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Colin D. Howell

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COLIN D. HOWELL

Reform and the Monopolistic Impulse: The Professionalization of Medicine in the Maritimes

In recent years Canadian and American historians alike have given considerable attention to the managerialism and social engineering inherent in the progressive reform tradition. Concentrating upon the attempts of businessmen and professionals to make the reform impulse conform to their own needs, modern historians have discovered a preoccupation with efficiency, scientific management and social improvement in the progressive reform movement.¹ In the name of a more scientific and rational socio-economic order, turn of the century progressives in Canada and the United States discarded traditional Darwinian notions of economic activity in favor of a more efficient, responsible, and regulated capitalist system.² The tendency to concentrate authority in the hands of the scientific "expert" extended far beyond the factory or industrial workplace; it also permeated the reform of politics, municipal government, education, conservation, criminal justice, and public health.³ Professionals were particularly active in the movement for reform. Increasingly aware of their own professionalism, engineers, doctors, social scientists, and other strategically situated elite groups responded to the unfortunate conditions that accompanied

- 1 Ramsay Cook and Robert Craig Brown, *Canada 1896-1921: A Nation Transformed* (Toronto, 1974); Alvin Finkel, *Business and Social Reform in the Thirties* (Toronto, 1979); Ernest R. Forbes, *The Maritime Rights Movement, 1919-1927: A Study in Canadian Regionalism* (Montreal, 1979); Gabriel Kolko, *The Triumph of Conservatism: A Re-interpretation of American History* (New York, 1963); Leo Panitch, (ed), *The Canadian State* (Toronto, 1977); Tom Traves, *The State and Enterprise: Canadian Manufacturers and the Federal Government, 1917-1931* (Toronto, 1979); and Robert Wiebe, *Businessmen and Reform* (Cambridge, 1962).
- 2 Michael Bliss, *A Living Profit: Studies in the Social History of Canadian Business, 1883-1911* (Toronto, 1974); Samuel Haber, *Efficiency and Uplift: Scientific Management in the Progressive Era, 1890-1920* (Chicago, 1964); Samuel P. Hays, *The Response to Industrialism* (Chicago, 1957); James Weinstein, *The Corporate Ideal in the Liberal State* (Boston, 1968); and Robert H. Wiebe, *The Search for Order, 1877-1920* (New York, 1967).
- 3 John English, *The Decline of Politics: The Conservatives and the Party System 1910-1920* (Toronto, 1977); Samuel P. Hays, "The Politics of Reform in Municipal Government in the Progressive Era", *Pacific Northwest Quarterly*, LV (1964), pp. 157-69; David Noble, *America By Design* (New York, 1978); George Rosen, "The Efficiency Criterion in Medical Care, 1900-1920: An Early Approach to an Evaluation of Health Service", *Bulletin of the History of Medicine*, 50 (1976), pp. 28-44; Reginald Whitaker, *The Government Party: Organizing and Financing the Liberal Party of Canada, 1930-58* (Toronto, 1977); and Stanley K. Schultz and Clay McShane, "To Engineer the Metropolis: Sewers, Sanitation, and City Planning in Late Nineteenth-Century America," *The Journal of American History*, LXV (1978), pp. 389-411.

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modern industrialization in such a way that the demand for their services was increased.⁴ In the long run, professionalization facilitated the transformation of capitalism from its personal form to its modern paternalistic form, where “experts” provide professional services to every segment of society.⁵

The medical profession in the Maritime Provinces between Confederation and the First World War provides an interesting example of a self-conscious elite intent upon developing its professional expertise and harnessing it to social needs. The industrializing towns and cities of the Maritimes in the last quarter of the nineteenth century provided doctors with a multitude of opportunities to demonstrate their professional worth. Towns and cities were concerned about clean water, drainage, heating and ventilation of homes and businesses, medical inspection of tenement housing, sanitary conditions of factories and schools, the location of playgrounds, garbage collection, and the adulteration of foods, all of which invited the involvement of the medical profession. Doctors gave particular attention to the need for sanitary reform. Public and personal hygiene became something of a medical commandment, the breaking of which would bring the retribution of epidemic disease. When a virulent diphtheria epidemic struck Halifax in the winter of 1890, for example, the editor of the *Maritime Medical News* warned that “back-yards reeking with filth, cesspools filled to overflowing, ashes and garbage deposited in the close proximity to highways and dwellings . . . , an extremely imperfect system of sewerage” and the absence of any “provision for dealing with infectious diseases” left the city vulnerable to further epidemics.⁶ Obviously, doctors considered it time for the public to follow the advice of its medical priesthood.

But if this was a period in which doctors had an opportunity to demonstrate the social value of their scientific expertise, it was also a period of challenge and reorganization for the profession. Faced with widespread public suspicion, with various alternative forms of medical treatment and practice, and with the flooding of the market with an alleged “oversupply” of doctors, the pre-war medical profession in the Maritimes adhered to a policy of professional redefinition which it hoped would restrict competition from both inside and outside its ranks and enhance its professional reputation and authority. The leadership in this campaign was taken by the provincial medical societies of Nova Scotia, New Brunswick, and Prince Edward Island (established in 1854, 1881, and 1889, respectively), the Maritime Medical Association founded in 1891, and the

4 Barton J. Bledstein, *The Culture of Professionalism, The Middle Class and the Development of Higher Education in America* (New York, 1976); Thomas Haskell, *The Emergence of Professional Social Science* (Urbana, 1977); Christopher Lasch, *The Culture of Narcissism, Life in an Age of Diminishing Expectations* (New York, 1978).

5 Christopher Lasch, “The Siege of the Family,” *New York Review of Books*, 24 November 1977. See also Thomas Haskell, “The Power of the Expert”, *ibid.*, 13 October 1977.

6 *Maritime Medical News*, III (January 1891), p. 17.

various county medical societies in the three provinces. It should be noted that the impulse towards professional reorganization was strongest among the elite members of the profession — those attached to hospitals, medical colleges, and the public health bureaucracy — and weakest among the rank and file. Although a serious treatment of developing intra-professional rivalries will not be attempted here, the differences between elite doctors and the rank and file seem to demonstrate that the professionalization movement was intended not merely to advance the quality of medical treatment, but to solidify the dominance of the elite within the profession as well.

The results of the professionalization movement in the years before World War One were mixed. The profession was still hampered by its failure to establish a clear theoretical foundation for medical therapy and the negligible pre-war advances in the field of bacteriology. Nevertheless, by 1914, improvements in medical education, a more scientific approach to the prevention of disease (as opposed to its cure), and a more effective and intimate relationship with the state, left the profession prepared to extend its professional hegemony in future years.

Beneath the late nineteenth century impulse toward medical professionalization lay a half-century of advancement in etiology, cellular pathology, instrumentation, materia medica, and surgery. In addition to the stethoscope (1819), a number of other mechanical inventions including the ophthalmoscope (1851) and laryngoscope (1855) assisted the doctor in diagnosis. The thermometer, introduced by Boerhaave, was rarely used until the clinical researches of Traube in 1856 demonstrated its utility. Subsequently it became the constant companion of the general practitioner. For the surgeon the great advances came in the field of anaesthetics and in the antiseptic treatment of wounds. Morton's use of ether in 1846, and Sir James Simpson's introduction of chloroform a year later, reduced the horror of the operating table for patient and doctor alike, although deaths attributable to poorly administered anaesthetic were still relatively commonplace at the end of the century. Equally important was Sir Joseph Lister's practical application of the "germ theory" to surgery and the treatment of wounds. Antisepsis or asepsis, often referred to as Listerism, not only resulted in a significant reduction of surgical mortality rates, but paved the way to surgery that earlier would have been considered criminal, especially that involving the thoraxial and cranial cavities.⁷

Despite these advances, the medical profession in the last quarter of the nineteenth century was a divided and troubled one. Doctors in the region divided

7 Rosemary Stevens, *American Medicine and the Public Interest* (New Haven, 1972), pp. 39, 98-103; Dr. William Bayard, Presidential Address to Maritime Medical Association, St. John, N.B., July 1891, *Maritime Medical News*, III (August 1891), pp. 137-8; John Stewart, "The Contribution of Pathology to Surgery," The Address in Surgery, Canadian Medical Association, 17 September 1902, MG I, vol. 711, Public Archives of Nova Scotia [PANS]; J.F. Black, "Surgery Today", *Maritime Medical News*, II (November 1890), pp. 81-2.

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at the theoretical and experimental level on the implications and legitimacy of the germ theory.⁸ Although Pasteur's discovery of the microbic origin of disease, Koch's subsequent description of the anthrax and tubercle bacilli, and Lister's experiments in antiseptic surgery challenged conventional theories about disease and its origins, most doctors continued to regard disease as a product of decomposing and fermenting organic matter in the atmosphere and water.⁹ The failure of doctors to understand the disease process had serious implications for clinical medical practice. Lacking a firm set of etiological and therapeutic principles, doctors were compelled to take a dangerously experimental approach to medical treatment, often treating symptoms instead of disease. As William Rothstein has demonstrated, the medical therapy of the nineteenth-century physician "had no scientific basis. Contemporary medical theorists constructed nosologies, in which they categorized disease into families based on some assumed or symptomatic similarity (e.g.) eruptive diseases. Then they deduced that therapy should be similar for all diseases of that type".¹⁰ Although the emphasis in medical therapy shifted away from blood-letting, blistering, and strong emetics to a heavier reliance on chemical drugs and electro-galvanic therapy in the last quarter of the century,¹¹ the change did not represent a qualitative therapeutic advance. Doctors had simply replaced one set of medically invalid therapeutics with another.¹²

In the absence of effective medical therapy, lingering public suspicion of physicians and surgeons continued to thwart the profession's desire for enhanced power and prestige. In an address to the Maritime Medical Association in September 1896, Dr. R. MacNeill, President of the Prince Edward Island Medical Society, observed that although doctors might lay claim to "celestial origin" and "divine lineage", the truth of the matter was that "the people look upon them as enemies, whose sole object is to fleece and rob them".¹³ This public

- 8 Dr. John Stewart, "Antiseptic Surgery", Presidential Address to Nova Scotia Medical Society, 23 June 1886, Nova Scotia Medical Society, Annual Meetings, Minute Book, Kellogg Medical Library, Dalhousie University. See *ibid.*, 18 June 1873, 18 June 1884; Clinical Society of Halifax, Minute Books, October 1869-January 1884, and Halifax Medical Society, Minutes of Scientific Business, 1867-1886, Kellogg Medical Library, Dalhousie University.
- 9 Gert H. Brieger, "American Surgery and the Germ Theory of Disease", *Bulletin of the History of Medicine*, 40 (1966), pp. 135-45; Fritz Winder and Hugh Forrest, "The Propagation of Lister's Ideas", *British Journal of Surgery*, 54 (1967), p. 420.
- 10 William G. Rothstein, *American Physicians in the Nineteenth Century. From Sects to Science* (Baltimore, 1972), pp. 41-2.
- 11 R.S. Black, Presidential Address to Nova Scotia Medical Society, 17 June 1874, N.S. Medical Society, Annual Meetings, Minute Book, Kellogg Medical Library, Dalhousie University.
- 12 Rothstein, *American Physicians in the 19th Century*, pp. 158-60.
- 13 Dr. R. MacNeill, "Higher Medical Education and one Qualification for Canada", paper read before the Maritime Medical Association, July 1896, *Maritime Medical News*, III (September 1896), p. 215.

antagonism affected doctors in two ways. In the first place it limited the profession's influence in the legislature and made it vulnerable in the courts; and secondly, it encouraged the continuation of "unprofessional" forms of medical treatment.¹⁴ The apparent willingness of the courts to uphold claims of malpractice against doctors,¹⁵ the failure of provincial legislatures to respect the profession's claims for payment for services rendered under provincial public health laws,¹⁶ and the widespread reliance on patent medicines, home cures, irregular practitioners and quacks,¹⁷ counteracted the attempt by doctors in this period to enhance their influence through the monopolization of medical practice.

What could be done to cultivate public confidence in the profession? In an article entitled "The Status of the Profession", in the *Maritime Medical News* for September 1890, Dr. Edmund Moore outlined many of the strategies which the profession's elite would employ over the next two decades in the hope of extending its professional hegemony. Moore's initial suggestion was that the profession do away with "pseudo-philanthropy and sickly wishy-washy sentimentalism" in the matter of assessing fees, and make its operation conform to strict "business principles". To this end he urged legislation compelling

14 Dr. R. MacNeill, "Higher Medical Education". *ibid.*, XI (July 1899), p. 223.

15 *Maritime Medical News*, 3 (January 1890), pp. 15, 16. In particular the profession was upset by a court decision involving a Dr. Toombs of Mt. Stewart, Prince Edward Island, and one William Seller. While at Seller's home another man, John Coffin, fell ill and called for Dr. Toombs. Although the disease was subsequently diagnosed as typhoid fever, Toombs neglected to tell Seller. Seller instead assumed that Toombs' initial diagnosis of the ailment as a liver problem was the correct one and had taken no precautions against its spread. When Seller's family contracted the disease he sued Toombs for damages. Toombs argued that he was under no obligation to tell Sellers of the change in diagnosis, and that the original statement was made in good faith. But Judge Allen decided in Seller's favour, pointing out that once Toombs was aware that the original diagnosis was wrong, it became a fraudulent misrepresentation even though it had not been so originally. James McLeod, Presidential Address at the meeting of the P.E.I. Medical Association, July 1891, *Maritime Medical News*, 3 (October 1891), p. 176; *ibid.*, 3 (September 1891), pp. 154-5.

16 "The Profession and the State", *Maritime Medical News*, VI (July 1893), pp. 333-4; *ibid.*, I (January 1888), p. 18; III (January 1890), p. 12. With the introduction of the Workmen's Compensation Act in Nova Scotia in 1917, the issue of compulsory medical service arose once more. Halifax Medical Association, Minute Book (Spring 1917), Kellogg Medical Library, Dalhousie University. See also Dr. M.D. Morrison, "The Operation of the Workmen's Compensation Act in Nova Scotia", read at the Annual Meeting of the Nova Scotia Medical Society, 1927, Morrison Papers, MG I, vol. 711, no. 16, PANS.

17 Halifax Medical Society, Minute Book of Scientific Business, 6 February 1877, Kellogg Medical Library, Dalhousie University; Provincial Medical Board of Nova Scotia, Minutes, 15 April, 15 July 1908, 20 January 1909, 20 April, 19 October 1910, 15 January 1913, 15 July 1914, 21 April 1915, 8 April 1917. See also Guenter B. Risse, Ronald Numbers, and Judith Walzer Leavitt, eds., *Medicine Without Doctors. Home Health Care in American History* (New York, 1977); Rothstein, *American Physicians in the Nineteenth Century*, chs. 7 and 8; John Duffy, *The Healers. The Rise of the Medical Establishment* (New York, 1976), ch. 9; and "Osteopathy", *Maritime Medical News*, X (May 1898), pp. 152-4.

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municipal and provincial governments to pay for a wide range of medical services, including the registration of births and deaths, the rendering of expert medical advice in court proceedings, and the medical treatment of indigents. Moore's second suggestion was to limit "overcrowding" of the profession by restricting entrance into it. The proliferation of medical colleges in the United States in the post-Civil War years, many of them second-rate, had led to excessive and destructive competition. In the light of this, Moore jettisoned Darwinian notions of survival of the fittest and advocated the restraint of competition. "The struggle for existence is not conducive to the development of genius", Moore wrote. "In a society where this struggle is most intense, where the pit is narrow and the fight fierce, the higher and nobler sentiments are crushed out, and man becomes not merely carnal but devilish". The obvious way to restrain competition was to establish uniform standards in medical education in order that poorly trained students would be kept out of an already overcrowded profession. This led Moore to his final point, the need for greater attention to professional ethics in the training of young doctors. If all medical schools required courses or established chairs in medical ethics, the profession as a whole would benefit. Younger doctors would be educated against undercutting the fees of their more established colleagues and restrained from using "questionable additions to professional cards and signs". At the same time, a rigorous code of ethics would distinguish members of the medical profession from their competitors on the outside.¹⁸

Apart from the problem of establishing a medically valid therapeutic knowledge, Moore's suggestions addressed the three most serious concerns of the rank and file of the profession in these years: the relationship of the medical profession to the state, both in regard to fees and to the development of state bureaucracy; the problem of overcrowding and the consequent need for higher education standards; and the desire to restrict the influence of irregular practitioners.

The medical profession in the last quarter of the nineteenth century was acutely conscious of the need to establish a more effective relationship with the state. This is not to suggest that doctors feared a loss of autonomy in professional matters; on the contrary, by 1890 each of the provinces in the Maritimes had granted the profession control over medical education, registration, and discipline, and this was not likely to change. Indeed, doctors believed that their new-found professionalism entitled them to an important advisory role in government. Medical experts could direct the state on numerous policy questions, including the workability of existing public health machinery, the collection of vital statistics, and the operation of the criminal justice system. "If there has been in the past only a distant relationship between the science of

18 Edmund Moore, "The Status of the Medical Profession", *Maritime Medical News*, III (September 1890), pp. 71-3.

medicine and the affairs of state”, Dr. Edward Farrell told the Maritime Medical Association in August 1895, “we are glad to see that a closer union is growing”.¹⁹ As was the case elsewhere, doctors in the Maritime Provinces believed that involvement in government bureaucracy would elevate the social status of the entire profession. To this end, the Maritime Medical Association advocated a government department in the area of vital statistics and public health, and a more formal medical presence in the criminal justice system.

The failure of government to give serious attention to the collection of vital statistics troubled doctors greatly. Although some provinces began to collect vital statistics prior to Confederation — Nova Scotia, for example, began to collect birth, death, and marriage statistics in a haphazard fashion during the 1850s, and instituted a more systematic registration procedure in 1864 — the British North America Act gave the responsibility for vital statistics to the Federal Government. For a decade after Confederation Ottawa operated a statistical department in Nova Scotia, but it was dismantled by the Mackenzie government in 1877 as an economy move. In the wake of this decision Nova Scotia maintained only its marriage registration procedures.²⁰ This left those working in the area of public health in Nova Scotia bereft of the data necessary to gauge the success of their efforts. Doctors legitimately complained that government gave more attention to commercial matters than to the health of its citizens. “They can give you the number of quintals of fish caught, or the number of bushels of barley raised”, complained Dr. C.J. Fox of Pubnico before the Nova Scotia Medical Society in August 1894, “but they cannot tell the number of souls born in any given year or number of years”.²¹ Convinced that reliable statistics would at once demonstrate their worth to society and provide a more “scientific” basis for improving health services and preventing disease, the medical profession in Nova Scotia lobbied aggressively for a vital statistics act. Finally, in 1908, the Nova Scotia Government passed “An Act to Provide for the Registration of Births and Deaths”, establishing a system similar in many respects to that in operation immediately before Confederation.²²

In addition to promoting vital statistics collection, the profession advocated major reforms in the criminal justice system in order to incorporate recent advances in the field of medical criminology into the legal process. The work of Lombroso, Krafft-Ebing, Maudsley, and Ellis which suggested a causal link between criminality and mental defectiveness, led doctors to champion a

19 Dr. Edward Farrell, Presidential Address to the Annual Meeting of the Maritime Medical Association, *Maritime Medical News*, VII (August 1895), pp. 162-3.

20 “Vital Statistics”, *Maritime Medical News*, XX (March 1908), p. 89.

21 Dr. C.J. Fox, Presidential Address to Nova Scotia Medical Society, *Maritime Medical News*, VI (August 1894), p. 349.

22 *Nova Scotia Statutes*, 1908, ch. I, pp. 1-16.

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therapeutic rather than a punitive approach to criminal behaviour.²³ Calling contemporary methods of dealing with criminals “unjust, inhuman, and unscientific”, the *Maritime Medical News* felt that much of what was considered crime was merely the outgrowth of a disordered mental condition. Accordingly, the treatment of the offender should be made dependent upon the criminal rather than upon the crime.²⁴

Of course a therapeutic approach to criminal justice assumed the involvement of doctors in the judicial process. In an article entitled “Why Medical Men Should Be a Court of Justice in Criminal Cases”, Dr. J.J. Cameron of Antigonish argued that it was the medical profession, not judge and jury, that was most capable of judging the capacity of a criminal to discern right from wrong. As an alternative to the existing system, Cameron suggested a medical court for criminal cases, “one composed of educated medical ‘experts’ . . . whose professional skill will enable them to adjudge and differentiate the motives, capital, the power of resistance of the unfortunate criminal, and who will prescribe treatment or punishment according to the necessities of the case”.²⁵ Unfortunately, the profession’s “scientific” approach to criminality led some to investigate the physical characteristics of the “criminal type”. In a presidential address to the St. John Medical Society in February 1905, Dr. O.J. McCulley noted the following features of the criminal: ears “large and outstanding”, jaw (except in the case of a receding chin) “heavier, squarer, and projects forward”, nose “generally rectilinear and larger than usual and deflected to the side”, and eyes “very small and restless”. Criminal women were easily identifiable as well; they have “an abundance of hair . . . and hairy bodies”.²⁶ Although this was of course nonsense, it indicates the extent to which the profession regarded its new scientific awareness as a force for social betterment. Not surprisingly, doctors desired to bring their recently acquired expertise to bear upon the state’s bureaucratic machinery.

Equally important to the profession as the reform of criminal justice was the establishment of a “well-qualified, well-disciplined, and thoroughly efficient” public health bureaucracy.²⁷ In a recent study of English doctors and public

23 For a particularly interesting discussion of the emergence of the therapeutic sensibility, see Christopher Lasch, *The Culture of Narcissism*, pp. 7-13, 30, 48-9, 94, 157-8, 163, 182-6, 211-2, 218, 224, 229-30.

24 “The Treatment of the Criminal”, *Maritime Medical News*, XIII (September 1900), pp. 320-1; “The County Cure of the Insane”, *ibid.*, XI (April 1899), pp. 125-6; “The Penal Institutions of Nova Scotia”, *ibid.*, XIV (March 1902), pp. 100-1; Halifax Medical Association, Minute Book, 18 November 1912; Nova Scotia Medical Society, Minutes, 7 July 1909.

25 J.J. Cameron, “Why Medical Men Should Be a Court of Justice in Criminal Cases”, *Maritime Medical News*, XII (August 1900), p. 274.

26 O.J. McCulley, “The Doctor and the Criminal”, Presidential Address to the Saint John Medical Society, *Maritime Medical News*, XVII (February 1905), pp. 41-53.

27 “A Minister of Public Health”, *Maritime Medical News*, XX (February 1908), p. 79.

health administration, Steven Novak has revealed the extent to which British doctors “looked to public health for a chance to enter the civil service”.²⁸ Doctors in the Maritimes displayed a similar interest. Although the public health acts of 1888 and 1898 in Nova Scotia and New Brunswick provided for Provincial Health Boards with extensive authority to deal with health and disease, by 1900 the profession was already looking forward to the establishment of permanent provincial health departments staffed by qualified and salaried civil servants. In a report on the public health system in Nova Scotia in 1899, Dr. A.P. Reid, Secretary of the Provincial Board of Health, complained that Nova Scotia’s health legislation “is scarcely carried out and perfunctorily There is no paid official to see that the law is carried out or who has any responsibility for its performance”.²⁹ In 1903, as a result of Reid’s report and the lobbying of the Nova Scotia Medical Society, the Provincial Board of Health was abolished and administration of the public health laws was made a Department under the Provincial Secretary. A salaried Provincial Health Officer was placed at its head. But a formal health ministry would not be established in Nova Scotia until 1931, largely because of the involvement in public health activities of the Massachusetts-Halifax Relief Association, a body established in the wake of the Halifax explosion.³⁰ In New Brunswick the campaign for a more formal public health bureaucracy was more successful: in 1918 W.F. Roberts was appointed to head the first ministry of Health in the British Empire. A year later in 1919, the Canadian Government established a national Department of Health, a forerunner to the Department of Pensions and Health (1928), and the Department of Health and Welfare (1944).³¹

If doctors worked towards a closer relationship with the state in matters of public policy and reform of the bureaucracy, they resented the fact that municipal and provincial governments refused to remunerate them for various services demanded under the public health laws. “Act after act passes the legislature compelling . . . [doctors] to give their services not only without payment but with the option of fine and imprisonment for neglect,” the *Maritime Medical News* complained in July 1894.³² The New Brunswick Public Health Act, for example, made it the responsibility of the physician to report to the Board of Health every case of smallpox, scarlet fever, whooping cough,

28 Steven Novak, “Professionalism and Bureaucracy: English Doctors and the Victorian Public Health Administration”, *Journal of Social History*, 6 (1973), pp. 440-62.

29 Report on General Public Health Situation in Nova Scotia. Submitted by Dr. A.P. Reid, Secretary of the Provincial Board of Health, RG 25, Series C, no. 1, PANS: A.P. Reid, “The Public Health Act in Nova Scotia”, *Maritime Medical News*, XVI (August 1904), pp. 311-5.

30 Massachusetts-Halifax Health Commission, Minute Books, MG 20, vol. 197, PANS. See, in particular, 25 September 1919.

31 Dr. W. Brenton Stewart, *Medicine in New Brunswick* (New Brunswick, 1974), p. 20; H.E. MacDermott, *100 Years of Medicine in Canada* (Toronto, 1967), p. 81.

32 “The Profession and the State”, *Maritime Medical News*, VI (July 1894), p. 333.

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typhus and typhoid fever, measles, cholera, and diphtheria. In addition, doctors were required to list the occupation of the infected person and to notify the schools attended by his or her children. In short, the doctor was made an unpaid sanitary policeman of the state.³³ In the fall of 1903 in a protest against compulsory gratuitous service, sixteen doctors in New Brunswick were arraigned before the Police magistrate in St. John for refusing to report within five days the births of children at which they assisted. The charge was subsequently withdrawn when the constitutionality of the New Brunswick legislation was challenged by the doctors' legal representatives, leaving the issue of payment unresolved.³⁴

In making their case for regularized charges for official services, doctors were attempting to compensate for the unreliable nature of private service fees. Private fees varied from community to community depending upon its prosperity, and from individual to individual depending upon his wealth. Then again fees might differ depending upon the severity of the case and the success of the treatment provided. Because of these fluctuations it is difficult to generalize about the economic status of the private practitioner at the turn of the century. In some areas, however, there are indications that doctors were finding it difficult to maintain traditional fee levels. Dr. H.A. March of Bridgewater, Nova Scotia considered "a respectable code of fees" as "perhaps the most important reason for the formation" of the Lunenburg-Queens Medical Society. Speaking to that body in April 1903, March observed that "when in the fall of 1886 I began to practice medicine in the town of Bridgewater, fees were higher than they are today. But as new men kept coming in there has been a reduction made here by one and there by another".³⁵ Short of a government scheme of medical service insurance little could be done to regularize charges for private practice, although the various medical societies in the region often urged doctors to adhere to a prescribed code of fees.³⁶ But medical witness fees, fees for registering births and deaths, and fees paid by life insurance companies or other corporations, were another matter. In these matters doctors took the position that no scale of fees would be satisfactory that had been arranged without consultation with the profession.³⁷

33 J. W. Daniel, "The Public Health Act of New Brunswick", *Maritime Medical News*, XVIII (April 1906), pp. 131-5.

34 "Compulsory Notification of Births", *Maritime Medical News*, XVI (July 1904), pp. 259-60.

35 Dr. H.A. March, "Some Objects of this Organization", paper delivered before the Lunenburg-Queens Medical Society, *Maritime Medical News*, XV (April 1903), pp. 118-26.

36 Minute Books of Medical Societies in Nova Scotia, no. 3, Yarmouth, 18 January 1868, 22 January 1870, 10 June, 2 July, 9 July, 1889, Kellogg Medical Library, Dalhousie University; *ibid.*, no. 2, Pictou, 2 September 1873, 15 July 1890, 5 January 1892, 26 July 1911: "Tariff of Fees", 1914, Halifax Medical Society, Halifax Medical Association, Minute Book, 17 June 1914.

37 "Medical Fees", *Maritime Medical News*, 8 (August 1904), pp. 311-5; Minute Books of Medical Societies in Nova Scotia, no. 2, Pictou, 21 July 1891.

In part the anxiety about medical fees was a product of the doctor's second major concern in these years, the proliferation of medical schools and the apparent "overcrowding" of the profession. In the last half of the nineteenth century the mushrooming of new medical schools, many of which gave less than rigorous attention to educational standards, had a significant impact upon the medical profession in the Maritime Provinces. Earlier, most doctors in the region had pursued their studies overseas in the medical schools at Edinburgh or Dublin. In 1845, for example, of thirteen senior practitioners in Halifax, all but one had been trained at Edinburgh.³⁸ Because the cost of overseas training was substantial, the number of doctors in the region in this period remained relatively low. But by the end of the century the lure of the less costly, and often less demanding medical schools in North America had drastically altered the character of the medical profession in the Maritimes. The official Nova Scotia Medical Register for 1890, for example, showed that of 326 doctors registered, 236 had been trained in the United States, 63 in Canada, and only 27 overseas.³⁹ The subsequent emergence of medical schools in Canada completed the shift away from foreign training. In 1910 there were 549 doctors registered in Nova Scotia, 300 of them trained in Canada; 208 in the United States, and 41 in the British Isles. Of those trained in Canada, 151 had received their medical training in Halifax, 139 at Dalhousie and the remaining 12 at the Halifax Medical College.⁴⁰

In addition to the changing educational background of the medical profession in the quarter century before World War I, census records reveal a significant alteration in patient-doctor ratios. Between 1881 and 1911 patient-doctor ratios in Nova Scotia fell from 1,519:1 to 1,207:1; in New Brunswick they declined from 1,397:1 to 1,252:1; and in Prince Edward Island they dropped from 1,728:1 to 1,274:1.⁴¹ In a calculation based upon the medical register, Dr. Daniel MacNeil Parker estimated that the ratio of population to doctors in Halifax had dropped from 1,214:1 in 1851 to 820:1 in 1891.⁴² The increased supply of graduates from medical schools in Canada and the United States, and the declining rate of population growth accompanying the widespread out-migration of the 1880s and 1890s, was responsible for the change.⁴³

38 Dr. Daniel MacNeil Parker, "On the Completion of Fifty Years Active Professional Work", *Maritime Medical News*, VII (October 1895), p. 209.

39 *Belcher's Farmer's Almanac*, 1890.

40 *Ibid.*, 1910.

41 Figures calculated from data contained in *Census of Canada*, 1880-1, 1911.

42 Parker, "On the Completion of Fifty Years Active Professional Work", p. 210.

43 Alan A. Brookes, "Out-Migration from the Maritime Provinces, 1860-1900: Some Preliminary Conclusions", *Acadiensis*, V (Spring 1976), pp. 30-1. The issue of overcrowding is a difficult one to assess because of the prevalence of irregulars or unlicensed doctors. Without reliable statistics relating to this group, it is impossible either to refute or sustain doctors' claims.

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Concern about the overcrowding of the profession stimulated a demand for sweeping changes in the medical education system. Doctors hoped that high entrance standards and a lengthened course of study would discourage less committed applicants from entering medical school and thereby shrink the ranks of the profession. Opponents argued that a lengthened course of instruction would make the profession a rich man's club. But medical reformers, especially the older and more established ones, cavalierly brushed aside this opposition, and even asserted the legitimacy of medical elitism. To Daniel MacNeil Parker, the profession's difficulties lay in the tendency of young men "to select Law and Medicine, in preference to Agricultural, Mechanical, or other employments, in which many of their fathers were engaged". The entrance into the profession of young men "without adequate mental training or ability, without any natural liking or aptitude" for medical practice led to the erosion of the "due or proper proportion which should exist between these professions and the population".⁴⁴ Parker's concern about the erosion of the elite character of the profession was shared by the editor of the *Maritime Medical News*. "We are not aware that poor men or poor men's sons make better doctors than the rich or rich men's sons", this journal declared. "The entrance into the profession of the sons of the wealthy will be a positive benefit, by bringing into its fold a more liberally educated and independent set of men than sometimes now find their way in".⁴⁵

This is not to imply that doctors regarded educational reform merely as a device to maintain the elitism of the profession and to limit competition. Doctors in the vanguard of reform felt a professional and social obligation to improve the quality of medical care. Reformers were well aware of the deficiencies in training of many of the licensed doctors in the Maritime Provinces. For one thing, the better medical schools in the United States had traditionally practised a form of "streaming", giving better students greater attention and encouraging them to specialize in research, while applying a lower set of standards to those likely to practise in the northern back-country or on the western American frontier.⁴⁶ Many of the lower stream came to Nova Scotia in the middle of the nineteenth century. "I have known men come amongst us, from the States and elsewhere, who could not write small-hand, many who could not spell, and one who lived and died not twenty miles from this place — who could not have written the names of half the medicines correctly", Truro's Dr. Muir told the Nova Scotia Medical Society in June 1872.⁴⁷ As a result, the

44 Parker, "On the Completion of Fifty Years Active Professional Work", p. 215.

45 *Maritime Medical News*, III (November 1891), p. 199; Gerard E. Markowitz and David Karl Rossner, "Doctors in Crisis: A Study of the Use of Medical Education Reform to Establish Modern Professional Elitism in Medicine", *American Quarterly*, 25 (March 1973), pp. 83-107.

46 Stevens, *American Medicine and the Public Interest*, p. 40.

47 Nova Scotia, Medical Society, Annual Meetings, Minutes, 19 June 1872.

profession looked upon the establishment of the Medical Faculty of Dalhousie College in 1868 (subsequently the Halifax Medical College) with a great deal of sympathy and hope. Unfortunately, lack of money and disagreements between the Halifax Medical College and Dalhousie reduced its effectiveness. When the Flexner Report on medical schools in Canada and the United States was published in 1910, the Halifax Medical College received a scathing critique.⁴⁸

In the Maritime Provinces educational reform emerged from the aggressive lobbying of provincial medical societies rather than from the universities. In April 1872, at the urging of the Nova Scotia Medical Society, the provincial legislature passed "An Act to Regulate the Qualifications of Practitioners in Medicine and Surgery". Although the Medical Act of 1856 had earlier required physicians to present their credentials to the Provincial Secretary for registration, there was no apparatus established to determine the quality of the training received by the candidate. The Act of 1872 did just that, establishing a Provincial Medical Board which was empowered to add and erase names from the medical register, to grant licenses to practitioners in the province, and to apply the minimum standards enshrined in the Act. As a minimum requirement for licensing and registration, candidates had to satisfy the Board that they had passed a Preliminary Examination or its equivalent in English (including grammar and composition), arithmetic, algebra, geometry, and one further optional subject. This was to be followed by a four year professional course with a curriculum that included at least twelve months of lectures in Anatomy, practical Anatomy, Surgery, the Practice of Medicine, Midwifery, Chemistry, Materia Medica, Pharmacy, and Physiology, a three months' course in Medical Jurisprudence, six months in clinical medicine and clinical surgery, and at least one year's attendance at a Hospital of not less than fifty beds. Under the Act professional examiners were also to be appointed to examine candidates with incomplete or unsatisfactory credentials.⁴⁹ After 1902, all applicants for registration were required to pass a licensing examination conducted by examiners appointed by the Provincial Medical Board.⁵⁰

When in the two decades following the Act of 1872 New Brunswick and Prince Edward Island gradually established registration standards that conformed to those in effect in Nova Scotia, a movement emerged in favor of

48 Abraham Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching* (New York, 1910), p. 13; J.A. MacFarlane, *Medical Education in Canada* (Ottawa 1965), pp. 19-21; "The Halifax Medical College", *The Canadian Medical Association Journal*, I, Part I (1911), pp. 63-70; and C.B. Stewart, "One Hundred Years of Medical Education at Dalhousie", MG 20, vol. 112. PANS

49 *Nova Scotia Statutes*, 1872, ch. 31, pp. 45-55.

50 "Professional Examinations of the Provincial Medical Board", *Maritime Medical News*, XV (June 1903), pp. 213-4.

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inter-provincial registration of doctors. Reciprocal registration was effected in the Maritimes in 1894 when the Medical Boards of the three provinces agreed to a treaty of reciprocity, but the agreement collapsed five years later.⁵¹ Subsequent efforts were directed at securing reciprocity in registration with Great Britain and establishing a Canadian Medical Act which would allow physicians registered in any province to carry their registration to any other. The first objective was achieved in May 1907, when the General Medical Council of Great Britain adopted reciprocal registration with the province of Nova Scotia.⁵² But attempts to establish a national registration scheme met with serious difficulties. Ontario and Quebec both resisted inter-provincial registration, fearing an influx of practitioners from the other provinces. Arguing that their standards of training were higher than elsewhere, these provinces refused to admit out-of-province doctors to their medical registers without examination.⁵³ Ironically, it was a physician from Quebec, Dr. T.G. Roddick, who led the fight for Dominion registration. After winning a seat in Parliament in 1896, Roddick laboured for the next fifteen years to secure a national medical act. Finally in 1912 Parliament passed the Roddick bill, establishing a national medical council, medical register, and reciprocal registration among the provinces.⁵⁴

Despite the medical profession's achievements in upgrading educational standards and securing reciprocal registration, doctors still faced serious challenges from those outside their own ranks. Medical quackery and the patent medicine trade disturbed doctors the most, because they provided clear indication of the general public's resistance to their desire to define and control medical expertise. Legal constraints against irregular practice provided only a partial remedy. Early medical acts were passed in New Brunswick in 1816 and in Nova Scotia in 1828 excluding "ignorant and unskilful persons from the practise of physick and surgery" and giving authority to the Governor to license doctors.⁵⁵ But the failure of this legislation to protect against the unlicensed doctor or against fraudulent credentials soon led to a demand for more stringent procedures. In Nova Scotia, the Medical Act of 1856 required doctors to register their diplomas at the Provincial Secretary's office, and made fraudulent assumption of a registrable title an indictable offense. Once registration was required, the

51 D.A. Campbell, "Reciprocal Registration", Presidential Address to Maritime Medical Association, *Maritime Medical News*, X (August 1898), p. 256.

52 "Nova Scotia Provincial Medical Board, Registrar's Report, 1907-8", *Maritime Medical News*, XX (September 1908), p. 351.

53 *Maritime Medical News*, VIII (April 1896), p. 135.

54 H.E. MacDermott, *100 Years of Medicine in Canada* (Toronto, 1967), pp. 56-7.

55 D.A. Campbell, "Medical Legislation in Nova Scotia; Past, Present, and Future", Presidential Address to Nova Scotia Medical Society, *Maritime Medical News*, I, (July 1889), pp. 95-6; Stewart, *Medicine in New Brunswick*, p. 40.

next step was to establish provincial medical boards whose responsibility it was to oversee the profession and initiate legal proceedings against those who practised illegally. This was accomplished in Nova Scotia in 1872, in New Brunswick in 1874, and in Prince Edward Island in 1890. While these provincial boards usually had limited financial resources and found it impossible to prosecute every medical pretender, they made some advancements in the struggle with the unlicensed practitioner by carefully selecting appropriate cases for prosecution.⁵⁶

The profession was less successful in dealing with the abuses emanating from the production and sale of patent medicines. Although patent medicines had been available as early as the eighteenth century, the market for these nostrums had remained relatively stable until the middle of the next century. But with the industrial and urban expansion of post-Confederation Canada, and the concomitant expansion of Canadian and American newspaper circulation, the patent medicine industry expanded rapidly.⁵⁷ Throughout the last quarter of the nineteenth century the bulk of newspaper advertising revenue came from the various tonics, elixirs, purgatives, and other assorted remedies whose main purpose, one wag suggested, “appear[ed] to be to open men’s purses by opening their bowels”.⁵⁸ Sufferers were offered cures for almost every imaginable malady from dizziness to dyspepsia, or from sexual impotence to epilepsy. In most cases, however, these medicines were little more than medicinal cocktails, blending a hearty dose of alcohol with the narcotic delights of opium, morphia, codeia, cocaine, belladonna, and choral.⁵⁹

56 Perhaps the most important case involved the Provincial Medical Board of Nova Scotia and a Dr. Ira T. Dyas of Amherst, Nova Scotia, who was practising with forged credentials from Tufts Medical School. When the Board erased his name from the medical register in 1907, Dyas enlisted the support of a number of influential citizens in Amherst and defied the Board. Not only did Dyas continue his practice, but the Attorney-General William Pipes introduced legislation that, if passed, would have restored his name to the medical register despite the objections of the Provincial Medical Board. Not only did this defiance indicate the widespread suspicion of professional medicine in the region, but it challenged directly the right of the profession to regulate its own affairs. Eventually the bill was amended to establish a procedure for appealing decisions of the Medical Board to the Supreme Court of Nova Scotia, except in cases of “infamous professional conduct” where the Board’s authority was made supreme. In 1908 the Board’s decision with respect to Dyas was upheld in the courts, and the erasure of his name was thus made final. Nova Scotia Medical Board, Minute Book, 17 July 1907, 15 April, 15 July 1908, RG 25, Series C, vol. 10, no. 5, PANS.

57 James Harvey Young, *The Toadstool Millionaires: A Social History of Patent Medicine in America Before Federal Regulation* (Princeton, 1962).

58 Quoted in James Harvey Young, *The Medical Messiahs: A Social History of Health Quackery in Twentieth-Century America* (Princeton, 1967), p. 23.

59 W.H. Moorehouse, “President’s Address — Canadian Medical Association”, August 1903, *Maritime Medical News*, XV (October 1903), p. 413; “Alcohol in Patent Medicine”, *Maritime Medical News*, XVIII (February 1906), p. 41. A survey of 36 patent medicines undertaken by the United States Department of Internal Revenue found that the alcohol content ranged from

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But the significance of the patent medicine trade has little to do with its ability to slake an unhealthy thirst. Patent medicine's popularity reveals the lack of public confidence that accompanied the medical profession's inability to establish an effective system of medical therapeutics. Doctors were obviously right to suggest that the patent cures were worthless and fraudulent. Unfortunately, while attacking "this mad fashion for self-drugging",⁶⁰ doctors themselves administered drugs in a manner that could hardly be considered scientific. For one thing, doctors still lacked a coherent theoretical foundation for therapy. For another, the extremely rapid expansion of the medical drug industry provided doctors with a bewildering array of remedies to choose from. Dr. H.A. March observed that the plethora of drug samples available to doctors from competing drug companies often led them to choose new preparations simply because they were new, and feared that doctors were becoming mere "agents of the manufacturers of drugs".⁶¹ In turn, patients often had little faith in the remedies prescribed by their doctors, and pressured druggists to supply them with cheaper "equivalents". The crisis in therapy, the modification of prescriptions, the over-the-counter sale of drugs and patent medicines, and the sale of liquor by pharmacists with or without a doctor's prescription, all made some sort of regulation of the drug industry seem imperative. What was needed was "a definite and scientific procedure in the administration of remedies".⁶²

One step in this direction was regulation of the patent drug trade. Encouraged by the muckraking series on the proprietary medicine industry in *Collier's Weekly* and the *Ladies Home Journal*, the Halifax Branch of the British Medical Association struck a committee in 1906 to draft legislation regulating the sale of patent medicine.⁶³ Acting in conjunction with Dr. Ellis, MP from Guysborough County, a bill was prepared requiring that the formula of each remedy be printed upon the bottle's label, and that all preparations containing more than a stated percentage of certain drugs should be labelled "Poison". The introduction of the bill led to immediate resistance. The press, dependent as it was upon patent medicine advertising, denounced the sweeping character of the legislation. The Halifax *Morning Chronicle*, in an editorial entitled "Kill This Bill", argued that it would cripple drugstore proprietors and country traders who had large inventories, and deny the public a service that it desired. "Probably more than half of all the medicines used in the Province are

12 to 45 per cent. In 14 cases the content was less than 20 per cent; in 12 it was more than 25 per cent.

60 *Maritime Medical News*, X (February 1898), p. 56.

61 March, "Some Objects of this Organization", *ibid.*, XV (April 1903), pp. 118-26.

62 *Ibid.*, II, pp. 60-1.

63 "The War Against Quackery", *ibid.*, XVIII (February 1906), p. 47; "The Patent Medicine Question", *ibid.*, XVIII (March 1906), pp. 85-8; "The Patent Medicine Bill", *ibid.*, XVIII (April 1906), p. 130.

proprietary”, it observed. “The majority of the people depend upon them for all simple ailments, and whatever clamor for the destruction of proprietary medicines does not come from them”.⁶⁴ Largely because of this opposition, the bill died in the legislature.

In its campaign for regulation of patent medicines, and more generally in its desire to establish greater control over the activities of druggists, the medical profession revealed its hope of dominating related but competing professions. This desire was even more completely revealed in its relationship with opticians, professional nurses, and traditional midwives. Responding in part to the challenge that derived from medical professionalization and the urge of doctors to monopolize medical practice, opticians and nurses in particular began to elevate their own professional standards. In the spring of 1905 a group of Halifax opticians prepared a bill to regulate their own activities. Although the bill was intended to establish minimum standards of performance for opticians, doctors vigorously opposed it. “These philanthropic opticians wish to save the country from the ravages of the optical fakirs who roam freely and unmolested all over this country”, the *Maritime Medical News* said condescendingly. “In this respect their case is a meritorious one, but on the other hand these roaming opticians are just as competent and just as incompetent as their stationary brethren”.⁶⁵ The main argument made by doctors was that opticians regarded the eye purely as a physical piece of apparatus, separate from the human body and capable of being treated as such. In fact, opticians were often quite adept in the correction of refractive difficulties, and so long as there were strict prohibitions against them treating diseases of the eye they could provide a legitimate and inexpensive service. Nevertheless, the doctors were successful in postponing the registration of opticians. Though the licensing bill passed the Legislative Assembly in the spring of 1906, it was subsequently defeated in the Legislative Council.⁶⁶

The nursing profession provided an equally formidable and in some ways more important challenge to the monopolization of medical practice by doctors. The rapid emergence in the late nineteenth century of modern hospitals with training facilities for nurses resulted in a significant expansion in the number of trained nurses. As schools of nursing were developed in St. John, Fredericton, and Halifax around the turn of the century, the number of trained nurses in the region increased rapidly. Between 1881 and 1891 the number of nurses and midwives in New Brunswick rose from 50 to 136, in Nova Scotia from 138 to 221, and in Prince Edward Island from 17 to 39.⁶⁷ By 1911 there were 318

64 *Morning Chronicle* (Halifax), 16 April 1906.

65 “Licensing Opticians”, *Maritime Medical News*, XVI (February 1905), p. 71.

66 “The Optical Bill”, *ibid.*, XVII (March 1905), pp. 108-9; “The Optical and Medical Costs and Fees Bills”, *ibid.*, XVII (April 1905), pp. 144-5.

67 *Census of Canada*, 1881, 1891.

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professional nurses in New Brunswick, 429 in Nova Scotia, and 48 in Prince Edward Island.⁶⁸

As the profession expanded in numbers, the curriculum in nursing schools became more elaborate. By 1900 few schools required less than a three years' course while many demanded four years. Doctors viewed the advent of the trained nurse with some concern, recognizing that as nurses became professionalized it would be more difficult to ensure their subordination to the medical practitioner. Consequently, doctors were compelled to argue against a 'scientific' approach to nursing with as much vigor as they promoted it in their own case:

There can be no doubt that an understanding of the why and the wherefore adds to the interest of a nurse's work just as it does to that of anyone in any walk of life. But nursing is nursing, and not the practice of surgery. There is no danger of over-training in the practical work of nursing, but the tremendous burden of theoretical instruction — most of which is quite inapplicable in practice — is not only needless, but doubtless harmful. Every doctor has had annoying instances of interference by nurses whose ethical knowledge has been less in evidence than presumption, and whose heads have been turned by a smattering of such information as need belong to the physician alone. These young women might have been admirable aids had their training been limited to the really fundamental things, and had they not been distracted and rendered dissatisfied by ill-directed excursions beyond their proper latitude.⁶⁹

Doctors warned of the dangers of partial knowledge. Nurses, they argued, had enough knowledge to speculate about symptoms, but not enough to overcome the inherent female proclivity to gossip. Doctors suggested that nurses dispense with the 'scientific' study of cases and return to the "gentle touch"; to them, the virtue of the nurse would ultimately depend upon her decorum, her personality, and her subordination to the doctor.⁷⁰

The case of the midwife differs from that of the nurse since it involves not just her subordination to the doctor but her replacement by the professional obstetrician. As early as 1872 doctors in the region had undertaken to place midwives under the control of the profession. In the Nova Scotia Medical Act of that year midwives had to secure a license if they wished to practise in Halifax. But prior to World War One doctors made few advances in their competition with midwives. Although the Provincial Medical Board occasionally received complaints about midwives practicing in rural areas, it was not disposed to do anything

68 *Ibid.*, 1911.

69 "Evolution of the Nurse", *Maritime Medical News*, XVIII (May 1906), p. 168.

70 *Ibid.*

about them.⁷¹ Doctors, of course, recognized the significance of child-birth to their practice: often the delivery of the child was the first important contact a doctor made with a family, and a future professional relationship could be inaugurated as a result of his delivery of the offspring. By the Second World War traditional midwifery was virtually non-existent in the Maritimes. In the long run, the midwife found herself unable to withstand the challenge of a profession which had masculinity, a professional style (although not necessarily greater competence), and the virtues of efficient hospital care — modernity in fact— upon its side.⁷²

The quarter century before World War One was a critical time for the medical profession in the Maritimes. Although the individualistic, laissez-faire, and cut-throat Darwinism that accompanied nineteenth-century capitalism gave way to the “expert management” and public responsibility of the industrial state, it was clear that control of public health and medical treatment would remain firmly in private hands. The movement for the professionalization of medicine, therefore, represented the attempt of one interest group to assert its supremacy in health matters in the name of efficiency and scientific expertise. Possessed of a sense of public responsibility and a sincere desire to improve medical care, turn of the century practitioners believed that the management of society by the professional expert would result in significant social improvement. Doctors thus advocated higher standards of medical training, a more efficient public health apparatus, the formal involvement of medical experts in the criminal justice system, and an end to “unscientific” forms of medical treatment. In the short run the aim of the professionalizers (supported by the rank and file of the profession) was the restriction of the destructive competition of an overcrowded medical market-place; in the long run their aim was the monopolization of medical influence and the concomitant subordination of the competing professions to their authority. Above all, doctors wanted the unquestioned authority to define what was meant by professional medical expertise.

But there are serious questions that emerge from the continuation of private control of public health and medical treatment in the progressive period, and the concomitant impulse of doctors to monopolize medical care. Convinced that they could serve public needs in an efficient and scientific way, doctors strove to control the definition of professional expertise. The problem was that doctors found it impossible to recognize any conflict between the public welfare and their own private interests. Yet if one reflects for a moment upon the deficient character of medical therapeutics, the inadequate application of prescription

71 Nova Scotia, Provincial Medical Board, Minute Book, 15 January 1913; 16 July 1916.

72 Kathy Kuusisto, “Midwives, Medical Men, and Obstetrical Care in Nineteenth Century Nova Scotia” (MA thesis, University of Essex, 1980); Francis E. Kobrin, “The American Midwife Controversy: A Crisis of Professionalization”, *Bulletin of the History of Medicine*, 40 (July-August 1966), pp. 350-63.

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drugs, the attempts to deny nurses, opticians, and other professional groups the right to engage in professional improvement, the assault on traditional mid-wifery by often poorly trained obstetricians, and the attempts to maintain the elitist character of the medical profession through internal reform, one is led to the conclusion that the public welfare and the interest of the doctor did not automatically coincide.

Although doctors in the quarter century before World War One did not resolve all of the challenges confronting them, many important steps were taken that contributed to their growing professional influence. Steps were taken to limit entrance to the profession, to provide for a more effective control of irregular practitioners and the competing professions, and to encourage an improved public image. Subsequent decades would witness the resolution of the therapeutic crisis, an even more effective and intimate relationship with the state, and the monopolization of medical practice by the medical "expert".