

The Confinement of Women: Childbirth and Hospitalization in Vancouver, 1919-1939*

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Only relatively recently have large numbers of women been confined to institutions for the delivery of their children. The institutionalization of childbirth has radically transformed a major human experience, and the impact of this transformation has been a subject of debate among mothers, childbirth reformers, medical professionals and social scientists.¹ For its defenders, the hospital has served as an important vehicle for wider distribution of obstetrical supervision and treatment with a concomitant reduction of maternal morbidity and mortality. Critics have responded that delivering these services within the confines of a hierarchical, bureaucratized institution has contributed to the medicalization of childbirth, depriving women of control over their bodies and creating new psychological and physiological disorders.

As this contemporary debate rages, historians have begun to examine the historical process whereby doctors appropriated, and to some degree women relinquished, control over childbirth.² This study contributes to

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¹ See Ann Oakley, *Women Confined: Towards a Sociology of Childbirth* (London: Billing & Sons Ltd., 1980); Shelly Romalis, ed., *Childbirth: Alternatives to Medical Control* (Austin: University of Texas Press, 1981); and Tim Chard and Martin Richards, eds., *Benefits and Hazards of the New Obstetrics* (Philadelphia: J. B. Lippincott Co., 1977). See in particular Oakley's "Cross-cultural Practices," pp. 18-33, in which she distinguishes between the medical treatment women received and the broader issue of the "medicalization" of pregnancy and childbirth, that is "people's dependence on medicine and . . . the control of health and sickness by the medical profession," p. 19.

² See Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 Years of the Experts' Advice to Women* (London: Pluto Press, 1979); E. Shorter, *A History of Women's Bodies* (New York: Basic Books, Inc., 1982); and Nancy

that ongoing investigation by examining the medicalization of childbirth in Vancouver during the 1920s and 1930s. It begins with a discussion of the general trends in maternal care and then turns to the specific obstetrical treatment provided by the Vancouver General Hospital (VGH). Within this institutional setting medical professionals found new opportunities to set the terms on which the city's women experienced childbirth.

Although the issue of maternity has attracted recent attention from historians of British Columbia and Canada as a whole, the focus of their work has been on pre-natal and post-natal care of reproductive women.³ Few works concern themselves more directly with issues related to the delivery process. One article on the effect of abortion deaths on maternal mortality in B.C. makes some useful mention of the treatment by medical practitioners of unwillingly pregnant women, but their care is not of concern to the authors' argument.⁴ Of greater relevance are two works dealing with the shift from home to hospital deliveries in twentieth-century Ontario. That transition is closely identified with fears about levels of maternal and infant mortality and the campaign of the medical profession to control health care. Both authors conclude that hospitalization itself did little to improve women's chances for survival before World War II. What was improved in the hospital was doctors' opportunity to monopolize the provision of services during confinement.⁵ A less critical view is presented in an article examining attempts to reduce maternal mortality in British Columbia. That author sees hospitalization as a substantial advance which parturient women recognized and utilized.

Schrom Dye, "History of Childbirth in America," *Signs: Journal of Women in Culture and Society* 6, 11 (1980): 97-108.

³ See, for example, Norah Lewis, "Advising the Parents: Child Rearing in British Columbia During the Inter-War Years" (Ph.D. thesis, U.B.C., 1980); Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality," in Linda Kealey, ed., *A Not Unreasonable Claim: Women and Reform in Canada 1880s-1920s* (Toronto: Women's Press, 1979); and Strong-Boag, "Intruders in the Nursery: Childcare Professionals Reshape the Years One to Five, 1920-1940," in J. Parr, ed., *Childhood and Family in Canadian History* (Toronto: McClelland & Stewart, 1982).

⁴ Angus and Arlene Tigar McLaren, "Discoveries and Dissimulations: The Impact of Abortion Deaths on Maternal Mortality in British Columbia," *BC Studies* 64 (Winter 1984-85): 3-26.

⁵ Jo Oppenheimer, "Childbirth in Ontario: The Transition from Home to Hospital in the Early Twentieth Century," *Ontario History* 75, 1 (March 1983): 36-60, and Catherine Lesley Biggs, "The Response to Maternal Mortality in Ontario, 1920-1940" (M.A. thesis, University of Toronto, 1982). Biggs argues that only the introduction of sulpha drugs in 1937 made hospital birthing as safe as home delivery.

However, the author's conclusion that institutionalization of the delivery process was the logical follow-up to good pre-natal care and just as essential to the reduction of maternal mortality stops short of considering either the nature of hospital obstetrical therapy itself or possible alternative methods and facilities for distributing obstetrical services.⁶

Improved maternal care was desperately needed in post-World War I Vancouver. During the 1920s, B.C., with the lowest birth rate of the provinces, also had one of the highest rates of maternal mortality. As table 1 indicates,⁷ maternal mortality rates per 1,000 births in B.C. ranged from 4.7 to 6.7 between 1926 and 1935, then dropped permanently below the 5.0 mark in 1936 and slid steadily to 3.1 in 1940. While in 1926 B.C. had been significantly above the Canadian average of 5.7

TABLE 1
*Maternal Mortality Rates per 1,000 Live Births in Canada,
by Provinces, 1926-1940*

<i>Year</i>	<i>Canada</i>	<i>P.E.I.</i>	<i>N.S.</i>	<i>N.B.</i>	<i>Que.</i>	<i>Ont.</i>	<i>Man.</i>	<i>Sask.</i>	<i>Alta.</i>	<i>B.C.</i>
1926	5.7	4.6	4.6	6.4	5.2	5.6	5.9	7.1	5.9	6.5
1927	5.6	2.4	6.8	6.2	4.9	6.0	5.1	5.4	6.4	6.7
1928	5.6	6.1	5.2	5.8	5.3	5.8	5.1	5.8	6.8	5.9
1929	5.7	7.8	4.2	7.3	5.3	5.4	6.8	6.2	7.3	5.6
1930	5.8	2.9	6.7	5.4	5.5	6.2	5.2	5.1	6.5	5.8
1931	5.1	6.9	4.7	5.6	4.8	5.4	4.8	4.4	5.0	6.3
1932	5.0	6.4	4.6	5.8	5.1	5.1	4.8	4.9	3.8	5.3
1933	5.0	4.1	4.7	6.0	5.0	5.4	4.1	4.6	4.5	4.7
1934	5.3	5.1	6.2	5.1	5.5	5.6	3.8	4.4	5.0	5.1
1935	4.9	4.0	5.3	4.6	5.4	5.0	4.2	4.1	4.3	5.2
1936	5.6	5.6	4.3	6.6	6.0	5.7	5.4	4.5	5.8	4.7
1937	4.9	5.7	3.0	3.7	5.2	5.2	4.3	4.6	4.8	4.5
1938	4.2	2.5	4.2	4.5	5.2	3.8	2.9	2.5	4.3	3.8
1939	4.2	7.5	4.1	4.8	4.6	4.3	3.5	3.3	3.6	3.1
1940	4.0	2.9	4.2	4.8	4.5	3.7	3.9	3.2	4.0	3.1

⁶ N. Lewis, "Reducing Maternal Mortality in British Columbia: An Educational Process," in B. K. Latham and R. J. Pazdro, eds., *Not Just Pin Money* (Victoria: Camosun College, 1984), pp. 337-55.

⁷ Canada. House of Commons, Special Committee on Social Security, *Health Insurance*, Report of the Advisory Committee on Health Insurance Appointed by Order-in-Council, P.C. 836, 5 February 1942, p. 266.

maternal deaths, it had improved substantially upon the national figure of 4.0 fourteen years later. In comparison to rural areas of the province, Vancouver was a slightly more dangerous place for mothers, but the discrepancy in favour of the countryside remained about the same as it was nationally and much less striking than it was in Ontario and Nova Scotia.⁸ Figures from a 1942 report cite 26 deaths or 6.9 per 1,000 live births in the city for the 1926-30 period, 15 deaths or 4.5 per 1,000 live births between 1931 and 1935 (a decrease of 34.8 percent), and 14 maternal deaths or 3.5 per 1,000 live births for the 1936-40 years (a decrease of 22.2 percent). While the precise pattern of this downward trend is not discernible, it is clear that a major decrease in Vancouver's maternal mortality occurred in the 1930s.

Meanwhile, B.C. led the nation in the institutionalization of its par-turient women. In 1942 the House of Commons' Special Committee on Social Security discovered that B.C. had dramatically increased its rate of hospitalization from 48.3 percent to 84.4 percent of live births between 1926 and 1940. These figures were extremely high when compared with the lowest figures in the country, reported for P.E.I. and Quebec, which ranged respectively from 2.7 percent to 26.2 percent and from 4.8 percent to 15.6 percent over the same years. Even Ontario, with its shift from 24.9 percent to 62.1 percent, far from matched the west coast. The only province to come at all close to B.C.'s rates was Alberta, but even in 1940 it reported only 72.9 percent of live births in its hospitals.⁹ As the most highly urbanized of all the provinces, B.C.'s figures are not surprising, particularly in light of Vancouver's preference for hospital births, which began early in the century¹⁰ and continued almost unabated during the 1930s (table 2).¹¹

⁸ *Ibid.*, pp. 257-58, "from 1926 to 1930 [Vancouver] had an annual average of 26 deaths or a rate of 6.9 per 1,000 live births, but by 1936 to 1940 the average annual rate had dropped to 3.5 or 14 deaths." In 1939, 17 rural women died in childbirth compared to 21 urban women. Dr. Helen MacMurchy, *Maternal Mortality in Canada* (Ottawa, 1927) cites mortality figures for the early 1920s, but they are based on a survey of physicians' cases rather than on the more complete statistics of the 1942 *Health Insurance* report.

⁹ *Health Insurance*, p. 309.

¹⁰ See L. O. Stone, *Urban Development in Canada* (Ottawa: DBS, 1967), p. 39, for statistics on rates of urbanization. See Margaret Andrews, "Medical Attendance in Vancouver: 1886-1920," in S. E. D. Shortt, ed., *Medicine in Canadian Society. Historical Perspectives* (Montreal: McGill-Queen's, 1981), pp. 431-34, for an assessment of one doctor's obstetrical patients who, beginning in the 1890s, turned slowly to hospital deliveries.

¹¹ Compiled from *B.C. Sessional Papers*, Reports of the Provincial Board of Health, 1929-1941/2. These figures are for registered births. Neil Sutherland claims that in the early 1930s unregistered births in B.C. were over 5 percent of the total regis-

TABLE 2
*Percentage and Number of Live Births in
 Vancouver Institutions, 1928-1939*

1928	67.9%	2,589
1929	70.6%	2,731
1930	76.8%	3,076
1931	77.8%	2,902
1932	78.5%	2,708
1933	79.8%	2,543
1934	75.7%	2,407
1935	77.9%	2,529
1936	80.2%	2,733
1937	83.8%	3,166
1938	86.0%	3,522
1939	89.0%	3,657

Overall, these trends indicate a percentage drop in maternal mortality substantially greater than the percentage increase in hospital births in the late 1920s and the 1930s. In addition, relatively high levels of hospitalization appear to have preceded any substantial reduction in maternal mortality. This lack of correlation suggests that there was no necessary causal relationship between increased hospitalization and mothers' survival rates in Vancouver.¹² But if pregnant women were not obviously spared death by hospital confinement, another group reaped evident benefits. For the medical profession, struggling to maintain its dominant position in health care, institutions in which it could regulate medical practice, eliminate non-medical competition and in time develop an effective therapy were promising indeed.¹³ The spread of hospital care

tered births. Neil Sutherland, "Social Policy, 'Deviant' Children, and the Public Health Apparatus in British Columbia Between the Wars," *Journal of Educational Thought* 14, 2 (August 1980): 80-91.

¹² In "Cross-cultural Practices" Oakley places the "home-hospital" debate in an international framework. Comparing Britain, with high rates of hospitalization, to the Netherlands, which supports mid-wife assisted home-confinements, Oakley concludes that the "correlation between the rise in hospital delivery and falling maternal and perinatal mortality rates cannot be taken as cause-and-effect" (p. 25), and that home birth has been a central feature of improved maternal health in many societies.

¹³ For an instructive analysis of the role institutions played in the development of the Maritime medical profession see Colin Howell, "Reform and the Monopolistic Impulse: The Professionalization of Medicine in the Maritimes," *Acadiensis* X, 1 (1981): 3-22.

correlates very positively with doctors' drive for professional dominance in the health care delivery field. Vancouver's expectant mothers, like other patients, were the presumed beneficiaries of doctors' enhanced authority. The nature of that advantage is examined below.

It was an overwhelmingly male profession which in the 1920s and 1930s presided over women in their experience of childbirth. Not only were there very few female doctors in the city, but obstetrics as a field was, ironically enough, especially difficult for women to enter. In 1939 VGH typically allowed only one female interne and St. Paul's Hospital none.¹⁴ In contrast to this exclusion from the profession, women supplied a critical part of the patient load. Targeted for special attention by local and national health agencies, pregnant women readily became consumers of medical advice which promised relief from the threat of disaster. For general practitioners such patients were essential in establishing a clientele.¹⁵

Yet, for all its significance in persuading Canadians of the value of medical superintendence and in providing doctors with entrée to the treatment of entire families, obstetrics was very late emerging as a specialty and remained a lowly cousin of more glamorous fields such as surgery. Just as inauspicious was its special affinity for surgical and later chemical and endocrinological solutions to labour problems.¹⁶ For students, inadequate training in obstetrics remained a continuing problem. VGH, for example, only offered its internes two months on the maternity wards; if any individual wanted more experience, he had to arrange to trade assignments with a colleague.¹⁷ In his address to the Toronto convention in 1928, the president of the American Association of Obstetricians, Gynaecologists and Abdominal Surgeons damned existing medical programs in his field in both Canada and the United States. He pointed out that McGill and Toronto, among many other schools, allocated surgery much more time, despite the fact that obstetrics was the backbone of most general practices.¹⁸

¹⁴ See "Hospitals Approved for Internships," *Canadian Medical Association Journal* (henceforth *CMAJ*) (September 1939): 304-05.

¹⁵ Lewis, "Reducing Infant Mortality," p. 342.

¹⁶ On these associations see R. W. Wertz and D. C. Wertz, *Lying In: A History of Childbirth in America* (N.Y. and London: The Free Press and Collier MacMillan, 1977).

¹⁷ Provincial Archives of British Columbia (PABC), Sound and Moving Image Division, West Coast Medical History Collection, Interview with Dr. Emile Therrien, 2,370: tape 1, track 1.

¹⁸ Dr. Palmer Findley, "The Teaching of Obstetrics," *American Journal of Obstetrics and Gynaecology* (henceforth *AJOG*) (November 1928): 611-24. For more details on the training of Canadian GPs and its shortcomings, see S. E. D. Shortt, "Be-

Owing in large part to the absence of a medical school, Vancouver was later than Montreal, Toronto and London, Ontario, in developing a body of recognized and certified obstetrical experts. By 1940 the American College of Surgeons had approved only Toronto General Hospital and Royal Victoria in Montreal for graduate training in obstetrics and gynaecology. Canadians, usually associated with the university medical faculties of McGill, Toronto or Western Ontario, were regular contributors to the premier publication, the *American Journal of Obstetrics and Gynaecology* (*AJOG*), from its inception, but between 1920 and 1945 no B.C.-based doctor published so much as a research note. In contrast, Alberta with its medical school in Edmonton produced several submissions. The pages of the *Canadian Medical Association Journal* (*CMAJ*) were equally dominated by eastern contributors, with only the very occasional appearance by a B.C. writer.

There were attempts to remedy this situation. Although it did not establish a Committee on Maternal Welfare until October 1938, the Vancouver Medical Association (VMA) was an eager proponent of a more educated and specialized body of doctors in the province.¹⁹ Its sponsorship of summer schools brought leading specialists from all across North America to lecture to B.C.'s doctors on the newest developments in their areas, and obstetrics was a regular part of these programs.²⁰ The inauguration in 1924 of a monthly publication, the *VMA Bulletin*, spread further news of changes in medical practice and procedure. The *Bulletin* produced a number of obstetrical articles from 1924 through to 1945, but most appear to have echoed, often by some years, concerns voiced by the more prestigious journals.

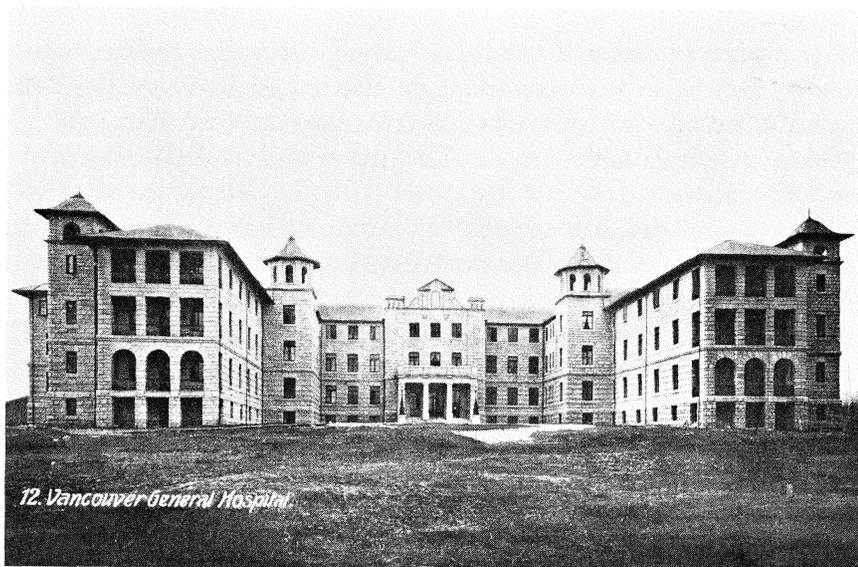
Such limited publishing credentials were accompanied by relatively little interest in acquiring specialist certification. The American Board of Obstetricians and Gynecologists, organized in 1930, for example, held regular exams after March 1931, but the first Vancouverite was not successful until 1938; the second until 1939. No others were certified before 1945.²¹ While some Vancouver practitioners undoubtedly oriented

for the Age of Miracles': The Rise, Fall, and Rebirth of General Practice in Canada, 1890-1940," in Ch. G. Roland, ed., *Health, Disease and Medicine* (Toronto: Hannah Institute for the History of Medicine, 1982).

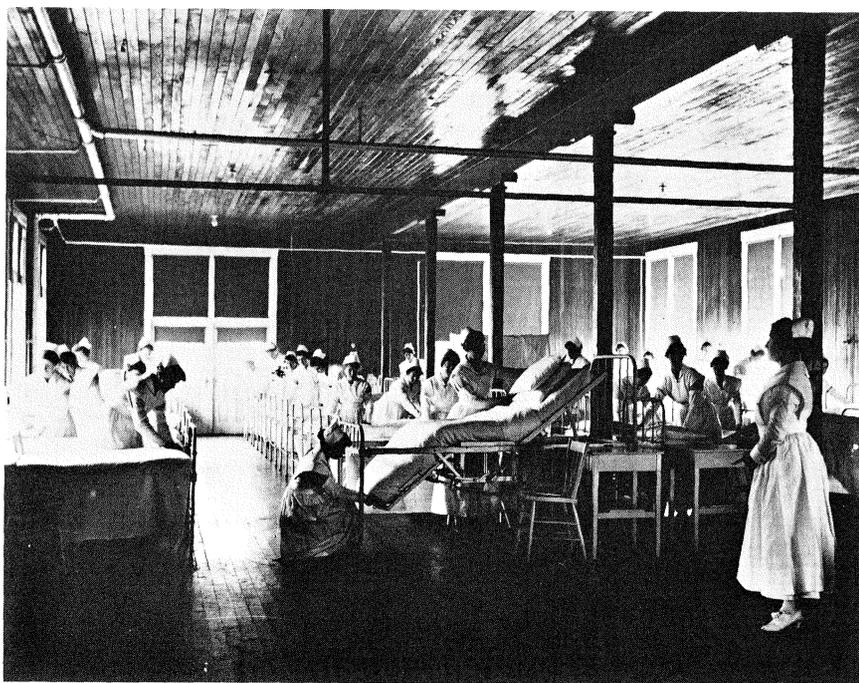
¹⁹ C. T. Hilton, "Maternal Welfare," *Vancouver Medical Association Bulletin* (henceforth *VMAB*) (September 1939): 352-53.

²⁰ See, for example, Dr. B. P. Watson, "Antepartum Haemorrhage," *VMAB* (August 1927): 339. Dr. Watson was a professor of medicine at Columbia University.

²¹ The first was A. C. Frost, the second Edward M. Blair. See first biannual and then annual examination reports, *AJOG*, 1931-45.



Vancouver General Hospital, ca. 1925



Vancouver General Hospital, ward interior, ca. 1919

more toward professional developments in Britain and Europe,²² their training seemed to be overwhelmingly North American in origin. The near-absence of specialist credentials from the American Board further confirms relatively low levels of obstetrical training on the part of the city's doctors.

This was the case, for example, with the first two heads of obstetrics and gynaecology at VGH, Doctors William B. Burnett and Walter Turnbull, who received their early medical education in Canada. Burnett, chief throughout the 1920s and much of the 1930s, was an 1899 McGill graduate who never took any specialized obstetrical training. He was, however, a member of the Pacific North West Obstetrical and Gynaecological Association and the American Gynaecological Association. Turnbull graduated from Toronto in 1903 and some twenty years later took post-graduate studies in "obs & gyn" in Europe, New York, Boston and Buffalo.²³ Both men published in their chosen field in the *VMA Bulletin* but in neither the *AJOG* nor the *CMAJ*. On balance, Vancouver then does not appear to have been a centre of obstetrical expertise in anything but a regional sense.

Although the city lacked an elite corps of obstetricians, doctors' training, reinforced regularly by that of immigrant professionals, combined with the directives of the medical press and powerful health institutions such as Vancouver General Hospital to ensure that the great majority of physicians and their treatments differed little from those found in Canadian or American cities of a similar size. Given the shortcomings in training and licensing, there is no reason to believe that Vancouver was exempt from the "meddlesome midwifery" on the part of obstetrician and GP alike of which medical literature regularly complained.²⁴ "Meddling" could take many forms, from the use of x-rays, to administration

²² The *Register* of the B.C. Medical Association during these years suggests that doctors with European or British training remained a minority of Vancouver practitioners. In 1920, 40 of 275 doctors (14.55 percent) living in Vancouver had trained or been licensed in England, Scotland or Ireland. By 1930 this figure had declined to 12.94 percent (44 of 340). In 1939, 12.71 percent (53 of 409) of Vancouver's doctors had credentials from Great Britain. *BCMA Register* 1920, 1930, 1939.

²³ See Vancouver Academy of Medicine, BCMA Biographical Files.

²⁴ See, for example, M. R. Bow, "Maternal Mortality as a Public Health Problem," *CMAJ* (August 1930): 169-73; Robert Ferguson, "A Plea for Better Obstetrics," *CMAJ* (October 1920): 901-04; J. R. Goodall, "Maternal Mortality," *CMAJ* (October 1929): 447-50; E. D. Plass, "The Relation of Forceps and Caesarian Section to Maternal and Infant Morbidity and Mortality," *AJOG* (August 1931): 176-99, and E. Johns, "The Practice of Midwifery," *Canadian Nurse* (January 1925): 11.

of anesthetics and substances such as pituitrin to produce more rapid contractions, to artificial induction of labour, to versions (turning the child manually in the womb), to episiotomies (cutting several inches through skin and muscles of the perineum, the area between the vagina and anus), to the use of low, mid and high forceps, to Caesarian sections and the use of manual or chemical means to extract the placenta. Such substances and techniques all presented problems even to the relatively skilled practitioner. And yet, for a number of reasons, they were tempting and their use tended to increase throughout these decades. On the one hand, they promised to save time for the "busy practitioner"²⁵ and to assert his authority over the timing and experience of delivery. On the other hand, as doctors pointed out, they often responded "to the pleadings of the patient and the relatives to 'do something.'"²⁶ Mortality and morbidity rates associated with intervention worried contemporaries, some of whom, like those in Montreal at Royal Victoria Maternity Hospital, became eager to label themselves "conservatives."²⁷ Unfortunately, it is impossible to tell how much such intervention contributed to rates of maternal death and disability. Many procedures, for example, added to the possibility of haemorrhage, but this in turn might be countered by new blood transfusion techniques. The actual human cost of medical intervention, like that of abortion, remains a matter of speculation.²⁸

²⁵ *CMAJ* (July 1920): 678.

²⁶ Ross Mitchell, "The Prevention of Maternal Mortality in Manitoba," *CMAJ* (September 1928): 293. See also D. Bjornson, "An Obstetrical Retrospect," *CMAJ* (December 1925): 1236-39, and W. K. Burwell, "Report from Staff (Gynaecological Division) of Vancouver General Hospital," *VMAB* (June 1937): 192-97. In 1919 the Ontario Medical Society was addressed by a representative of the Labour Party of Toronto, "who declared that, more particularly in obstetrics, labour felt itself at the disadvantage of being unable to secure for the wives of their class, those advantages that wealth could command." It is not, however, clear what those advantages were — whether mechanical, manual or chemical intervention or social and economic benefits of supervision and assistance during and after pregnancy. *CMAJ* (April 1920): 305.

²⁷ Wesley Bourne, M.D., "Anaesthesia in Obstetrics," *CMAJ* (August 1924): 702-03, concerning obstetrical anaesthesia at the Montreal Maternity Hospital. Bourne claims "it may be seen at once that we are conservative; we think advisedly so." W. W. Chipman makes similar claims for conservatism at the Montreal Maternity Hospital. *CMAJ* (June 1926): 681-82. Others proclaimed themselves "moderates"; see, for example, J. W. Duncan, "The 'Radical' in Obstetrics," *AJOG* (August 1930): 225.

²⁸ In the years 1931-40, for example, puerperal haemorrhage was "the third largest contributing factor to maternal mortality in Canada... the percentage of deaths from haemorrhage to the total maternal deaths has ranged from 11.3 in 1931 to 16.5 in 1939." *Health Insurance*, p. 260. See also M. Blair, "The Role of Haemorrhage in Mortality Rates in Pregnancy and Childbirth," *CMAJ* (February 1945): 168.

This question of excessive obstetrical intervention unsettled collegial relations within the medical profession. Lacking authority over the actions of doctors in private practice, hospital administrators and specialists across the continent sought to influence medical practice through their control over hospitals. As part of its certification standards which identified a modern North American institution, the American College of Surgeons informally set up in 1928, and soon required for approved hospitals, a "Minimum Standard for Obstetric Departments in Hospitals." This included a "properly organized and equipped department of obstetrics, providing exclusive and adequate accommodation for mothers and the newborn," "segregation or isolation of infected mothers," "adequate clinical laboratory, x-ray and other facilities, under competent supervision," the administration of a "competent, registered nurse, who has executive ability and assistance," adequate supervision by a chief or head of service or department, adequate and complete records, major obstetrical procedures to be performed only after consultations, the adoption of a standard for morbidity, minimum monthly review/analysis of obstetrics, and the opportunity for theoretical instruction and practical experience for student nurses.²⁹ Such external directives for standardized care were powerful inducements to change, and Vancouver's major hospitals — St. Paul's, Grace and VGH — all struggled to maintain certification standards.³⁰

Crucial to the effort to standardize procedures was the formation in 1918 of the B.C. Hospitals' Association, which annually brought together the senior medical and administrative personnel of the province's health institutions. Repeated constantly was the message that the application of more "scientific" and bureaucratic methods would save the mothers of the province and guarantee the authority of medically trained professionals. VGH's decision in the late 1920s to restrict its public wards to staff physicians typified efforts to assert control over the delivery of health care and indicate by example the standards which private practitioners were expected to imitate. Yet, ironically, in spite of complaints that unsupervised GPs attempted dangerous procedures in private practice, by promoting hospitalized care administrators and specialists brought women into an environment where the staff and the equipment, and thus the opportunity and temptation, for greater intervention were more readily available. For example, elaborate preparation procedures, such as shav-

²⁹ M. T. MacEachern, "The Program of the American College of Surgeons for Maternal Care in General Hospitals," *AJOG* (March 1938): 535-40.

³⁰ *American College of Surgeons Bulletin* 3A (October 1935): 80.

ing, enemas and lysol washes, and the insistence on stirrups, arm straps and a lithotomy position in which a woman lay on her back with her legs in the air were taken for granted as part of the normal environment of the modern hospital.³¹

The advantages for general practitioners and hospital medical staff of institutionalized confinement are clear. Women's motives for utilizing hospital services are less amenable to study, in part because few women recorded their thoughts or feelings on their experiences in childbirth and in part because they were rarely consulted by those who claimed to serve them. There is little doubt, however, that fear of childbirth loomed large in many women's lives.³² One city social worker acknowledged this in observing that "women are very, very frightened of this coming child and their health is undermined on account of that."³³ The prospect of death or lifelong disability³⁴ undermined pleasure taken in intercourse, encouraged a certain fatalism or denial, as with mothers' resistance to telling daughters the "whole" story,³⁵ and, more positively, inspired the search for better birth control and obstetrical assistance.³⁶ Finally, women's acquiescence to medical directives was ensured by repeated assurances from public health authorities and the popular media that experts know best and that doctors alone could guarantee the happy termination of pregnancy.³⁷ In general, while the safety of mother and child was presented as a legitimate concern, a woman's right to some say over the course of childbirth was not. As the Chairman of the Maternal Welfare Committee of the Canadian Medical Association concluded, "cooperation is more to be desired than self-reliance" in the nation's mothers.³⁸

³¹ See M. MacEachern, *Hospital Organization and Management* (Chicago: Physicians' Record Co., 1935).

³² For a sensitive discussion of women's anxieties see Judith Walzer-Leavitt, "'Science' Enters the Birthing Room: Obstetrics in America since the Eighteenth Century," *Journal of American History* 70, 2 (September 1983): 281-304.

³³ PABC, GR707, B.C. Royal Commission on State Health Insurance and Maternity Benefits, 1929-32, Transcript, Mrs. Fischer, p. 318.

³⁴ See Robert E. McKechnie II, *Strong Medicine: History of Healing on the Northwest Coast* (Vancouver: J. J. Douglas Ltd., 1972), pp. 155-56, for his description of physical damage to women.

³⁵ See, for example, the reticence of the mother in the account by "Violet Teti Benedetti," *Opening Doors: Vancouver's East End*, Daphne Marlatt and Carole Itter, eds., Sound Heritage Series, VIII, no. 1 & 2 (Victoria, 1979).

³⁶ See Angus McLaren, "Birth Control and Abortion in Canada, 1870-1920," *Canadian Historical Review* LIX (1978): 318-40.

³⁷ See Strong-Boag, "Intruders in the Nursery" for its discussion of the authority of medical professionals.

³⁸ W. B. Hendry, "Maternal Welfare," *CMAJ* (November 1934): 520.

Yet traditionally, women had often looked to collective solutions to the rigours of childbirth. Female relatives, neighbours and friends regularly pooled resources and knowledge in efforts at mutual aid.³⁹ This familiar female culture was undermined by the transiency which was so much a feature of expanding cities like Vancouver, but perhaps still more by concerted attacks from modern health and childcare professionals. Women's would-be advisors shored up their own claims to authority by ridiculing customary exchanges of information as "old wives' " tales.⁴⁰ As consumers in a society where scientific and technical knowledge was increasingly the property of professionals, prospective mothers were far from being the sole arbiters of their own destiny. The economics of a class and patriarchal society, in which material resources were distributed unevenly in general and within the family in particular, also placed major restraints on real choice in labour.⁴¹

To be sure, midwives or nurses were possible alternatives to male domination, although the unsupervised work of both was rigorously opposed by doctors. Just as forceps had been monopolized by male practitioners earlier,⁴² their twentieth-century successors were no more eager to share the results of obstetrical advances. The determination to maintain control over the use of anesthetics was typical.⁴³ The result was often, as a former nursing superintendent at VGH knew when she cited a senior VON authority, that "nurses are given a very inadequate maternity training so far as the technique of delivery is concerned. We are warned on no account to take a case without a doctor, and with our training we are not likely to do so. We make an attractive setting for a good obstetrician and an unwilling and critical collaborator with a poor one." She bluntly concluded, "The medical profession is responsible for this condition. They

³⁹ Hilda Murray's "The Traditional Role of Women in a Newfoundland Fishing Community" (M.A. thesis, Memorial University of Newfoundland, 1978) describes a female culture which survived well into the twentieth century in a stable Newfoundland community.

⁴⁰ See, for example, Jane Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939* (London: Croom-Helm, 1980) and Strong-Boag, "Intruders in the Nursery."

⁴¹ See the discussion of the unequal distribution of family income in Marjorie Griffin Cohen, "The Decline of Women in Canadian Dairying," *Histoire sociale/Social History* 18 (November 1984): 307-34, and V. Strong-Boag, "Pulling in Double Harness or Hauling a Double Load: Women, Work and Feminism on the Canadian Prairie," forthcoming in *Journal of Canadian Studies*.

⁴² See Wertz and Wertz, *Lying In*, pp. 34-35.

⁴³ See, for example, Dr. Wesley Bourne of McGill, "The Administration of Chloroform in Obstetrics by Nurses," *Canadian Nurse* (November 1930): 585-87.

do not fear the competition of the nurse in any other department of medicine."⁴⁴

Meanwhile, the medical establishment remained as opposed to midwives as it had been in previous decades.⁴⁵ True, the persistent lack of care and assistance for Canada's mothers and mothers-to-be, and the knowledge of low maternal mortality rates achieved by northern European countries which promoted midwife-assisted childbirth, led some medical commentators to support the reintroduction of midwives or obstetrical nurses.⁴⁶ Charlotte Hanington, superintendent of the Victorian Order of Nurses (VON) for Canada from 1917-23, placed her career on the line over her unsuccessful attempts to import midwives to Canada.⁴⁷ However, the disruption during urbanization of community and neighbourhood networks in which midwives traditionally had worked, combined with the absence of provision for their training or licensing, meant that creating a corps of skilled midwives would have required a major reallocation of resources and priorities. Most members of the medical establishment were unable or unwilling to envision such a move and held fast to the belief that "we have committed ourselves for generations to the policy of physician-accouchers. We cannot turn back now even if we should wish to."⁴⁸

Policy aside, there did occur for many years a significant, albeit declining number of non-institutional births in the city, and not all were

⁴⁴ C. Hanington, cited in Ethel Johns, "The Practice of Midwifery in Canada."

⁴⁵ Buckley, "Ladies or Midwives?"; Kathy Kuusisto, "Midwives, Medical Men and Obstetrical Care in Nineteenth Century Nova Scotia" (M.A. thesis, University of Essex, 1980) argues that by 1900 midwives in Nova Scotia had been marginalized, and eliminated as serious competition to doctors. In "Traditions and Neighbourhoods: The Folklife of a Newfoundland Fishing Outpost" (M.A. thesis, Memorial University of Newfoundland, 1971), G. J. Casey states that, in the community he studied, at least one midwife practised. She "had received no formal training except advice and the experience from some older midwife, and occasionally the advice of a medical person" (p. 119). Nancy Schrom Dye in "History of Childbirth in America" argues that the modern period in the history of childbirth in America began in the 1920s when physicians emerged as the unchallenged birth attendants. Authors such as Buckley and Kuusisto suggest that in Canada this periodization is applicable, though Casey's work is an important reminder of the different pace of developments in some rural areas.

⁴⁶ See H. M. Little, "What's the Matter With Obstetrics," *CMAJ* (May 1929): 647, who concluded "there is crying need for specially trained obstetric nurses, call them midwives if you will."

⁴⁷ Buckley, "Ladies or Midwives?", pp. 144-47.

⁴⁸ J. R. Goodall, "Maternal Mortality," p. 449. For a discussion of community disruption which accompanied Vancouver's rapid rate of urban growth, see D. L. Matters, "A Report on Health Insurance: 1919," *BC Studies* 21 (Spring 1974): 28-32.

under medical supervision. Between 1925 and 1929, for instance, Vancouver recorded at least 1,743 deliveries by midwives out of a total of 19,730.⁴⁹ Such lay help persisted despite critics. One of the latter, more sympathetic than most, described such competitors as “women, good-hearted souls and all that sort of thing, practising maternity work and calling themselves maternity nurses, and they have absolutely no such qualifications; they know absolutely nothing about the work. They don’t know about sterilizing; they don’t know the first rules of procedure. . . . They happen to drop in at a neighbour’s house when a case is coming off.” The critic conceded that “when it is an easy birth, they get through all right, but when there are complications it works out different.”⁵⁰ Lacking legal status, these attendants must have hesitated to call in medical authorities when complications did arise, but so long as the pregnancy was normal and hospitals remained centres of infection and intervention, domestic surroundings and experienced, if unlicensed, care might be a very sensible solution.⁵¹ Whatever their professional qualifications, such women were cheap, potentially extremely helpful with domestic duties and reassuringly familiar when compared with their more scientific and impersonal rivals. Complaints regarding women’s difficulty in finding unlicensed attendants indicate the role non-medical care continued to play for some expectant mothers in these years.⁵²

For less affluent women wishing institutional services, the options actually available in Vancouver in the 1920s and 1930s were very much limited by class and ethnicity. Oriental and native patients found that segregated facilities and/or different standards awaited them whenever

⁴⁹ W. N. Kemp, “The Stillbirth Problem in Relation to Iodine Insufficiency,” *VMAB* (December 1933): 58.

⁵⁰ PABC, GR707, B.C. Royal Commission on State Health Insurance and Maternity Benefits, 1929-32, Transcript, Mrs. Sadie Moore, p. 314.

⁵¹ A May 1929 *CMAJ* editorial by H. M. Little of the Montreal Maternity Hospital criticized the contemporary obstetrical surgical procedures and claimed, “Obstetrics is still in the large majority of cases a matter for the home,” “What’s the Matter With Obstetrics?”, p. 646. This opinion was supported by the international statistics for midwife deliveries often reported in the journal. For example, McGill professor of obstetrics and gynaecology J. R. Goodall’s article, “Maternal Mortality,” cites an Aberdeen, Scotland, inquiry into maternal mortality which discovered the maternal mortality rate of institutions to be five times greater and doctors’ rate two times greater than that of midwives. *CMAJ* (October 1929): 447-50.

⁵² Mrs. McLachlan’s testimony before the 1929-32 Commission on State Health Insurance and Maternity Benefits, “You can pick up all kinds of help to do housework when you cannot pick up a trained nurse,” is representative of such complaints. PABC, GR707, Royal Commission, Transcript, p. 324.

they applied to hospitals.⁵³ Even when race was no barrier to access, poverty, which growing numbers faced throughout these decades, meant reliance on the VON, hospital out-patient services and public wards. The pre-natal clinic established at VGH in 1932 saw women lining up along 12th Avenue. As the Women's Auxiliary noted, many outpatients "had a scanty breakfast — or, if coming for a blood test, none at all — leaky shoes on and no rubbers, the one cotton housedress a year issued by Central Clothing, and a raincoat." After walking or waiting for a street-car, they then waited for an hour or two "on a hard wooden bench" for a doctor to see them.⁵⁴ Costs of confinement itself, reckoned in 1921 as \$35 for a normal delivery, \$50 with haemorrhage, \$45 with instrumental labour and \$35 if a miscarriage occurred, were far beyond the budgets of many families.⁵⁵ Not unexpectedly, the first thing a woman often asked herself when she failed to menstruate was "How am I going to foot the bill?"⁵⁶ It is hard to be surprised that abortion tempted many.⁵⁷ Others resigned themselves to charity, and such cases made up a majority of VGH's public wards.⁵⁸ In fact, the pressure on VGH facilities became so serious in the early years of the depression that no normal obstetrical cases were admitted to public wards without the consent of the medical superintendent.⁵⁹ It was arranged with the City Relief Office to provide \$10 to the VON and \$20 to a doctor to provide for charity patients at home.⁶⁰

During these years some unmarried mothers, especially younger ones, turned to a variety of rescue homes operated by the city's churches. Some

⁵³ For instance, for some years, oriental maternity patients were regularly released some days sooner after childbirth than their sisters of European origin. See PABC, GR749, B.C. Provincial Secretary, Health Insurance Research, "Report on Information Collected and Compiled in Reference to Certain Phases of Hospital Work in British Columbia," 1934, p. 17.

⁵⁴ "Report of the Social Service Committee of the Women's Auxiliary," *Annual Report of VGH*, 1935, p. 37.

⁵⁵ PABC, GR706, B.C. Royal Commission on Health Insurance and Maternity Benefits 1919-21, File 2/5, "Report on Health Insurance, 1921," p. 55.

⁵⁶ PABC, GR707, B.C. Royal Commission on State Health Insurance and Maternity Benefits 1929-32, "Transcript of Evidence," Appendix H, V. II, testimony of Mrs. Manifold of the Women's Navy League, p. 317.

⁵⁷ See McLaren and McLaren, "Discoveries and Dissimulations."

⁵⁸ See for example PABC, GR706, Royal Commission on Health Insurance and Maternity Benefits 1919-21, File 4/5, "Proceedings," testimony of Dr. MacEachern, p. 668.

⁵⁹ In 1933, 772 of 1,773 or 43.5 percent of deliveries at VGH were in the public wards. While the number of deliveries in the VGH Maternity Building increased between 1934 and 1940 from 1,605 to 2,490, the percentage of public ward deliveries decreased from 31.2 percent to 20.9 percent.

⁶⁰ "Report of the Out-Patients' Department," *Annual Report of VGH*, 1933, p. 61.

of these, as with the homes maintained by the Catholic Church and the Salvation Army, were associated with hospitals where girls often became patients in the public wards before returning to religious chaperonage.⁶¹ Their special anxieties about the future of themselves and their babies must have only too often made the birthing process itself all the more intimidating and alienating.

Middle- and upper-class women, with greater financial resources, might choose to deliver at home, but for them the most specialized and certified of assistance was available. They might elect a licensed private maternity hospital or home, although these almost disappeared over the twenty years.⁶² Probably more important were the services of the small group of specialists appearing in the city who increasingly limited private practice to obstetrics and sometimes to obstetrics and gynecology.⁶³ Such privileged treatment continued into VGH, where home-like private rooms with meals on a silver service promised the best of results. Here too the perennial servant problem of the middle class was solved, at least in the short term, and prospective mothers could benefit from the compulsive standards of cleanliness which advertising's hard-sell told them should also characterize their own homes.⁶⁴ By 1920 the days were over when "no self-respecting woman, however much she dreaded the coming ordeal or the upsetting of her household, resultant upon its advent, would entertain for a moment the suggestion of going to the hospital. The hospital was only for the outcast and the unfortunate."⁶⁵ The belated passage in December 1926 of a municipal money bylaw to finance a new maternity

⁶¹ See Andrée Levesque, "Deviant Anonymous: Single Mothers at the Hôpital de la Miséricorde in Montreal, 1929-1939," *Historical Papers*, Canadian Historical Association, 1984, for her useful discussion of the distinctive treatment received by women bearing children out-of-wedlock. Unfortunately, it is not clear whether this extended to differences on the obstetrical table itself, although one suspects this may indeed be the case.

⁶² See listings under "Hospitals" in *Wrigley's B.C. Directory* for Vancouver 1919-1939. See also Margaret W. Andrews, "St. Luke's Home, Vancouver, 1888-1936," *Journal of the Canadian Church Historical Society* 24, 2 (1982): 90-98, for an example of an Anglican initiative in this area which succumbed to the superior obstetrical resources of the large hospitals.

⁶³ Vancouver physicians such as Harold Caple and Isabel Day travelled east in the 1930s for six to twelve months' post-graduate work in obstetrics and gynaecology, though according to the Vancouver Medical Association records the number of doctors specializing in this way were few. Vancouver Academy of Medicine, VMA Biographical Files.

⁶⁴ For a very useful discussion of middle-class responsiveness see Wertz and Wertz, *Lying In*, ch. 5.

⁶⁵ Dr. A. S. Munro, "The Hospital — Past, Present and Future," *Proceedings* of the First Convention of the Hospitals of B.C., 1918, p. 11.

building, eventually completed in 1929, made VGH all the more attractive a choice for those who could afford \$5 and more a day, plus physicians' fees, for privacy.

For all the differences which distinguished female experience, the fact or the possibility of childbirth encouraged bonds of sympathy between races and classes. The creation, for instance, of such national institutions as the federal Division of Child Welfare and the VON, which were instrumental in developing effective pre- and post-natal maternal and child care, owed a great deal to first-wave feminism's proclivity for women helping women.⁶⁶ Provincially, the campaigns of women's organizations for maternity insurance benefits and mothers' allowances, like the activities of the VGH Women's Auxiliary and the auxiliaries to the other hospitals, were very much predicated on a sympathetic appreciation of the difficulties of motherhood shared by all women.⁶⁷

Submissions by the city's women's groups to the provincial Royal Commissions on Health Insurance and Maternity Benefits of 1919-21 and then of 1929-32 reflect both the consensus within the women's community over the problems of inadequate maternity assistance and the changing beliefs as to how these problems could be solved. The 1919-21 Commission recommended that a maternity benefit be paid to women, or wives of men, who earned less than \$1,200 per year. These women would be given \$35 per child and \$25 per additional child born within twenty-four hours, if proof was presented that the mother was attended by a qualified doctor or, if no doctor was available, a qualified nurse.⁶⁸ Although there was some difference of opinion as to how and to whom benefits would be administered, the concept of a cash benefit was approved by the sixty-nine women's groups represented. There was also the strong sense that women, whatever their situation, should be insured as a group. A speaker for women in the Vancouver Trades and Labor Council endorsed universal coverage, arguing "all mothers should be covered because there are a number of people who would look upon it

⁶⁶ See Lewis, "Advising the Parents" and "Reducing Infant Mortality," and Strong-Boag, "Intruders in the Nursery."

⁶⁷ See Linda Hale, "The British Columbia Woman Suffrage Movement, 1890-1917" (M.A. thesis, U.B.C., 1977); Gillian Weiss, "As Women and as Citizens: Club-women in Vancouver, 1910-1928" (Ph.D. thesis, U.B.C., 1984) and Susan Walsh, "Equality, Emancipation and a More Just World: Leading Women in the B.C. CCF" (M.A. thesis, S.F.U., 1984).

⁶⁸ PABC, GR706, B.C. Royal Commission on Health Insurance and Maternity Benefits 1919-1921, Box 1, File 1, "Report on Maternity Insurance, 1921," p. 9.

otherwise as a charity.” A representative from the Women’s Forum also advocated the inclusion of married and unmarried mothers, urging women “let us stick together.”⁶⁹

Three points are especially significant in these hearings: first is the unanimous support for benefits by women of different classes; second is the support for a cash payment directly to pregnant women, which would increase women’s consumer power in the obstetrical care market; and third is the discussion of maternity benefits as distinct from other types of health insurance. It is noteworthy that the general superintendent of VGH reserved his opinion on maternity benefits until advantages to the province’s institutions could be demonstrated. In his mind, evidently, concern for the hospital outweighed the need to provide women with choice in the health care market.⁷⁰

By the time of the 1929-32 Commission, the degree of concern over maternal health had heightened, but with new solutions that VGH’s general superintendent would have found very congenial. As J. H. McVety of the B.C. Hospital Association advised, “have the maternity benefit part of the general scheme, recognizing it just as though it were a sickness” paid directly to the institution or individual providing the service so the money will be spent as intended, not “diverted.”⁷¹ Women’s testimony now also advocated direct financing of institutions and organizations. Unlike hospital representatives, however, women appeared less defenders of the institutions than cognizant of the shortcomings of the private health care market. As one woman concluded, “It is impossible for the majority of families today to pay \$35 a week for a trained nurse. And so few families can afford to put down \$25 before the mother can go to a hospital.”⁷²

This social concern over high levels of maternal mortality, pressure within their profession for doctors to perform obstetrical interventions within an approved hospital and the limited choice of assistance for home deliveries combined to promote the growth of institutional births in post-World War I Vancouver. By 1940 safer confinements meant utilizing professional staff and enhanced equipment within updated specialty wards and out-patients’ services such as provided by VGH, the publicly

⁶⁹ *Ibid.*, File 4, “Proceedings,” pp. 522-28.

⁷⁰ *Ibid.*, p. 698.

⁷¹ PABC, GR707, Royal Commission on State Health Insurance and Maternity Benefits 1929-32, “Transcript of Evidence,” Appendix H, V II, p. 357.

⁷² *Ibid.*, p. 316.

funded institution which accommodated more than one-half the city's hospital deliveries during these two decades.⁷³

Conditions in the province's largest hospital were, however, far from satisfactory during these years. Major investigations of VGH in 1912, 1930 and 1936 all described concerns with overcrowding, underfinancing, questionable procedures and limited facilities.⁷⁴ Maternity patients suffered along with others. In 1920 VGH's maternity wards, not untypically, experienced "a very pressing lack of accommodation, and such a large number of cases had to be handled constantly that at times . . . facilities were not capable of coping with the work."⁷⁵ Not unexpectedly, the maintenance of isolation and the restriction of infection were very difficult to guarantee. Although the need for a separate maternity facility was evident from the first study, the 1920 defeat in every ward in the city of a money bylaw requesting \$500,000 to build a new maternity building and a new nurses' residence retarded improvements until the end of the decade. Even with its construction in 1929 there were problems, as one head maternity nurse remembered: "That maternity building . . . my goodness, you ran your feet off. It was a headache! It was very cheaply built, you know. The plumbing was dreadful. You could hear every sound. You could be in a private room and hear every cough and sneeze above you and below you. . . . The plumbing made so much noise and the hot water pipes cracked in the night . . . but the doctors thought it was alright . . ."⁷⁶

Nor was accommodation the only cause for discomfort. The 1930 Commission, which included as chairman Dr. A. K. Haywood, VGH's future general superintendent, and Dr. Malcolm MacEachern, former

⁷³ At present the available documentation on the major alternatives to confinement within VGH — St. Paul's Hospital, run by the Sisters of Providence since 1892; Grace Hospital, managed by the Salvation Army beginning in 1927; and St. Vincent's, run by the Sisters of Charity from 1939 — is scanty. Still less is known about the operations of such small, privately owned, licensed and unlicensed institutions as Tolmie Maternity Home and Impey Maternity Hospital, both operating in the 1920s. VGH remained the largest maternity facility throughout the period. In 1935, for instance, VGH reported 1,585 births while St. Paul's reported only 683 and Grace another 370. See *Vancouver Sun*, 31 December 1935.

⁷⁴ B.C. Royal Commission on Vancouver General Hospital, *Report*, 1912; Vancouver Hospital Survey Commission, *Report upon the Hospital Situation of Greater Vancouver*, 1930; W. H. Welsh, M.D., with comments by A. K. Haywood, M.D., *A Study of the Vancouver General Hospital*, March 1936.

⁷⁵ "Report of the Medical Departments of the Hospital," *Annual Report of VGH*, 1920, pp. 44-45.

⁷⁶ PABC. Sound and Moving Image Division, Vancouver General Hospital Collection, Interview with Helen King, 520, tape 2, track 2, transcription, p. 2.

general superintendent, condemned routine examinations of maternity patients "which are not in accord with the teachings of the leading obstetricians who warn against certain practices in normal cases."⁷⁷ This critical assessment flew in the face of the earlier assertion by VGH's head of obstetrics that "every doctor . . . is a good maternity doctor because of the practical training he received in this department as a student, and by dint of the two cases he handled all by himself while 'Interne' in the surgical ward afterwards."⁷⁸ The Commission's further complaints about record-keeping and the refusal of some physicians to accept the discipline of up-to-date procedures suggested how far VGH and at least some of its medical chiefs had strayed from MacEachern's earlier standards.

As general superintendent of VGH between 1913 and 1923 and founder of the B.C. Hospitals' Association, MacEachern was instrumental in establishing standards which won VGH accreditation by the American College of Surgeons soon after the war. An energetic administrator, his talents soon took him far from Vancouver, eventually to become Associate Director of the American College of Surgeons and its Director of Hospital Activities. His *Hospital Organization and Management*, originally published in 1935 and reprinted many times, became a classic in the field. MacEachern himself donated a first edition to VGH's Internes' Library. The inclusion of a substantial section on obstetrical care was close to the heart of an author who was also the inventor of the MacEachern Obstetrical Table and former Surgeon and Medical Superintendent of the Montreal Maternity Hospital. MacEachern's influence in Vancouver was reaffirmed throughout the 1920s and 1930s by regular visits back to his former home and such official duties as membership on the Vancouver Hospital Survey Commission in 1930.⁷⁹

The appointment of the Commission's chairman as general superintendent that same year was an obvious attempt to bring about reform. Dr. Haywood, M.B. (Tor.), M.R.C.S., L.R.C.P., who took the superintendency over from 1930 to 1947,⁸⁰ shared MacEachern's enthusiasm for

⁷⁷ Vancouver Hospital Survey Commission, *Report*, 1930, p. 88.

⁷⁸ Burnett, "Maternity Work in the Small Hospital," *Report of the Proceedings of the Convention of the Hospitals of B.C.*, 1918, p. 81.

⁷⁹ On these visits see the B.C. News section of the *CMAJ*. On MacEachern himself see *The Canadian Who's Who*, vol. VI, 1952-4, pp. 648-49. See also Margaret Andrews, "Medical Services in Vancouver, 1886-1920; A Study in the Interplay of Attitudes, Medical Knowledge, and Administrative Structures" (Ph.D. thesis, U.B.C., 1979), especially chapter 3.

⁸⁰ *Who's Who Among Physicians and Surgeons*, vol. 1, 1938, ed. J. C. Schwartz (N.Y., 1938), p. 747. Also Anne S. Cavers, *Our School of Nursing, 1899-1949* (School of Nursing, Vancouver General Hospital, n.d.), p. 87.

raising hospital standards, but his dedication to making VGH a fully up-to-date and efficient operation ran full tilt into the municipal and provincial cutbacks to hospital funding in the depression.⁸¹ Wards W and X, for example, had to remain in the basement of the old main building. Despite being badly ventilated, without proper conditions for segregating patients, and containing inadequate provision for nursing and food service, they supplied the only accommodation “for a decent woman patient who might have become septic during childbirth or abortion.”⁸² There, because the Maternity Building itself lacked provision for isolating infected patients, she would join prostitutes and others needing treatment for VD. On the other hand, Haywood’s era did see the revival of the Women’s Auxiliary, which had collapsed in 1926 under the weight of its responsibilities for managing much of the Out-Patient Department and supplying the hospital with many of its regular supplies. Renewal of the Auxiliary’s assistance with layettes, food and practical advice to maternity patients entering the public wards was a significant benefit, for all the accompanying assumptions of superiority and authority.⁸³

Such sympathetic support was especially important when, as one Vancouver practitioner acknowledged, it was too easy for doctors to be insensitive when dealing with obstetrical patients. Noting that pregnancy bordered “on the pathological,” a growing belief within the profession, he urged his colleagues to postpone internal examinations during the first consultation with nervous patients and to make every effort to be helpful and supportive.⁸⁴ Such admonitions may well have been taken to heart, but after 1929, when public ward patients were denied the services of private practitioners and assigned routinely to the staff service, the reassurance of whatever prior contacts had been made with a sympathetic doctor disappeared, at least for the poor. The barring of family members from delivery rooms, in contrast to the likelihood of their presence at home births, still further depersonalized an institutional environment which might promise safety but also readily imposed alienation. It would be hard for an already overworked nursing staff — predominantly student nurses being taught the gospel of cleanliness, neatness and routine

⁸¹ For a useful discussion of these funding problems see Harry M. Cassidy, *Public Health and Welfare Organization* (Toronto: Ryerson Press, 1945).

⁸² Haywood in Walsh, *A Study of the VGH*, n.p.

⁸³ See the work and reports of the Women’s Auxiliary in the *Annual Reports of VGH*.

⁸⁴ Dr. C. F. Covernton, “Problems of Primipara,” *VMAB* (May 1931): 179-83.

procedure — to compensate for the emotional and personal deficiencies of such a system.⁸⁵

The procedures recommended upon the onset of labour continued the objectification of the patient. Her hair was arranged in “two tight braids”; the area around the vagina was shaved and bathed with soap, water and lysol. She was given only a liquid diet, “even though she does not ask for it” and was to excrete every hour. In the meantime, the prospective mother was checked regularly for her own and the baby’s pulse rate.⁸⁶ In the delivery room itself she was surrounded by doctors, nurses and students, commonly strangers, hidden in gowns, caps and masks. She herself was similarly disguised with elaborate draping. At this point the woman and her physician faced a number of options which varied not only with her condition but with shifting fashions in obstetrics and the relative skill and knowledge of those in attendance.

Unfortunately, given available records, dating the introduction at VGH of particular drugs and techniques is difficult. Between 1922 and 1929 the hospital’s annual reports did include appendices citing statistics for the various areas of medical and surgical treatment. However, few surgical or manual and no chemical procedures are specified for obstetrical cases, and while the type, frequency, outcome and average stay of obstetrical cases are indicated, no information regarding the relationship between particular therapies and patient health is offered. It is nearly impossible to gain insights from these reports into the efficacy of hospital obstetrical practices. Individual practitioners may have recorded this information, and hospital medical staff may have included it on record cards for public patients, but if so only a relatively small number of doctors benefited. The city’s medical profession and the public in general were left largely in the dark about the success of various obstetrical practices.

New kinds of records were created by VGH from at least 1933. These records emphasized the type and frequency of medical procedures employed by the hospital on maternity patients and provided staff and practitioners generally with empirical evidence with which to evaluate scientifically current obstetrical practices. The appearance of articles in the *Vancouver Medical Association Bulletin* and the *Canadian Medical Association Journal* which presented statistical analyses of VGH’s obstet-

⁸⁵ Like other Canadian hospitals, the VGH staffed its wards with student nurses enrolled in the VGH School of Nursing. For a discussion of the content of nursing training see Kathryn McPherson, “Nurses and Nursing in Early Twentieth Century Halifax” (M.A. thesis, Dalhousie University, 1982), chap. 2.

⁸⁶ MacEachern, *Hospital Organization*, pp. 866-75.

rical interventions indicated the wider dissemination of this evidence within the medical profession in the 1930s.⁸⁷ This shift in the nature of published statistics reflected the mounting preoccupation with the promise of intervention and the desire to confirm the “scientific” basis of medical action.

Just as with the statistical record, chemical treatments appear to have been in a state of some flux during these years. Chloroform and ether, old stand-bys from the 1840s, continued to be used into the 1920s. Their use was, however, more restricted since the possibility of damage to liver and kidneys was now recognized.⁸⁸ Twilight sleep, a combination of morphine to deaden the pain and various amnesiac drugs, notably scopolamine, had been used in Canada since its development in Germany in the early twentieth century, but its potential for causing vertigo and delirium in the mother and narcotizing the baby limited its popularity severely.⁸⁹ Also available to doctors were rectal anaesthesia, although this

⁸⁷ W. K. Burwell, “Report from Staff (Gynaecological Division) of Vancouver General Hospital,” *VMAB* 13 (1937): 193-97, and F. Sidney Hobbs, “Maternity Statistics,” *CMAJ* (January 1943): 48-51. Obstetrical statistics for the 1920s can be found in *VGH Annual Reports*. According to Frederick J. Fish, VGH’s director of medical records, the VGH changed its record-keeping system in 1932. This “effort at standardization which, although purely local, will have, it is hoped, an effect for good,” included adopting the Massachusetts General Hospital interpretation of disease nomenclature and discarding “the classification books, in which all diagnoses were recorded heretofore, . . . in favor of the more handy and efficient ‘Kardex’ cabinet.” See F. J. Fish, “The Medical Records System of the Vancouver General Hospital, Vancouver, B.C.,” *Bulletin of the American College of Surgeons* 18, 2 (June 1933): 52-58.

⁸⁸ Dr. G. M. Feldert, “Alleviating the Pains of Childbirth,” *Canadian Nurse* (August 1920): 470.

⁸⁹ For more negative views see U. E. Bateson, “Twilight Sleep in Obstetrical Practice in Reports of Cases,” *CMAJ* (June 1925): 639-40; W. Bourne, “Anesthesia in Obstetrics,” *CMAJ* (August 1924): 702-03. For a more positive assessment see Ross Mitchell, “The Use of Pituitary Extract and Scopolamine-Morphine in Obstetrics,” *CMAJ* (May 1921): 351-55. See also the critical editorial which follows Mitchell’s article. This condemned the “tendency in certain countries and localities” to make use of drugs recommended by Mitchell “as an incentive to the patient to choose certain centres as her temporary place of abode. To promise a patient the application particularly of the latter [i.e., twilight sleep] . . . has led without question to its abuse, and in large extent its discredit.” *CMAJ* (May 1921): 366. In another article D. Bjornson, “An Obstetrical Retrospect,” *CMAJ* (December 1925): 1236-39, asserts that modern women knew about, and demanded, twilight sleep, ether, etc., leaving young practitioners in a quandary. A later editorial claimed that one of the causes of maternal mortality in Canada was “the insistence of mothers and their relatives and friends on the speedy termination of labour”; see “Maternal Mortality and the Practice of Obstetrics,” *CMAJ* (February 1929): 180-81. There is some non-medical evidence that individual women did actively seek out chemical assistance in labour; for example, see Laura Salverson, *Confessions of an Immigrant Daughter* (Toronto: University of Toronto Press, 1981). However, Canadian women did not collectively demand greater

demanded considerable control by the patient,⁹⁰ and a combination of nitrous oxide and oxygen.⁹¹ The latter seems to have become especially popular. It did, for all the usefulness and success noted by a prominent Vancouver doctor, however, definitely require the presence of an anaesthetist.⁹² This added not only to the numbers of strange attendants surrounding the patient but also to her final bill at VGH as elsewhere.⁹³ Only with the introduction of spinal anaesthetics in the 1940s would choices change substantially, and even then the additional expense remained.

The extent of medical intervention also varied from private to public wards. There is some indication that staff doctors were rather more conservative than private practitioners. One report, examining VGH records for 1934, 1935 and 1936, made this point about induction, arguing that "when one is dealing with a private patient . . . there is a real urge to make it truly successful, to get it over with. Patients are not much impressed with the idea of going home and coming back and, as a result, the doctor gets the blame; it is rather poor advertising." This staff doctor believed that patients should not in fact be induced solely because they were at term, but he noted that VGH's chief of obstetrics disagreed with him.⁹⁴ This self-proclaimed conservatism changed markedly once it came to a discussion of the use of low forceps, admittedly much less serious than the mid or high variations. Usually done "for the benefit of the interne on the service," their employment was supervised by a resident or staff member. The author thought that more patients might be delivered this way since "it wouldn't hurt . . . and it would be a great help to the interne who is soon to embark in private practice." With his own primipara cases he preferred "prophylactic low forceps and median episiotomy" as a matter of course.⁹⁵ Despite this predilection, he observed that

availability of twilight sleep to the same extent as their American sisters, who publicly campaigned for such intervention to ease the lot of their sex. For the U.S., see Wertz and Wertz, *Lying In*, pp. 150-54, and Judith Walzer-Leavitt, "Birthing and Anesthesia: The Debate Over Twilight Sleep," *Signs* 6, 1 (1980): 147-64.

⁹⁰ See R. N. Ritchie, "Rectal Anaesthesia in Obstetrics," *Canadian Nurse* (July 1924): 352-54, and J. D. Graham, "Rectal Anesthesia in Obstetrics," *CMAJ* (September 1925): 935-39.

⁹¹ W. Bourne, "Nitrous Oxide-Oxygen Analgesia and Anaesthesia in Obstetrics," *CMAJ* (November 1921): 818-22.

⁹² Bergland, "The Relief of Pain in Labour," pp. 57-59. See also MacEachern, *Hospital Organization*, p. 282.

⁹³ See Haywood, *Hospital Survey Commission* 1930, pp. 89-90.

⁹⁴ Burwell, "Report from Staff," p. 193.

⁹⁵ *Ibid.*, p. 195.

instrumental deliveries are far more common on the private than on the staff side." Even then they made up a small part of the caseload in these years since 1,253 of 1,519 confinements, or 82.49 percent, were assessed as normal, with 129 cases of low forceps, 27 of midforceps, 20 of version, 45 of caesarian section and 45 breech deliveries.⁹⁶

This staff doctor's preference for instrumental intervention, however "moderate," helped change the percentage of so-called "normal" deliveries over the longer period 1933-1941, when only 13,359 of 18,539 or 72.2 percent were so identified at Vancouver General.⁹⁷ This trend occurred despite the retirement in 1937 of Dr. Burnett, head of obstetrics, who had been a devotee of elective versions and whose patients made up a majority of these interventions.⁹⁸ Table 3⁹⁹ reveals some significant trends.

What stands out here is the difference, not always large but almost always present, between private and public patients. The fact that 44 percent of false labours over the 1933-41 period occurred in the public ward, which accounted for only 26 percent of VGH's deliveries in those years, indicates a willingness on the part of staff doctors and their charity patients to wait for natural labour rather than attempt induction.¹⁰⁰ In almost every case the degree of medical intervention, including all types of forceps and the very dangerous, if "glamorous," C-section,¹⁰¹ was greater on private wards. Explanations for this phenomenon vary. Patients anticipating difficulty may have made additional efforts to raise funds to pay for confinement and doctors' fees. Certainly more and more women were turning to private or semi-private accommodation over these years. What cannot be ignored, however, is the fact that interventions such as versions or C-sections added to medical fees and incomes while simultaneously asserting the supremacy of the professional. They also commonly shortened the length of the delivery, a boon perhaps to a weary mother but always to a busy practitioner. Nor is the fact that the majority of cases were delivered by GPs without significance.¹⁰² Obstetricians regu-

⁹⁶ *Ibid.*, p. 196.

⁹⁷ F. Sidney Hobbs, "Maternity Statistics," *CMAJ* (January 1943): 49.

⁹⁸ *Ibid.* See also Burnett, "Versions," *VMAB* (November 1928): 42; "It is essential for every obstetrician to be able to do a version."

⁹⁹ Calculated from Hobbs, "Maternity Statistics," table 1, p. 49.

¹⁰⁰ *Ibid.* Burwell states that in public wards "one may not hesitate to let the patient return home after one or two unsuccessful inductions of labour where no obstetrical abnormality is present," "Report from Staff," p. 193.

¹⁰¹ Burwell, "Report from Staff," p. 196.

¹⁰² Hobbs, "Maternity Statistics," p. 48.

TABLE 3
Maternity Statistics, VGH, 1933-1941

		1933	1934	1935	1936	1937	1938	1939	1940	1941	Total
Deliveries	To*	1773	1605	1647	1728	1991	2191	2343	2490	2771	18,539
	Pr	1001	1104	1171	1231	1463	1592	1748	1970	2426	13,706
	Pu	772	501	476	497	528	599	595	520	345	4,833
False labour	To	117	63	55	57	54	59	80	76	62	623
	Pr	44	37	29	16	37	33	45	55	51	347
	Pu	73	26	26	41	17	26	35	21	11	276
Normal deliveries	To	1363	1111	1245	1265	1447	1547	1684	1763	1934	13,359
	Pr	680	704	830	834	969	1042	1168	1306	1634	9,167
	Pu	683	407	415	431	478	505	516	457	300	4,192
Caesarians	To	45	48	69	48	61	70	74	87	110	612
	Pr	29	38	49	33	52	58	68	82	101	510
	Pu	16	10	20	15	9	12	6	5	9	102
% of Caesarians	To	2.5	2.3	4.1	2.7	3.0	3.1	3.1	3.4	3.9	3.3
	Pr	2.9	3.4	4.2	3.6	3.6	3.6	3.9	4.2	4.2	3.7
	Pu	2.1	2.0	4.2	1.7	1.7	2.0	1.0	.96	2.6	2.1
Versions	To	52	63	26	31	22	13	11	8	3	229
	Pr	49	51	22	27	17	9	11	5	3	194
	Pu	3	12	4	4	5	4	—	3	—	35
High forceps	To	3	2	—	—	2	5	2	7	5	26
	Pr	3	2	—	—	1	2	2	7	5	22
	Pu	—	—	—	—	1	3	—	—	—	4
Mid forceps	To	61	69	67	59	62	102	121	121	149	811
	Pr	38	59	58	51	59	85	102	111	146	709
	Pu	23	10	9	8	3	17	19	10	3	102
Low forceps	To	249	312	240	325	397	454	451	504	570	3,502
	Pr	202	250	212	286	265	395	397	459	537	3,103
	Pu	47	62	28	39	32	59	54	45	33	399

*To=Total; Pr=Private; Pu=Public

larly condemned this group for attempting treatments beyond their experience or understanding. Their interventions were characterized as frequently providing later employment for gynaecologists.¹⁰³

¹⁰³ Robert Ferguson, "A Plea for Better Obstetrics," *CMAJ* (October 1920): 901-04. Ferguson claimed that 30 percent of the work of gynaecologists was created by bad obstetrics. John Osborn Polak of Brooklyn, N.Y., claimed that 60 percent of gynaecological cases were direct results of poor obstetrical practice, "Effect of Popular Gynaecological Procedures on the Future Child-Bearing Women," *CMAJ* (September 1924): 797-803.

TABLE 4
Percentage of Maternal Morbidity, VGH, 1933-1941

	<i>Total</i>	<i>Private</i>	<i>Public</i>
1933	4.6%	3.5%	6.1%
1934	5.4%	3.6%	9.5%
1935	4.4%	3.0%	7.6%
1936	6.1%	4.1%	11.9%
1937	5.4%	3.5%	10.0%
1938	7.5%	7.5%	7.5%
1939	7.4%	9.7%	5.2%
1940	6.8%	7.3%	5.0%
1941	5.3%	5.4%	4.9%

TABLE 5
Percentage of Maternal Mortality, VGH, 1933-1941

	<i>Total</i>	<i>Private</i>	<i>Public</i>
1933	0.5%	.8%	.3%
1934	0.5%	.5%	.6%
1935	0.3%	.3%	.2%
1936	0.3%	.4%	.2%
1937	0.05%	.05%	—
1938	0.1%	.1%	—
1939	0.04%	.04%	—
1940	0.2%	.2%	—
1941	0.03%	.03%	—

The trends in maternal morbidity and mortality, as evident in tables 4¹⁰⁴ and 5,¹⁰⁵ also reveal differences between private and public wards but are somewhat inconclusive about the exact effect of differential treatment over the nine years surveyed.

At the very least, however, it is fair to say that the benefits of private care in terms of these two major variables are uncertain. The erratic

¹⁰⁴ Calculated from Hobbs, "Maternity Statistics," table II, p. 50.

¹⁰⁵ *Ibid.*

pattern of morbidity over the years 1933-41 also suggests that the hospital experienced considerable difficulty in controlling infection. The introduction of sulfonamide drugs in the late 1930s, as acknowledged by one 1943 observer, appeared to have been critical in lowering pregnancy's dreaded costs.¹⁰⁶

In keeping with its effort to maintain institutional standards, Vancouver General made some attempt to regulate doctors' regimes. The increase in the incidence of C-sections, for example, prompted a rule requiring the prior consent of the general superintendent or one of his assistants.¹⁰⁷ In other developments the institution concurred. The steady increase in episiotomies revealed in table 6¹⁰⁸ reflects a trend which was becoming normative in North American hospitals.¹⁰⁹

TABLE 6
Percentage of Episiotomies, VGH, 1933-1941

	<i>Total</i>	<i>Private</i>	<i>Public</i>
1933	8.7%	14.4%	1.7%
1934	13.2%	17.7%	3.6%
1935	13.5%	17.2%	6.5%
1936	17.6%	22.2%	9.9%
1937	23.3%	27.1%	13.1%
1938	28.4%	31.3%	20.7%
1939	32.3%	34.2%	27.1%
1940	35.3%	35.1%	35.8%
1941	36.6%	38.3%	25.2%

Again there is a significant difference between private and public wards. In every year but one the patient under the care of her own physician faced a substantially higher chance of experiencing this form of intervention. It is also quite clear, however, that episiotomies were being "democratized" over this period as well.

¹⁰⁶ *Ibid.*, p. 51. See also Biggs, "The Response to Maternal Mortality in Ontario," for a discussion of the role sulfonamide drugs played in that province's maternal health.

¹⁰⁷ See G. McKee, "A Review of Caesarian Sections in the Vancouver General Hospital, 1941," *VMAB* (April 1943): 206-10.

¹⁰⁸ Calculated from Hobbs, "Maternal Statistics," table II, p. 50.

¹⁰⁹ Wertz and Wertz, *Lying In*, pp. 141-43.

Once the baby arrived, and if the hospital was not overcrowded, the woman might rest in the delivery room under observation for an hour. Should there be bleeding, pituitrin and ergometrine would be given; haemorrhage, with its threat of shock, brought the administration of intravenous fluids by a specialist.¹¹⁰ After her pulse returned to safe levels and there were no signs of distress, the woman would be returned to her room, where the extent of comfort and nursing care depended on a private or public location. The increasing employment of registered nurses, still assisted by students, in these decades, especially the 1930s, also brought changes to patient care.¹¹¹ That transformation, with its promise of more knowledgeable staff, undoubtedly helped convince expectant mothers to choose hospitals for their confinements. What it actually meant in terms of real contact is more difficult to say.

In her own bed the patient could not expect unregulated access to her new baby. The modern hospital of VGH's ambition imposed a strict regimen based on the most up-to-date strictures about successful child care. Breast-feeding was a central dictum, but some procedures, such as MacEachern's recommendation that it was "most important" not to nurse the baby for at least six to eight hours after delivery,¹¹² very likely made it more difficult. The attempt to inculcate regular habits right from the onset may have had the same effect, as with the "Standing Orders" for

¹¹⁰ M. Blair, "The Role of Haemorrhage," pp. 166-69.

¹¹¹ 1931 B.C. Hospital statistics report a 1:2 nurse-patient ratio, with 455 nurses (181 graduate nurses and 274 students) responsible for up to 1,153 patients. PABC, GR707, Box 5, Appendix D "Hospital Statistics, B.C. 1931." However, these figures do not reflect the fact that nurses worked in shifts and were not all on the wards at one time. Nor was their distribution in the hospital even. Some wards and wings required higher levels of staffing, while the staffs of private wings were augmented by graduate nurses hired by individual patients. As staff requirements grew, so too did the number of students accepted into the school, but by the mid-1920s shortage in student residence space began limiting enrolment. Staff shortages and unhealthy working and living conditions for students became so acute in the 1930s that the hospital was forced to hire Graduate or Registered Nurses on its staff, a move which most Canadian hospitals did not have to resort to until the 1940s and 1950s. These graduate nurses faced the same long hours and heavy work load as student nurses, and in 1940 the superintendent of nursing was still claiming that "in our desperate effort to keep expenses down to what we think the city 'will stand for,' we have been placing an all too great burden on our staff, which has necessitated the unpleasant closing of our eyes to continuous long overtime." *Annual Report of VGH, 1940*, p. 22. Thus the employment of graduate nurses did not necessarily improve the availability of nurses to patients, though graduate nurses could be relied on for swifter, calmer responses in emergencies and more experienced execution of therapeutic techniques. For a comparison of VGH nursing staff size to those across the country see J. M. Gibbon and Mary S. Mathewson, *Three Centuries of Canadian Nursing* (Toronto: Macmillan Company of Canada Limited, 1947), pp. 489-91.

¹¹² MacEachern, *Hospital Organization*, p. 283.

an efficient obstetrical department which recommended feedings at precise four-hour intervals for three days and "only fifteen minutes" at a time with the mother. Later, twenty minutes would be allowed on the same schedule.¹¹³ The baby herself or himself was carefully tagged and distinctively stenciled with the family surname by exposure to a sun-lamp.¹¹⁴

Mothers' activities were also closely regulated. They were to recline in bed until the fifth or sixth day, only then to sit up if all went well. Not until five or so days passed were they allowed out of bed for limited periods. They were not to leave the hospital for twelve to fourteen days.¹¹⁵ VGH seems to have observed this rule throughout these years, despite the circulation problems it might have caused for the patient, the added risk of infection and the contribution such stays made to the hospital's chronic problem with overcrowding.¹¹⁶ On the other hand, it may be that mothers without urgent domestic responsibilities awaiting their arrival looked forward to such respites from labour.¹¹⁷

Throughout this course of treatment women and their relatives undoubtedly demanded the full range of up-to-date procedures which might in any way ease childbirth's pains and dangers. For them, like the professionals they consulted, there were trends and fads. Nevertheless, however much they might "shop around," prospective mothers were finally expected to deliver themselves into the hands of their doctors. Joint decision-making was not encouraged. MacEachern's influential recommendation that "No information regarding baby other than 'favorable' is to be given mother by the nurse"¹¹⁸ represented a common enough attempt to control the flow of information and thus to determine the process.

¹¹³ *Ibid.*, pp. 870-71.

¹¹⁴ Vancouver City Archives, *Sun* and *Province* Clipping File, "VGH," "General Hospital is Mother to 27,395 Babies," 2 November 1935.

¹¹⁵ MacEachern, *Hospital Organization*, p. 283.

¹¹⁶ In the early 1930s white maternity patients between the ages of 16 and 45 in the VGH, St. Paul's and Grace were hospitalized on average between 12.32 and 12.70 days each. *PABC* GR749, "Report on Information Collected and Compiled in Reference to Certain Phases of Hospital Work in British Columbia," 1934. Given the shortage of space at the VGH in these years, it is not surprising that "The gynaecological and obstetrical section of the staff keeps constant watch upon the efficacy of their treatment and their efforts towards reducing the length of stay in hospital." Frederick J. Fish, "The Medical Records System of the Vancouver General Hospital, Vancouver, B.C.," *American College of Surgeons Bulletin* (June 1933): 56.

¹¹⁷ Wertz and Wertz, *Lying In*, chap. 5.

¹¹⁸ MacEachern, *Hospital Organization*, p. 869.

Once home, the model patient was to continue consultations with her doctor and public health nurse. The reality for many women, however, was an immediate return to postponed duties and tasks.¹¹⁹ Domestic labour and family budgets made medical visits a low priority for many families in the days before medicare. The highly centralized services of the hospital did not easily follow the patient upon release, and it was only too likely that poverty in the case of the clients of the public wards would undo whatever good had been achieved.¹²⁰ The conditions of poor nutrition and abysmal housing which undermined women's health in the city at large remained for the most part untouched.¹²¹

Within the confines of the hospital women encountered a highly bureaucratized set of procedures presided over by male medical professionals. In this setting, where pregnancy was so readily defined as an illness, doctors found ample opportunity to assert their overriding authority and an equal temptation to employ techniques of intervention which dramatically influenced the pace and quality of childbirth. As a group women found themselves more highly regulated. Patients' status in the world beyond the walls of the institution was also reaffirmed by individual assignment to private rooms or public wards. Differences in treatment appear to have continued into the delivery room itself, where private patients were more likely to encounter intrusive procedures such as C-sections and forcep delivery. Over time, however, the common denominator of sex was powerful and the experience of public patients came to match that of the more fortunate.

Just as it is hard to credit hospitalization with responsibility for a significant reduction in maternal mortality in these years, it is difficult to judge the effectiveness of new medical regimes in improving women's experience of confinement. Given an allocation of public resources which favoured institutions and doctors rather than home care and domestic assistants, choices for pregnant women were limited. The absence of real

¹¹⁹ See Strong-Boag, "Keeping House in God's Country," in R. Storey and C. Heron, eds., *On the Job* (Toronto: McGill-Queen's, 1986) for its discussion of the extent of home based work.

¹²⁰ In 1920 Dr. MacEachern acknowledged this problem, stating that many poor women, whose health had improved during their stay at VGH, return home and "drift back into poverty condition." His solution, "more care of the financial condition," was beyond the mandate or resources of the hospital. PABC, GR706, B.C. Royal Commission on State Health Care and Maternity Benefits 1919-21, Proceedings, Letter from Dr. MacEachern, p. 7.

¹²¹ See W. Peter Ward and Patricia C. Ward, "Infant Birth Weight and Nutrition in Industrializing Montreal," *American Historical Review* 89 (February 1984): 324-45, for an insightful discussion of the effects of maternal malnutrition on infant health.

alternatives and the medical profession's ability to campaign for its own interpretations of the road to good health directed women to the relief that hospitals could provide. Some patients benefited from advances in medical procedure such as blood transfusions and anaesthetics which were most safely performed in a hospital setting. Relief, however, did not include provision for allowing women to make an informed choice about their experience of confinement nor address factors in the community which made pregnancy and illness in general the special burden of the poor. The overall result in these two decades was to leave decision-making firmly in the hands of professionals, who alone were deemed capable of understanding the physiology of women and the relative benefits of intervention. In time, however, disillusionment would set in. This would provide fertile ground for women's rebellion against the tyranny of the medical expert and their demand for informed choice and effective therapy in childbirth.