"HEALTH SCOUTS" FOR THE STATE? SCHOOL AND PUBLIC HEALTH NURSES IN EARLY TWENTIETH-CENTURY TORONTO*

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Introduction

According to many historians, urban social reforms in Canada during the late nineteenth and early twentieth century were promoted by relatively small groups of Anglo-Saxon, middle-class men and women. Moved by reports of poverty and crime, poor and overcrowded housing, and high death rates—especially among infants and children—they pushed for a wide range of reforms in local government and schooling.[1] Many of the reforms initiated in this period focused on the health and welfare of children.[2] According to some observers, it was in the area of public health in general, and the health of children in particular, that reformers achieved some of their greatest successes.[3] Historians have analysed a wide range of issues in regard to these initiatives, arguing about whether they constituted efforts to "raise the lower classes" or to improve mechanisms and institutions of social control, and about what motivated the leaders of reform.[4] Feminist historians have focused on the relations between women as clients and workers within the emerging welfare state, as well as on women's roles in political movements which shaped late nineteenth and early twentieth-century social reforms.[5]

In this paper, I want to discuss one aspect of state health reforms in an English-Canadian city: the practice of home visits by school and public health nurses in Toronto during the first two decades of this century. During this period, visiting nurses—all women—were added to the staff of the departments of school medical inspection and public health. It was largely working-class and recent immigrant families who were visited by these nurses, and it was the women in those homes who were the primary recipients of their instructions and advice.

I will not discuss whether or not visiting nursing represented a "good" or "bad" social reform. I will hope, however, to show that visiting nurses cannot easily be placed within either a "progressivist" or a "social control" interpretation. Both these approaches focus on the relations of reformers to some "other" group presumed to be in need of reformers' assistance or control. While such motivations were certainly present in visiting nurses' practice, interpretations which focus only on early "professional" women's relation to their "clients" have little to say about the effects of professionalism on the women involved in its practice. Sociologists and historians have tended to think of state regulation primarily in

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terms of social control of "other" groups: the poor, native people, children, immigrants, and women as clients. It is equally important, however, to analyse how state regulation works in relation to middle-class life, the "middle-class family," and women in so-called professional occupations. In this paper I will take up one aspect of such an analysis and show that, as a group of state employees aspiring to professional status and involved in social regulation of working-class and immigrant family life, nurses were themselves subjected to the very regulation they organized and implemented in relation to "others."[6]

Through an analysis of conflicting ideologies of femininity and professionalism, and an examination of nurses' hierarchical work organization, their documentary work practices, and nurses' compliance and resistance, I will argue that women who took up this work often found themselves in a contradictory relationship to the people they visited, to their supervisors, and to the emerging health and social welfare bureaucracy at the municipal level. Nurses were expected to use their "natural" femininity to obtain the confidence of women, and to solicit co-operation and information from them. On the other hand, they were trained to behave "professionally" and to organize their work, and their reporting of it, through "objective" forms and procedures intended to facilitate "efficient" regulation and management of health and social services. As Dorothy Smith has suggested, the documentary work processes which characterize welfare state institutions, such as report writing, standardized forms, and case files, help to accomplish the transformation of personal troubles into professional problems and public issues in such a way that they can be managed and ruled.[7] Nurses constituted one link in a long chain through which written documents were circulated and in which their descriptions became "real" and "actionable" within state institutions. However, as I intend to demonstrate in this paper, nurses' reports were also used to control and regulate nurses themselves and to account for their work. This was an important consideration for physicians and managers since nurses' home visiting work was carried out in places where it could not be directly supervised or inspected. Therefore, I hope to show in this paper that nurses often found it difficult to satisfy the conflicting expectations facing them: some refused to produce "proper knowledge," while others were "allowed to go" because they did not adopt the behaviour and appearance expected of the "good nurse." We cannot assume, therefore, that all visiting nurses happily adopted the role of "health scout"[8] assigned to them by their state employers, nor that every nurse quietly accepted her subordinate position.

Laying the Groundwork for School and Public Health Nursing

The Province of Ontario established a Board of Public Health in 1882, and very soon its officials became involved in several strategies aimed at improving the health of the population, and especially the health of children. The school became one field where health reforms were put into practice. As the schools gathered ever larger numbers of children, this institution offered a practical entry point for health inspectors so that diseases and defects could be identified and

treated before they could do permanent damage or spread to other children. At the same time, schools were considered dangerous breeding grounds for contagious diseases precisely because large numbers of children were assembled there, and because children were thought to be especially vulnerable to diseases and defects. On the other hand, it was also believed that regular health inspection and free treatment (however limited) for those who could not afford to pay would serve to increase regular school attendance among children of the poor.

Making school children the objects of state health reform was justified in several ways. Reformers believed that children, more than adults, could be influenced and "saved" through education and supervision. Moreover, health reformers believed that the larger community had a right to protect itself from the spread of contagious diseases, even over the objections of individuals. They argued that children did not simply "belong" to parents, they were "assets of the state," and the state, therefore, had "a right to interfere to protect the child."[9] Children were future workers and citizens, and it was important to ensure that their capacities to labour and bear children within a changing class and patriarchal society would be properly developed. Public health intervention thus became one of the strategies whereby sexual, familial, and intergenerational relations within the working classes were to be made more regular and dependable.

The cleanliness, light, temperature, ventilation, and spatial organization of school buildings and grounds were the first targets of school health intervention.[10] With the support of women's organizations such as the Women's Christian Temperance Union, health reformers also attempted to introduce health teaching—physiology, temperance, and "health habits"—into the regular school curriculum.[11] The third aspect of early school health intervention consisted of medical examinations of pupils by doctors, treatment of minor ailments, referrals to family physicians, and the practice of excluding children who were found to suffer contagious diseases. Historians have documented the considerable resistance towards public health initiatives from local politicians, school officials, physicians, and parents.[12] According to Paul Bator, for example, such programmes provoked "violent reactions from parents who regarded such activities as an interference with their rights."[13] Physicians, on the other hand, suspected that the provision of "free" health services would undermine the profitability of their profession. Local politicians, for their part, worried about the expense associated with health reforms, and about the negative electoral consequences which some of the more unpopular initiatives—such as vaccinations—could cause.

In order to counter opposition, health reformers spent considerable time producing evidence of the urgency of health problems, especially among children, and of the necessity to use scientific methods and state intervention to ameliorate them.[14] The collection of statistics on births and deaths, infant mortality, housing and sanitary conditions, sewers and water supply, and so on, soon became important features of public health reform. Reports compiling such facts were used to document social problems and to argue for increased health,

education, and social service provision on the part of local and central governments.

Closely related to the increased reliance on science and "objective" research procedures was a shift in how health and social reforms were promoted and justified during the late nineteenth and early twentieth centuries. Arguments which focused on the religious and moral duty to "save" children and the poor continued to be put forward, but in addition social reformers also argued that their proposals were urgent matters of "national efficiency."[15] Intervening in the lives of the poor was not just a matter of individual charity, but a much larger project of producing a population fit for changing production relations, citizenship, and war. Middle-class women's organizations and leaders of the labour movement also accepted this line of reasoning, and became eager supporters of "scientific" social reforms. Upon his inauguration as Chairman of the Toronto Board of Education in 1910, labour leader James Simpson warmly endorsed school health inspection in general and school nursing in particular. "It bids fair," he declared, "to become the most powerful means of combatting disease and degeneracy, and of raising the national standard of mental and manual efficiency and skill. It is not a fad, but a social movement for human betterment."[16]

Another key ingredient in the rhetoric of reformers was the claim that some parents could not or would not provide a healthy upbringing for children. The Medical Inspector for Hamilton complained at an educational conference in 1909 that "some parents unfortunately are found, too ignorant, or too lazy, or with too little inclination or even too resentful to follow the advice given [by nurses or physicians]."[17] Public health officials in Toronto lamented that patients (adults and children) and their families were "very badly informed and careless" about prevention and treatment.[18]

Visiting nursing grew out of the early twentieth-century social reform and women's movement, and was seen as a relatively cheap solution to real or imagined problems of fitness and efficiency in the population. While health inspection of children in school had occurred for several years, this was not deemed sufficient, as it did not reach the people who were thought to matter most—mothers of young children. If mothers could be educated in hygiene and health, family life could be reorganized according to public health principles of cleanliness, order, discipline, and regularity. Thus one of the objects of organizing regular home visits, especially among the poor, was to enlist mothers in the service of state and nation-building.[19]

From the outset of school and public health reform, then, we can see an uneasy balance of arguments which emphasized national efficiency and broader social responsibility on the one hand, while focusing causes and solutions on individual inadequacies and individual improvement on the other. Mothers, especially those in poor and immigrant communities, found themselves the targets of both rhetoric and practice of emerging public health and social welfare measures. At the same time, women who entered the new feminine "professions," such as teaching, social work, and nursing, found themselves in contradic-

tory positions in relation to the ideology and practice of English Canadian social welfare and health reforms.[20]

The Sexual Division of Labour in Public Health Reform

The move to employ public health and school nurses to visit children and mothers in their homes constituted a considerable widening of the scope of state regulation of familial relations. It was a controversial step over which even public health promoters disagreed. Physicians were concerned that nurses would usurp their practice, while politicians on City Council and the Board of Education worried about the costs of such an expansion. Toronto's Medical Officer of Health initially dismissed school nursing as a "fad" promoted by middle-class women's organizations.[21] In spite of these objections, however, school and public health nursing were added to Toronto's Department of Public Health and the Board of Education in 1910.

Once they had been convinced that home visits were warranted, local politicians did not take long to decide that this was a task best undertaken by women. An ideological argument was often used to suggest that women—nurses—were better equipped than men to achieve results in re-educating mothers. Nurses' femininity was to be mobilized in their work: "If she comes as one wielding authority that must be obeyed, she will always fail to gain the best cooperation, although she may gain her point....Her great weapons of attack will be unvarying courtesy, amiability, persistency and child love."[22] Moreover, since nurses could not be seen to promote their own private practice, as physicians could, it was expected that they would not face charges of self-interest.

As far as local politicians were concerned, however, it is likely that economic arguments were equally important. It would have been possible to employ physicians, most of whom were men, to do home visiting, but nurses' salaries were considerably lower than those commanded by the medical profession. The Toronto Board of Education's budget estimates for 1911 show that the annual salary of the Chief Medical Inspector (a male physician) was to be $2,500, while eight part-time, male Assistant Medical Inspectors would be paid $800 each for their services. The female Superintendent of Nurses, on the other hand, was to have a salary of $1,800 per year—rather good pay for a woman at the time, and also compared to other areas of nursing[23]—while seventeen nurses, all women, would be paid $600 each for full-time work.[24]

In 1907 a nurse was transferred from the staff of the Toronto General Hospital to become the first public health nurse employed by the City of Toronto.[25] Initially her primary area of practice was with tuberculosis patients. Very rapidly the nursing staff was expanded, and in 1914 a separate Nursing Division was created within the Public Health Department, consisting of three sections—Tuberculosis, Child Welfare, and Public Health. Eunice Dyke became the Division's first Director, a position she held until she resigned in 1932.[26] Meanwhile, the Toronto Board of Education hired Lina Rogers in 1910 as the city's first school health nurse. Within the School Board as well, the numbers of

nurses and the scope of nurses' work grew considerably during the first few years. Sixteen nurses were appointed by the Board in 1911,[27] and in 1916 there were forty-six nurses on the staff.[28]

Both Dyke and Rogers reported to male physicians, the Medical Officer of Health and the School Health Inspector respectively. After a municipal referendum in 1916, school medical inspection and school nursing were transferred to the Toronto Board of Health in an effort to "increase efficiency" and "reduce waste" incurred by two health departments sharing the same jurisdiction and population of "clients."[29] It should be noted that this move was resisted by staff and trustees of the Board of Education; thus we cannot assume that state agencies always acted in concert.

Eunice Dyke and Lina Rogers were both active in women's and social reform organizations.[30] Both took part in meetings of the Ontario Educational Association and the Toronto Local Council of Women. Rogers was vice-president of the latter organization, and had pioneered the school nursing programmes of New York City, working with the widely known social reformer and feminist Lillian Wald of the Henry Street Settlement House.[31] While Dyke remained unmarried, Rogers left active nursing in 1913 to marry her boss, Dr. James Struthers, the Toronto Board's Chief Medical Inspector. Four years later she wrote and published *The School Nurse*, a book which gave a detailed account of nurses' work.[32]

Public health and school nurses had many and varied duties. They established and ran baby clinics, taught "Mother-craft" classes, and administered milk depots. A great deal of school nurses' time was spent drilling children in daily routines, such as brushing their teeth and blowing their noses. They also helped to establish and administer special programmes for children suffering from tuberculosis, malnutrition, and anaemia, while "Little Mothers' Leagues" were organized for girls in "downtown" schools to learn proper care of young children.

During in-school inspections, nurses discovered and recorded an astonishing number of children with various diseases. In their first year (1910), Toronto school nurses inspected 13,169 children. A staggering 12,433 of these children were found to suffer from decayed teeth, while hundreds of others had poor eyesight or ear infections, skin diseases, and pediculosis (head lice). Although nurses did treat minor ailments, such as cuts, bruises, and head lice, made sure that some children obtained free glasses, and had teeth filled or tonsils removed without charge, the majority of problems were referred to private family physicians on the understanding that parents would pay for the treatment.[33] School and public health nurses were not to emphasize treatment; education and prevention were considered more important.

In order to provide efficient prevention and health education, nurses were encouraged to work with other welfare workers, charitable organizations, teachers, and others. It was expected that there might be times when they would raise issues which required broader and more concerted intervention and improvement, such as housing reform. However, when pointing to this political

dimension of their work, nurses were reminded of their femininity and position of subordination within the social welfare and medical hierarchy. Wrote Lina Rogers: "A live and diplomatic school nurse will get somebody interested who has power to produce a change, and she will heroically hide her own agency and efficiency behind the powers that be for the good of the child."[34] As I will show below, this was not the only area where nurses were expected to behave according to their "natural" femininity, and to hide their own agency.

Nurses' Home Visits

Dyke and Rogers both argued that the need for their services could be located in the woeful ignorance and inadequacy of parents, particularly mothers. Rogers wrote in *The School Nurse* that

> far too many parents, even those well-educated, are absolutely ignorant of the simplest laws of health, and what mothers need is a knowledge of the laws of health rather than medicine for their children. The mother as well as the child should be instructed in the personal care of the body, the importance of ventilation, a proper diet, suitable clothing, amount of recreation and sleep, the irreparable damage done by tea drinking, coffee drinking, or candy and pastry eating to a young child.[35]

Eunice Dyke, on her part, stated that "nurses had become convinced that lack of knowledge and skill among mothers was a cause of many of the problems affecting children's health."[36]

Despite claims that "many parents, even those well-educated," were ignorant of "health laws," the home visiting practices of school and health nurses were focused almost exclusively on working-class and immigrant women. Rogers began her work by seeking the co-operation of teachers and principals of "downtown" schools and by visiting the homes of poor working-class and non-English-speaking children. Similarly, Dyke concentrated most of the efforts of her staff on working-class neighbourhoods, and especially on those which housed the city's poor and recent immigrants and where mothers were frequently engaged in wage labour outside the home. Home visits were frequently praised as "possibly the most productive of good."[37] In *The School Nurse*, Rogers made the point more bluntly when she wrote that "the nurse who fails in her home visiting may as well give up school nursing."[38]

During home visits, nurses carried out education about childrearing, cleanliness, nutrition, temperance, budgeting, household management, home decorating, gardening, and so on. Mothers of newborn or school-aged children were the primary recipients of nurses' instructions and advice; women were held responsible for the physical and mental well-being of all family members. The definitions of what constituted well-being, or its opposite, were replete with middle-class and Anglo-Saxon assumptions. Dyke, for example, found wage-earning mothers "strikingly abnormal" and she urged nurses to do whatever they

could to re-create "normal" family relations.[39] Rogers wrote in a similar vein that "many mothers are capable in the lines that are revenue producing, but have no knowledge of the household duties that are vital to the health and development of their children."[40]

Such assumptions did not arise in a vacuum; they were deeply embedded in the middle-class social reform movements of the day and in the ideology and practice of nurses' work. In a talk to the Ontario Educational Association, Rogers described the role of the nurse visiting a family and the relations she would ideally produce: "She is a friendly adviser to the mother and helps to regulate all the family affairs, from getting work for the father to helping the mother provide clothes for the new babe."[41] In this form of family, parental responsibility for children extended beyond provision of nourishment and health in a narrow sense; it implied a clear sexual division of labour and care inside and outside the household. From this last quotation we can also see that the nurse was to position herself as a manager of the family's relations and affairs.

Home visits were not just to educate mothers or to reorganize family life, however. It was equally important that nurses used the occasion to gather information.[42] According to Dyke, "the public health nurse excels all other members of the department in scouting capacity. The occasion for her entry may prove to be unimportant in comparison with the conditions her experience and skill reveal."[43] In a similar vein, Rogers claimed that through her visits, "the nurse becomes the mothers' confidante; she is the one person who has the entree to the house on a familiar footing, and obtains a thorough knowledge of conditions, gained by many interviews with parents."[44] Elsewhere she wrote that the nurse "knows the home conditions and the environment better than any one else; she knows the personal and home habits of the child and the things that tend to lower his ideals and corrupt his morals."[45] Through their observations and reports, nurses' home visits became one procedure through which the lives of working-class women and children were made visible as "social problems" for local authorities and therefore subject to new forms of state assistance, intervention, and regulation. As I will show, they gathered information which entered into the management process of school, welfare, and public health departments, thus influencing policy and decision making, albeit indirectly.

How were nurses received by the people they visited? Documents available in the archives only tell the story from nurses' or supervisors' perspectives, and it must be kept in mind that those who wrote them took for granted that home visiting was a "good thing," although at times difficult to accomplish. There is little doubt that for many women the visiting nurse was someone who truly supported and helped in trying and insecure circumstances. But it is also very evident that home visiting was frustrating for nurses due to the poverty and desperate living conditions which they regularly encountered. Nurses were not unfamiliar with poverty, but because of their staggering workload and the institutional constraints which they worked under, the Public Health

Department's personnel records indicate that several felt that their work was useless and ineffective.

Perhaps even more important, parents often resented nurses' interference. "Not infrequently," wrote Rogers, "the parents are prejudiced against the nurse before they ever see her, for they conceive the idea that she is interfering with their authority over their children. Some will receive her cordially, while others will pour a tirade of abuse upon her unlucky head." To illustrate the kind of perseverance which was sometimes required in the face of such reception, she cited one school nurse who "reported ninety-nine visits to one home to gain her objective."[46]

Public health intervention became one of the strategies whereby sexual, familial, and intergenerational relations within the working classes, especially recent immigrants and the poor, were to be made more regular and dependable. Nurses were to reinforce a form of family where dispassionate heterosexuality, and age-based and sexual divisions of labour, were normalized. Moreover, the family form promoted through nurses' work (and that of many other private and state welfare and educational institutions) was based on Anglo-Saxon, middle-class assumptions, including the presumption that a man was able to earn a wage sufficient to support a dependent wife and children. The emphasis on educating women for their part in this family—as dependent wife and mother—ignored the reality that one wage-earner could not realize an adequate income for a large, often extended family. This class and cultural bias also ignored the fact that other family forms, kinship networks, religious and ethnic organizations, and neighbourhood co-operation were preferred by many of those whom nurses tried to educate.[47]

Regulating Nursing and Nurses through Discursive Practices

Much of nurses' "normalizing" work was accomplished through documents. In the case of school nursing, a myriad of forms had to be sent to parents, principals, dentists, physicians, and the school medical inspector. Such documents were used to instruct parents about necessary treatment of children, and nurses' supervisors (principals and physicians) were informed in detail about the work being done and about courses of action to follow. While school nurses (who existed as a separate entity under the Board of Education until they were transferred to the City's Department of Public Health in 1917) regularly provided teachers and principals with information about children who were absent from school, public health nurses transmitted a wide range of information about homemaking, neatness, and sanitary conditions to the Board of Health.

One type of nurses' records was the so-called "family case history." These were not statistical entries on standardized, pre-set forms, but rather more like daily logs of visits and other forms of interaction with families who were in frequent contact with nurses. In this type of report nurses would record their visits, treatments, counselling, and follow-up. They would also describe any contacts which they made with other social agencies for information or referral,

including the courts and the police. They noted the initiatives they took to secure employment for unemployed men, along with assessments of men's willingness to follow through on such assistance. Women, on the other hand, were evaluated according to their interest in or capacity to care for children and other family members, as judged by their skills in homemaking, cleanliness, budgeting, cooking, and home decorating.

While there may have been instances where nurses used such records to express the frustrations and poverty of the people they visited, the requirement to monitor, standardize, and centralize their collection greatly restricted their subversive potential.[48] Case histories, organized around "social problems," were collected to build up a comprehensive description of working-class life in such a way that health and social agency intervention could be efficiently managed and monitored. As a practical organizational matter, centralized record-keeping procedures were used to reveal and prevent what welfare and health administrators called "overlapping." This phenomenon was said to occur when members of the same family were interacting with staff in different social agencies at the same time, and particularly when they were receiving material assistance from more than one such organization. Rogers maintained that "indiscriminate giving which fails to bring about lasting results" could be eliminated through regular and centralized record-keeping.[49] How this "problem" appeared from the position of those who were at the receiving end of "indiscriminate giving" was never considered.

One clear indication of the importance for the "City Fathers" of record-keeping and reporting procedures is given by the size and activities of Toronto's Division of Records and Statistics. In 1917 the Division's Director reported that eleven people were employed full-time, including two working solely on a "central history file of families supervised by the Public Health nurses," based on family case histories. Two other staff members devoted their time to a "complete analysis of nurses' time and work, by day and by month."[50] Thus we discover that the practice of producing written accounts of nurses' work not only facilitated efficient management of "clients," but also made it possible to account for, and thus to regulate and manage, the work of nurses themselves. Public health and school nurses worked relatively independently compared to other nurses and to women in the wage-labour force in general. Written records provided one mechanism through which they could be brought into regular and subordinate relations to their supervisors.[51] It was through regular written records which they themselves completed that nurses could demonstrate that they were doing "proper" school and public health nursing, and it was through the practice of producing them that nurses were constantly kept accountable as individuals and as a Department.

District supervising nurses and the head of the Nursing Division collected and co-ordinated individual nurses' reports into accounts of "her" staff's work on a monthly basis. In her written reports to the Medical Officer of Health, Eunice

Dyke frequently mentioned nurses' complaints about the number and length of the reports they regularly had to complete. In 1917 she wrote that district supervising nurses were "annoyed at present over the necessity for reporting upon the work of all their nurses." Although she claimed to be sympathetic to this complaint, Dyke nevertheless confessed that "I think it is good experience for them and much more valuable to me than unreliable verbal reports which I must otherwise receive."[52] As manager of the Nursing Division, Dyke relied on these reports in order to make the Division's work visible and to show her superiors that she was a competent administrator. Within the formal lines of accountability of the Board of Health, written records were essential to establish regularity of practice, as well as to make it possible to predict future needs for staff and resources. The reporting practices of nurses were thus important to the policy and management structure of local government and the school board.

Femininity, Professionalism, and Resistance

Although women were thought to be endowed with "natural" instincts for motherhood and caring, in the eyes of "experts," modern motherhood required special training derived from scientific knowledge. At one point, Rogers wrote that "in modern life mother instinct is an inadequate guide for the rearing of children into capable men and women. The mother needs the assistance of those with special knowledge and teaching aptitudes."[53] In order for nurses to impart "special knowledge" to mothers, Dyke and Rogers organized staff training within their departments. They were also involved in establishing public health nursing courses at the University of Toronto. Again and again they stressed how important it was for nurses to "get scientific knowledge, a sane, reasonable knowledge of how to live, and tell it to others. Get your intimate friends interested in it. Do not depend on either your own or someone else's experience."[54] Here we can see that the task of the nurse was not just to learn and transmit "laws of health" derived from science and experts, but to suppress those forms of knowledge which she herself, or the women she visited, had obtained from their experience. The "laws of health" could only operate successfully if they operated alone. This was one reason why in-school health inspection and teaching were considered inadequate; the children would move between (at least) two competing types of knowledge about health and the body. Mothers (and fathers) would contradict the advice and teachings of school, and thus "undo" the amount of good achieved there. The claim of medicine, public health, and hygiene to authority and truth rested precisely upon the suppression and exclusion of all other alternatives as dangerous, immoral, and unscientific.

But training was not enough. Nurses had to be or become particular persons in order to be successful at their work. Lina Rogers wrote: "A nurse should be tactful, courteous and cheerful, slow to take offense and as patient as an Eastern

mendicant."[55] Nurses' dress and appearance were also important, and they were provided with long lists of do's and don't's in this regard:

> The nurse who goes into the school and homes of the poor dressed in a low-neck silk waist, fashionable skirt, silk stockings and high-heeled boots will only antagonize, when she may genuinely wish to assist....On the other hand, the dowdy nurse with bedraggled skirts, untidy hair, and holes in her gloves is no inspiration to personal neatness and cleanliness in others. Any nurse while on duty should be dressed neatly and smartly but plainly. The School nurse should be immaculate in uniform. She should wear a washable shirtwaist and a white one-piece apron. Her hair should be tidy, her nails well trimmed and clean, and her teeth white and in perfect condition. The nurse who fails to observe thse things wastes half of her energy, because she is trying to impress in words what she fails to carry out in practice.[56]

These strict requirements were taken very seriously and enforced. Several nurses were "allowed to go" from the city's Public Health Department because they were unable, or unwilling, to comply. Some temporary nurses who were not hired onto the permanent staff were described in the personnel records as "too stout" or "too old," while others were "inappropriately dressed." For visiting nurses, then, it was not sufficient to do competent nursing work; they had to teach by example, by being particular, feminine persons. To accomplish this they were required to regulate their behaviour and appearance, and to suppress their own feelings and sexuality. The practice of automatically excluding married women from visiting nursing can be considered in this context, and in the context of notions that motherhood and marriage were incompatible with wage work, as I have discussed above. Furthermore, it is likely that women who had themselves had the experience of motherhood might not retain the necessary enthusiasm for scientific childrearing methods.

On the other hand, nurses were often told that they should at all times behave in a professional manner, a requirement which often came into conflict with those "natural" feminine traits which elicited mothers' confidence and trust. One nurse was dismissed from the Public Health Department because she was unable to establish the proper distance between herself and her patients. Another, who had been hired temporarily in 1914 to work in the University District, was discharged after a few months because supervising nurses found her "very difficult to influence in her work." This difficulty was ascribed to "her extreme sympathy and absorption in her cases, [which] made it difficult to influence her point of view."

Several other nurses resigned or were discharged from the Public Health Department between 1911 and 1917. Most did so when they married, after which it was taken for granted that a woman could no longer be a suitable nurse. Others moved on to different lines of nursing work, but little is known as to what their

reasons might have been for doing so. Some indications can be gleaned from Eunice Dyke's personnel logs, however. When one nurse resigned after barely two months in 1915, Dyke wrote that "the insurmountable difficulty was probably the home conditions under which she worked." While most nurses who resigned appear to have done so quietly, a few were critical. "She stated frankly," wrote Dyke of one such nurse, "that she had not been happy with the Department. The aggressive policy of [visiting] nurses' work was disagreeable to her and she craved actual nursing work. The result of her present work was apparently too remote." Dyke added: "It is possible that the terrible nerve strain of trying home conditions had combined with her difficulties in her work to make her crave more simple tasks." Here the difficulties faced by nurses in their practice were ascribed to individual deficiencies in nurses themselves. It was true that the home conditions they encountered were difficult, but a "good nurse" would have been able to handle the strain this would cause. It is perhaps not surprising that a medical diagnosis—"nerve strain"—was used to explain this nurse's departure, and thus to dismiss her criticism of the Health Department's practices. The notation "nerve strain" was entered as the cause of several other nurses' resignation or dismissal; thus this form of medicalizing women's reactions and behaviour was quite common.

Matilda Simoni was another visiting nurse who was outspoken in her job. She resigned in 1921, after she had criticized the treatment given by a physician to one of "her" patients. Simoni was originally hired as a "second-language nurse" to work with Italian families, and she became a strong advocate, especially for Italian mothers. Her loyalties to the Public Health Department were called into question, not just because she criticized a physician, but precisely because she communicated with patients in a different language, and often acted as an interpreter for them. Even more so than "ordinary," English-speaking nurses, Simoni represented a management problem, and she could not easily be "fitted" into a standardized mould. As a result of her resignation, the Public Health Department reconsidered its earlier practice of hiring second-language nurses.[57]

Simoni's resignation and the controversy it caused reveal several features of visiting nurses' work and the social relations in which it was embedded. In relation to individual women and families, nurses could perhaps become advocates in the social welfare, schooling, or local health bureaucracies. However, the potential for nurses to act on other women's behalf was severely limited. Nurses who were "too close" to their patients were considered problematic, and in Simoni's case this "problem" was further compounded because she was not Anglo-Saxon. It is interesting to note, in this age of "multiculturalism," that the local Board of Health saw fit to employ what they called second-language nurses in the 1910s. In this respect they were pioneering practices which were re-invented in the 1960s and 1970s. However, the fate of Matilda Simoni underscores the shortcomings of such policies when they are not anchored in strong commitments to institutional change, but rather oriented to individual attributes and communication difficulties. Taking the viewpoint of patients was certainly

discouraged, and their knowledge was to be considered inherently inferior and unscientific. Moreover, the training which nurses had received taught them to accept the superiority of medical knowledge, professional behaviour, and "objective" procedures, as compared to knowledge derived from women's experiences, sympathetic closeness, and personal relationships.

More often than not, nurses who remained on staff with the School Board or the Board of Health found that they had but little scope to challenge the judgement of their supervisors, the access to and quality of health, welfare, and schooling in the city, or the routine organization of their own work. These limits were experienced by Dyke herself when she was forced to resign in 1932, after she publicly defended a nurse on the staff against a physician and the Medical Officer of Health.[58]

Women, Knowledge, and Power?

As one of a wide range of social reforms introduced in the early twentieth century, school and public health nursing does not easily fit either a social control or progressive thesis. What both of these approaches to social history fail to address are the ways in which reformers themselves, and the new "professionals" who implemented reforms, were both products and producers of social and state regulation. The sexual division of labour between nurses and physicians, and between nurses and male administrators of schooling, health, and welfare bureaucracies, was organized both as an ideological and an economic matter. Women were considered to have a special and virtuous calling for those low-level and low-paid "professions" dealing with mothers and children. Nurses' "natural" femininity was to be mobilized in the work itself, while such traits would also, presumably, lead women to accept a subordinate position and a low wage compared to men.

On the other hand, the professional and "objective" features of nurses' work often came into conflict with the femininity they were expected to embody. Their records, for example, relied on closeness and trust between women so as to produce factual knowledge showing the inadequacy of poor working-class and "foreign" women. Nurses were not simply employed by local governments to respond to social needs which existed *a priori* within their jurisdictions. Indeed, they were expected to demonstrate needs, and to do so in a form which showed that needs could best be administered and met through state intervention in and regulation of working-class and "foreign" families. Through the social organization of nurses' work, the economic and personal difficulties which they encountered were transformed into individual shortcomings and "social problems" which could be addressed through educational, medical, or welfare interventions. At the same time the persistent requirement to produce "reliable" records shaped the relations of nurses to the people they wrote about, and confirmed their own subordinate status within the public health and school hierarchies.

During the late nineteenth and early twentieth centuries, health reform and social science methods provided avenues for middle-class women to struggle for

political and economic emancipation. Such women could show that they were capable of reason and scientific thought, while at the same time extending their "private" maternal virtues into the "public" sphere. In the process, they helped to create the institutional beginnings of the Canadian welfare state, and open up new occupations for women. In this paper I have analysed the demands and experiences of women in one such occupation. Through hierarchical work organization, documentary work practices, and conflicting claims to femininity and professionalism, visiting school and public health nurses shaped—and were themselves shaped by—social class relations and state regulation. This was a contradictory process for women, and it is important to remember that nurses did not always co-operate and, at times, "failed" to produce the desired results. We thus need to know a lot more about nurses' own experiences of their work, both their pleasures and achievements, as well as their difficulties and shortcomings.

NOTES

* An earlier version of this paper was presented to the Canadian History of Education Association, London, Ontario, October 1988.

1. See for example, Paul Rutherford, "Tomorrow's Metropolis: The Urban Reform Movement in Canada, 1880-1920," Canadian Historical Association *Historical Papers* (1971), 203-24; Richard B. Splane, *Social Welfare in Ontario, 1791 to 1873: A Study of Public Welfare Administration* (Toronto: University of Toronto Press, 1965); Alan F. Artibise and Gilbert A. Stelter, eds., *Planning and Politics in the Modern Canadian City* (Toronto: MacMillan, 1979).
2. Paul A. Bator, "'The Struggle to Raise the Lower Classes': Public Health Reform and the Problem of Poverty in Toronto, 1910 to 1921," *Journal of Canadian Studies* 14, 1 (Spring 1979): 43-49; James Pitsula, "The Emergence of Social Work in Toronto," *Journal of Canadian Studies* 14, 1 (Spring 1979): 35-42.
3. Neil Sutherland, "'To Create a Strong and Healthy Race': School Children in the Public Health Movement, 1880-1914," in *Medicine in Canadian Society: Historical Perspectives*, ed. S.E.D. Shortt (Montreal: McGill-Queen's University Press, 1981), 361-93.
4. See for example Bator, "'The Struggle to Raise'," as an example of the former position; and T.R. Morrison, "The Child and Urban Social Reform in Late-Nineteenth Century Ontario, 1870-1900" (Ph.D. diss., University of Toronto, 1970), as a representative of the latter position.
5. See several articles in Linda Kealey, ed., *A Not Unreasonable Claim: Women and Reform in Canada, 1880s-1920s* (Toronto: The Women's Press, 1979); Caroline Andrew, "Women and the Welfare State," *Canadian Journal of Political Science* 17, 4 (Dec. 1984): 667-83; and Kari Dehli, "Women and Class: The Social Organization of Mothers' Relations to Schools in Toronto, 1915 to 1940" (Ph.D. diss, University of Toronto, 1988).
6. Martha Danylewycz and Alison Prentice have looked at similar questions as they pertain to women teachers; see "Teachers' Work: Changing Patterns and Perceptions in the Emerging School Systems of Nineteenth and Early Twentieth Century Canada," *Labour/Le Travail* 17 (Spring 1986): 59-80.

7. Dorothy E. Smith, *The Everyday World as Problematic: A Feminist Sociology* (Toronto: University of Toronto Press, 1987), especially chap. 6.
8. Eunice Dyke, "The Public Health Nurse," *Educational Health Circular*, State Department of Public Health for Illinois. No. 35 (1928), 4. Deposited in City of Toronto Archives, Record Group 11, F 1, Public Health, Nursing Division.
9. Lina Rogers Struthers, *The School Nurse: A Survey of the Duties and Responsibilities of the Nurse in the Maintenance of Health and Physical Perfection and the Prevention of Disease Among School Children* (New York: G.P. Putnam's Sons, 1917), 2. Hereafter cited as Rogers, *The School Nurse*.
10. "Health in Schools," *Canada School Journal* 2, 12 (May 1878): 103-4. For an historical overview of school health programmes, see W.F. Chapman, "Medical Inspection of School Children," Ontario Educational Association, "Proceedings" (1908), 318-27 [OEA "Proceedings"]; and City of Toronto, Medical Officer of Health, School Health Services, "Report," City of Toronto Department of Public Health (Aug. 1933), 1-6.
11. Sutherland, "'To Create a Strong and Healthy Race'."
12. Paul A. Bator, "'Saving Lives on the Wholesale Plan': Public Health Reform in the City of Toronto, 1900 to 1930" (Ph.D. diss., University of Toronto, 1979), 179, 343.
13. Ibid., 176.
14. Norah Lewis, "Physical Perfection for Spiritual Welfare: Health Care for the Urban Child, 1900-1939," in *Studies in Childhood History: A Canadian Perspective*, ed. Patricia T. Rooke and R.L. Schnell (Calgary: Detselig Enterprises, 1982), 135-66.
15. Patricia T. Rooke and R.L. Schnell, *Discarding the Asylum: From Child Rescue to the Welfare State in English Canada (1800-1950)* (New York: University Press of America, 1983).
16. "Inaugural Address of James Simpson, Chairman of the Board of Education for the City of Toronto, 1910," Toronto Board of Education, "Minutes" (1910), Appendix 2, 6.
17. Dr. James Roberts, "The Relation of Teacher and Nurse to Medical Inspection," OEA, "Proceedings" (1909), 376.
18. Dr. Charles Sheard (Medical Officer of Health) to the Mayor and Board of Control, 26 June 1907, City of Toronto Archives, RG 11, F 1, Box 4.
19. Jacques Donzelot has made a similar argument in *The Policing of Families* (New York: Pantheon Books, 1979). Unlike Donzelot, however, I do not assume that these strategies always worked.
20. It is worth noting that nursing had only recently been transformed into a "profession" within the medical hierarchy, subservient to physicians. Indeed, earlier forms of nursing were practised quite independent of doctors, often by working-class women who learned their trade by apprenticing with experienced and older women. Nursing as a "profession" with more scientific and middle-class aspirations was a creation of the nineteenth century, associated in England with Florence Nightingale and in Canada with the Victorian Order of Nurses.
21. Sutherland, "'To Create a Strong and Healthy Race'."
22. Rogers, *The School Nurse*, 71.
23. Jodi Coburn, "'I See and I Am Silent': A Short History of Nursing in Ontario," in *Women at Work 1850-1930*, ed. Janice Acton et al. (Toronto: Women's Educational Press, 1974), 127-63.
24. Toronto Board of Education, "Minutes" (1911), Appendix, 32 [TBE, "Minutes"].

25. Z. Keefer, ed., "The History of Public Health Nursing in Toronto," typed manuscript, Toronto Department of Public Health (1945), 1, City of Toronto Archives, RG 11, F 1, Box 4.
26. "Staff Records," Department of Public Health, City of Toronto Archives, RG 11, F 1, Box 7. All subsequent references to staff evaluations, discharges, and resignations from the City of Toronto Public Health Department, Nursing Division, are to this source and will not be specifically cited.
27. TBE, "Minutes" (1911), Appendix, 35, 494, 685.
28. TBE, "Annual Report" (1916), Department of Medical Inspection, School Nurses' Yearly Report, n.p.
29. "Do You Realize That Citizens of Toronto Pay Taxes to Support Two Departments of Health?" Bureau of Municipal Research, *White Paper*, No. 8, 4 Jan. 1916, n.p.
30. Marion Royce, *Eunice Dyke, Health Care Pioneer: From Pioneer Public Health Care Nurse to Advocate for the Aged* (Toronto: Dundurn Press, 1983).
31. "School Nursing Pioneer Gave Lead in Many Fields," *Globe and Mail*, 13 June 1946, in University of Toronto Reference Library, *Canadian Obituaries*, vol.3, part 2, 186.
32. Although Lina Rogers wrote *The School Nurse* under the the name Rogers Struthers, I refer to her by her maiden name throughout for reasons of consistency and to avoid confusion with statements made by her husband, Dr. Struthers, who was also an active participant in public health reform. I will draw on this book, as well as on primary sources from Toronto's Boards of Health and Education, in the analysis which follows.
33. TBE, "Annual Report" (1910), 53.
34. Rogers, *The School Nurse*, 237.
35. Ibid., 74.
36. Royce, *Eunice Dyke*, 59.
37. TBE, "Annual Report" (1913), Medical Inspector's Report, 32.
38. Rogers, *The School Nurse*, 72.
39. Royce, *Eunice Dyke*, 52.
40. Rogers, *The School Nurse*, 258.
41. Lina Rogers, "The Nursing Aspect of Medical Inspection of Schools," OEA, "Proceedings" (1913), 298.
42. Mary E. McPhedran, "The Essentials of an Adequate Investigation," *The [Canadian] Public Health Journal* 10, 4 (Apr. 1919): 151-56.
43. Eunice Dyke, "The Public Health Nurse," *Educational Health Circular*, State Department of Public Health for Illinois, No. 35 (1928), 4, deposited in City of Toronto Archives, Record Group 11, F 1, Public Health, Nursing Division.
44. TBE, "Annual Report" (1913), Medical Inspector's Report, 32.
45. Rogers, *The School Nurse*, 234.
46. Ibid., 71.
47. See several articles in Jean Burnet, ed., *Looking Into My Sister's Eyes: An Exploration in Women's History* (Toronto: The Multicultural History Society of Ontario, 1986).
48. Eunice Dyke, "Sickness and Poverty," *The Public Health Journal* 10, 6 (1919): 287-90.
49. Rogers, *The School Nurse*, 76.
50. Robert E. Mills to H. A. Rowland, Secretary and Chief Accountant, Department of Public Health, 19 Mar. 1917, City of Toronto Archives, RG 11, F 1, Box 4.
51. Coburn, "'I See and I Am Silent'."

52. Dyke to Hastings, 1 Jan. 1917, 4, City of Toronto Archives, RG 11, F 1, Box 4.
53. Rogers, *The School Nurse*, 259.
54. Ibid., 255.
55. Ibid., 70.
56. Ibid., 226.
57. Keefer, "The History of Public Health Nursing," 6.
58. Royce, *Eunice Dyke*.