighth in 1887 (a small total), to less than 4 percent in the 1970s.