

Rural Medical Lives and Time

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REVIEW ESSAY

Rural Medical Lives and Times

J.T.H. CONNOR

Noel Murphy. *Cottage Hospital Doctor: The Medical Life of Dr. Noel Murphy, 1945-1954*. (Edited by Marc Thackray) St. John's, Creative Publishers, 2003, ISBN 1894294726.

John K. Crellin. *The Life of a Cottage Hospital: The Bonne Bay Experience*. St. John's, Flanker Press, 2007, ISBN 1897317050; ISBN 9781897317051.

Esther Slaney Brown. *Labours of Love: Midwives of Newfoundland and Labrador*. St. John's, DRC Publishing, 2007, ISBN 0978343409; ISBN 9780978343408.

PEOPLE WHO LIVE IN rural or remote settlements, especially in the North, are subject to illness and injury like their southern urban counterparts — even more so due to harsh environments and climate, dangerous occupational conditions, and increased distance from health services. Today 20 per cent of the population of Canada is considered to be rural, but that segment of the population is served by only 10 per cent of the country's doctors. The history of medicine and health care of these populations remains largely unwritten due often to a lack of interest by professional his-

torians and to a paucity of sources. A window on the development of medical and health care delivery and practice in remote areas is available instead through the contemporary life writings of physicians, midwives, and nurses who lived and worked in these communities. Typically these autobiographies and biographies are not widely disseminated, and are thus available only as “local” publications. Yet a close reading of these accounts reveals a wealth of historically useful material that otherwise would have been lost.¹ Often authors write these anecdotal accounts many years after the events took place, and it is important to recognize that some “slippage” might have resulted due to forgetfulness or invention over time. Whatever inaccuracies they may convey, in the absence of corroborating or supplementary materials, we must rely on them for the time being. These narratives also reveal the often intimate and emotional connections between people, institutions, and the communities that nurture them. Thus they contribute to our understanding of what constitutes rural medicine and health care, demonstrating in particular that it is much more than simply a type of medical practice defined negatively as “not urban.”²

The three books discussed reveal much about professional activities and inter-professional and personal relationships. Insights into clinical practice under harsh environmental and the socio-economic conditions of the people abound. The primary dependence on foot power and on other forms of transportation technology (horse and dog sleigh, planes, ships, and boats) for patients and practitioners is evident in all works. Gender is also an important theme in all of these books, for women occupied a vital place in the practice of rural and remote medicine. Occasionally, as spouses, but more typically as midwives and nurses, women carved a niche for themselves that was indispensable in Newfoundland and Labrador. It is incontrovertible that the scope of work of informal and formal nurses in remote regions far exceeded that of their urban counterparts. Even when subordinated to a physician-in-charge, nurses often put their (male) bosses in their place. If a midwife/nurse was the only professional practitioner in a region, she would assume the *de facto* role of doctor. Indeed, sometimes these women even performed limited surgery (minor amputations, suturing, tooth extractions, obstetrical work) and prescribed medications. In addition to the women discussed here, there is also the example of Myra Bennett of Daniel’s Harbour who became the stuff of legend due to her over 50 years of service. In addition to national awards and recognition, playwrights, biographers, and documentary film makers have devoted attention to her.³ Also notable from these works is that much of the cost of rural health care in Newfoundland was publicly subsidized and community based. Indeed, this fact did not escape the attention even of the United States Public Health Service when Assistant Surgeon General R.A. Vonderlehr reported in 1940 that the “provision for medical care of the people in Newfoundland at public expense is more effectively developed administratively than in any part of the United States.”⁴

Considered together, the preceding generalizations suggest that a “health care ecosystem” existed around the mid-twentieth century that functioned successfully, albeit in fragile balance. This situation very much contrasted with the totally fragmented and underdeveloped state of Newfoundland medical care of the preceding decades, and it also differed from the later twentieth-century when increased medical specialization, technological sophistication, rising costs, centralization, population redistribution, new transportation patterns, and, regrettably, a marked decline in the public trust of the provincial medical system became more pronounced. Additional research is needed to support or modify this perspective, but the three locally produced books discussed do suggest that we might learn a great deal from pre-Confederation rural medical practice, and that a more integrated, comprehensive, and scholarly study of Newfoundland’s pre-Confederation rural medical history might be called for.

The “cottage hospital” is a good starting point for any discussion of rural health care in Newfoundland. This overlooked and under explored species of the modern hospital has been fully appreciated by British historian Steve Cherry.⁵ Likely to be found in remote parts of England and Scotland (and occasionally in Canada) during the late-nineteenth and early-twentieth centuries, it can properly be understood as a British invention. Not surprisingly, the concept of the cottage hospital was readily imported to Newfoundland. Between 1936 and 1952, the government built 15 cottage hospitals to help deliver health care to those living in outports and other isolated settlements, which typically could be reached only by boat or with difficulty over harsh terrain. The Newfoundland cottage hospital was a grassroots institution. It was also an early experiment in socialized medicine as the government paid doctors at the cottage hospital on a standardized salary with patients paying an annual fee for basic hospital care.⁶

Cottage Hospital Doctor, Dr. Noel Murphy’s book-length memoir, offers a unique insider’s perspective on the activities at a cottage hospital at Bonne Bay near Norris Point over a ten year period. Murphy (1915-2005), born into a St. John’s medical family (his father, Dr. John Murphy, trained at the same institution as Sir Wilfred Grenfell), received his medical training in London. After graduating in 1943, Noel Murphy served two years in the Royal Air Force, returning to Newfoundland to take up his post at the Bonne Bay Cottage Hospital with responsibility for a population of about 6,000 people who were scattered along the rugged west coast from Deer Lake to St. Anthony. Murphy lived in Bonne Bay until 1954 when he and his family moved to Corner Brook where they remained for the next 50 years, and where he continued to practice medicine, became a radio and journalism personality, and entered into municipal and provincial politics as mayor of Corner Brook and MHA for Humber East. The first third of this autobiography is arranged in a roughly chronological fashion, while the remaining chapters are topical, covering various adventures, family reminiscences, “doctors’ stories,” and historical vignettes of pre-and post-Confederation Newfoundland.

Arriving in Bonne Bay at the end of World War II, Noel Murphy took over the work of a Dr. Robert Dove who ran the hospital from its opening in 1939. The hospital itself incorporated two main public wards of ten beds each, two private rooms for patients, an operating room, nurses' quarters, a kitchen, a laundry, a laboratory, an X-ray room, a darkroom, a doctor's office waiting room, a small drug dispensary, and other utility rooms. On the hospital grounds were the morgue, ice room, and the generator house which contained three electrical generators to supply electricity (one specifically for the radiology equipment, the others to supply direct current electricity which was stored in large batteries for use by the hospital). A doctor's residence was also located nearby. While basic, the hospital was self-contained. The minimal staff complement required that Murphy act as radiologist, laboratory technician, surgeon, anaesthetist, obstetrician, physician, and administrator. In addition to his hospital practice, he also did "house calls" along approximately 200 miles of the western coastline of the Northern Peninsula.

As the only doctor for hundreds of miles, Murphy was readily accepted as a member of the community, but he was conscious of maintaining his professional demeanor and "distance" as almost all who belonged to it were also his patients. A respected member of local society, he was often accorded a place of honour at wedding tables and other "times" but, interestingly, Murphy usually excused himself from such festivities before they got too boisterous, and, as a "responsible rural practitioner," he did not publicly imbibe alcohol or revel with his patients. Then, as now, rural doctors needed to establish boundaries when attempting to balance social expectations with professional obligations.

Dr. Murphy's case load was as broad as it was unrelenting. Mornings were devoted to surgery, and afternoons (which usually lasted an additional eight hours) to out-patient clinics which functioned on a "walk in" basis as it was impossible to establish an appointment system. What little schedule existed could be easily thrown off. When the coastal steamer *Northern Ranger* or *Clareville* arrived with passengers suffering aches, pains, illnesses, and ailments, they took priority. Health inspections of schoolchildren, immunization programmes against diphtheria, smallpox, and other infectious diseases were also undertaken. Psychiatric emergencies (such as disturbed people threatening to shoot others) and occupational and domestic accidents also contributed to the unpredictability of cottage hospital life. Medical missions of mercy by boat (Murphy captained his own cabin cruiser, *Tinker Bell*), Jeep, Bombardier snowmobile, dog sled, and occasionally private aircraft (often Murphy would hitch a ride with noted American outdoorsman and photographer Lee Wulff who operated a fishing camp on the west coast) all rounded out the hectic pace and practice of this cottage hospital doctor.

Of particular note are Murphy's comments about maternity cases, midwives, and nurses in light of one other of the books under review. During his early Bonne Bay days, Murphy did undertake confinements in patients' homes, but it is clear that over time he encouraged pregnant women to give birth in the cottage hospital

(on average about 100 cases a year). This shift from home to hospital births seems not to have been grounded in any attempt to supplant local midwives. Instead, it was a strategy to manage and coordinate a busy and mostly unpredictable practice. Perhaps another reason — one that so far has not surfaced in the literature of male-dominated midwifery and obstetrics — concerns the physical dimensions of practitioners and their domestic maneuverability. Murphy was a tall man who found that he could not operate skillfully and with ease in a typical Newfoundland outport house with its small rooms, low ceilings, and unfamiliar interiors. In one instance he actually fell on the bed of a pregnant woman, which then collapsed under all of them. Yet another inducement for Murphy to encourage hospital birthing was local communication habits and language. Murphy, although a Newfoundlander, was a “townie” who had spent most of his adult years in London before returning home. He had difficulty differentiating women who were *actually* ill from those who were “*merely*” pregnant because often the only communication conveyed by a husband or some other male messenger was that “the wife/woman was took sick” or some similar laconic phrase. If a woman were to be admitted to hospital, then he at least could be prepared for most medical contingencies.

Mutual professional and territorial respect and understanding seem to have been the order of the day with outport nurses such as Myra Bennett of Daniel’s Harbour (which was on his medical beat). Such professional relationships were influenced by rural custom and habit. For example, when Murphy was visiting Bennett at her home/clinic a man rushed in carrying his injured son in his arms ignoring Murphy but seeking aid from Bennett. She in turn also ignored the district doctor and began treating the young man. Murphy offered no protest over what other urban doctors might have construed a snub, but hung back until he was, in effect, invited to consult on the case. Other instances existed where this doctor readily supported outport nurses and their duties.

Noel Murphy’s account of his “medical life,” while unique, resonates with the many other similar examples of the nurse/doctor autobiographical genre. Aspects of his story would be repeated many times over elsewhere in rural Newfoundland. Of particular note here was Murphy’s response to one of the major challenges of practicing medicine on the margins. For bourgeois, educated people outport life could lose its charm, and after a decade of service, Murphy quit Bonne Bay for Corner Brook. Why did he leave his large handsome house with its cultivated lawn and flower beds reminiscent of an English country garden? As challenging as rural medical life could be on the practitioner, it could be even more difficult for a spouse and family. Edna, Murphy’s wife, although kept busy as a *de facto* laboratory technician, founder of the local public library and a Girl Guide company, child care giver, and educator for their daughters, no doubt appreciated relocating to a town with expanded educational opportunities along with more social and cultural amenities. This act can be viewed as a highly personal decision in Murphy’s case, but it can also be generalized.

John Crellin's *The Life of a Cottage Hospital* is a more general historical analysis of the Bonne Bay hospital. It is based on extant documents and resonates with Murphy's personal experiences showing that he and his counterparts at the hospital practiced an acceptable standard of routine, emergency, and maternity care. As we have seen, despite usage of the term "cottage," this hospital was actually a small rural health care centre. But even if the physical plant outgrew the dimensions of the original British cottage hospital concept, as Crellin nicely illustrates, the intimate domestic atmosphere (as contrasted with the impersonal institutional mindset of larger hospitals) of these community hospitals survived. The example of the Bonne Bay cottage hospital underscores this fact. From its opening in 1939 until 2001 when it ceased operating, the hospital at Bonne Bay was truly of and for the people — quite literally built by them too. Local contributors provided \$1,200, 8,000 hours of free labour, and the building lot on which the hospital stood as a supplement to Government funds. Accordingly, there was a real sense of community ownership.

Beginning in the 1960s the cottage hospital concept in general, including the Bonne Bay hospital, was under considerable pressure owing to a series of new priorities. With the increasing specialization of medicine and hospitals and their dependency on sophisticated technology in general, the idea of a stand-alone, all-purpose, small hospital was becoming outmoded. And, after Confederation with Canada, the province increasingly had to conform to national and international standards of hospital accreditation. The salaried doctors' programme also was under attack as physicians expressed their dissatisfaction in favour of more costly fee-for-service; it became increasingly difficult to attract doctors to work in a rural cottage hospital. Finally, due to much improved road communications and other transportation technologies, previously isolated outports were now linked and regionalization with broader-based health boards to govern regions became the order of the day. Thus, the autonomy previously enjoyed by the likes of the Bonne Bay cottage hospital was eroded as it fell under the jurisdiction of a larger regional general hospital located hundreds of miles away.

In 1984 the term "cottage" was officially eliminated. In 2001 the original hospital was closed and transformed into a historic site and museum. A long-term care unit was also built that maintained the tradition of health care in Bonne Bay, but as Crellin demonstrates through his deft use of oral histories, local residents may concede that this new unit was modern — maybe even better equipped than its predecessor — but it lacked the character and community spirit of the cottage hospital. The community *qua* "the people" just did not feel the same sense of ownership that they did for the cottage hospital that *they* built with *their* own hands. Crellin's study is a welcome contribution to the historiography of medicine in Newfoundland and Labrador. This book also ought to enjoy a wider readership in hospital history in general, for as a micro-history of a cottage hospital it tells us a great deal about this type of little-studied institution.

Esther Slaney Brown's *Labours of Love*, a collection of biographical sketches of almost 90 midwives from around the island and Labrador, is also suffused with the notions of community and service, and their connection to health care. This study, which provides a fascinating cross-section of those "anonymous" women who were midwives in the nineteenth and twentieth centuries, is not strictly speaking an historical analysis of its subject matter. It also does not contain the scholarly apparatus that one might expect in a book based on oral histories and personal narratives. Still, *Labours of Love* preserves and makes accessible valuable historical information. The patient reader of these colourful vignettes will discern interesting patterns that both allow general tentative conclusions about this currently defunct practice, and challenge some presuppositions.

First, while all midwives were women, not all were fully-fledged mothers or elderly. Certainly, many entered the field of midwifery as mature women who had already given birth and raised their own children, but it was not unusual for a young woman to become a midwife early in her life before motherhood. Indeed, in some cases, midwives never actually raised families themselves. Second, midwives' professional relationships with medical men appear harmonious. Doctors and midwives would frequently consult each other, share duties at the bedside, or give way to the other's experience and skill when necessary to the benefit of the pregnant woman and her unborn child. Professional competition or petty jealousies seem not to have arisen. Indeed, often doctors encouraged women to become midwives, suggested that they supplement their skills with formal hospital training and certification in St. John's, or even "reviewed" them as a form of continuing professional education. A third conclusion flows from this last insight and relates to the heterogeneity of midwives' training, backgrounds, and education. With respect to this "sample" of Newfoundland midwives, the majority learned their skills at the bedside from their mothers who, in turn, had also learned them from their mothers. Thus, midwifery was very much a tradition embedded within island oral culture. Other women might have engaged in formal training in hospitals in St. John's, occasionally in the United States, or with noted nurse-midwife Myra Bennett of Daniel's Harbour. The type of training received may have related to the level of formal education or literacy such midwives achieved. Accordingly, often formal written records of a midwife's career were never kept at all, or, if kept, have since been destroyed, or were primitive, such as the midwife who kept track of the number of babies she brought into the world by tying sequential knots in a pieces of twine (also since lost).

Whatever other disparities may have existed, one apparent quality uniting all these women was their success as midwives. Based on the data provided (admittedly often anecdotal and non-verifiable), midwives delivered (or "borned") between several hundred to a thousand babies each during their careers. Even more spectacular is the fact that both mothers and babies seem to have been lost very infrequently. Infant mortality during the first five years of life may have been high

due to such childhood diseases as diphtheria, typhoid, and diarrhea, but, for their part, midwives delivered. Another insight to the local understanding of birthing and motherhood can be drawn from casual remarks by a couple of midwives: pregnancy was not a topic for polite conversation. People were either silent about it, or referred euphemistically to it as “being sick.” This interpretation is borne out by the experience of Noel Murphy, as well as the oral testimony of other elderly Newfoundlanders collected elsewhere.⁷

What accounts for this enviable record of success given the difficult conditions they often found themselves in? Based on many of the testimonies related by Brown, divine guidance is one explanation. Whether Protestant, Roman Catholic, Salvation Army, or Methodist, many a midwife believed that her hands were implements of heaven. Prayer before, during, and after birthing was therefore quite common; similarly, the use of religious icons and paraphernalia. Occasionally, such faith-based practices would be extended to baptizing babies if their survival seemed questionable. But supplementing the power of any deity was the power of disinfectant. It would appear that no self-respecting midwife undertook her duties without the aid of a bottle of Jeyes Fluid, a potent English sanitizing agent popular since the Victorian era (even today it is marketed as a killer of H5N1 bird flu virus). Good aseptic technique (whether learned by formal training or practiced through “intuition”), the donning of a scrupulously clean bleached flour sack apron, and an abundance of experience and common sense further enhanced midwives’ overall success.

Another factor that must also be taken into account in their success, was the lavish and sustained care and stewardship exhibited by these women towards their kinfolk. While on many an occasion a midwife might arrive just in time to attend the birth, often she would be present before labour actually commenced; she would typically stay with the mother for nine days after the birth. During this period she would cook, clean, and care for her charge along with other family members. In effect, the midwife not only provided “medical” assistance, but also emotional and physical help. In modern parlance she acted as a *doula* (another woman who provides continuous support from the onset of labour until after the baby is born).⁸ This was time-consuming, the more so as often it took several days to travel to and from the birth house. It was also demanding. Memories abound of these women slogging through blizzards, gingerly crossing treacherous frozen ponds, rowing across rough water, or being hauled up sheer cliffs in a basket to attend a birth in a lighthouse. Physical stamina and courage, then, were also important in this occupation. Adding to these natural challenges was one of the supernatural kind. On Bell Island, the midwife was often forced to traverse Butler’s Marsh, home to the “little people.” While she did not actually believe in fairy abduction of humans, she still equipped herself with a small Bible and some pieces of hard bread as prophylactic measures.

Was all this effort worth it? That is, was midwifery in Newfoundland rewarding? No and yes. Midwifery was not a means to make a good living as is clear from this collective biography. Although, midwives were able to charge two dollars and

up for their services, this fee was rarely paid in full, if at all. Perhaps, payment in kind (fish, vegetables, or game) might be offered and received, but hard cash was in short supply and never expected. Instead, as the title of this book neatly expresses, these women's toils were "labours of love." Reward did come their way in the form of community respect and admiration. Midwives were, quite literally, vital to the survival and health of the outports they serviced. With most rural Newfoundland women giving birth five, ten, fifteen, or more times during their lifetimes in an earlier era, a caring and competent midwife was indispensable. Moreover, as is evident from this collection of narratives, midwives were also local healers, surgeons, and more. Many would prepare their own herbal tonics, tend to domestic and occupational injuries ranging from scalds and burns to puncture and gunshot wounds, and tend to serious lacerations. In the absence of "professional" medical care, such women rendered first aid often on par with that of an emergency paramedic today. Also included in their repertoire of skills was laying out of the dead. Thus rural midwives were integral to the full cycle of life in an outport, from cradle to grave, from womb to tomb.

But what caused the demise of midwives in Newfoundland and Labrador if they were so essential? Some scholars argue that for North America in general there was a male medical conspiracy to oust female midwives so that doctors could usurp them from their traditional role at the bedside and monopolize the medical marketplace.⁹ Perhaps for some decades (particularly the late nineteenth century) and specific locales that argument is valid. Yet, the fact that midwives practiced well into the decades after Confederation, and that midwives and doctors seemed to enjoy a mutually respectful relationship suggests some other explanation is necessary. Based on a snippet of a conversation here, a remark there, a comment somewhere else, we can infer that perhaps a conspiracy of sorts may be adduced to explain the eradication of the Newfoundland midwife. It was not, however, a conspiracy of organized medicine *per se*, but rather one of "modernity." Even the existence of cottage hospitals and the medical care that they dispensed apparently had less impact on midwives than the building of new roadways that allowed motorized ground transportation which eclipsed traditional ocean and waterway travel and created new social and community networks. According to informants government resettlement programmes and the scattering of families through relocation permanently disrupted accepted birthing practices. They also would have curtailed the training of a subsequent generations of midwives. Finally, the advent of Medicare payment schemes led the provincial government to cease issuing midwife licences by 1963. Yet, by this time most practitioners of traditional midwifery had already hung up their aprons and capped their bottles of disinfectant permanently. In sum, the fate of the midwife was similar to that of the cottage hospital — and for similar reasons. *Labours of Love* is a very different type of study of Newfoundland midwives from previous, more scholarly analyses of this topic, but it deserves a place along with them.¹⁰

These numerous accounts relate to how the delivery of health care in remote regions of Newfoundland and Labrador was both demanding and rewarding for practitioners. Similarly, all deftly portray rural people and the periods in which they lived. Considered together do these three studies offer any other insights into early healthcare delivery? Without falling into the trap of naively being charmed by the “good old days,” it is tempting to hypothesize that for a relatively brief historical moment — maybe from the late 1930s to 1940s — there was a “golden era” of medicine in Newfoundland (but by this I do not mean an *idyllic* era given the tremendously high rates of infectious diseases such as tuberculosis, and other diseases). At this time medicine, broadly construed, was not as overly specialized or totally dependent on technology as it would be later in the century, and the gulf between rural and urban practice was not as pronounced. In fact, most doctors considered themselves general practitioners regardless of their locale and were satisfied to be designated as such. Taken together, the formal (and relatively inexpensive) activities of cottage and Grenfell hospitals, the well-established Notre Dame Bay Memorial Hospital in Twillingate, the tradition of domiciliary medical practice by physicians, outpost nurses, the diagnostic and preventive health services offered by the personnel of the vessels *Lady Anderson* and *Christmas Seal*, and the help of lay and trained midwives *cum* “all-purpose” healers, made healthcare available to most people at the local level. Moreover the demand for, and expectations of, organized medicine roughly matched what it was capable of delivering to society.¹¹

Finally, although the books discussed here deal with medicine’s past, they also are a bridge to the future of health care in Newfoundland and Labrador. As a professor in a medical school, it is part of my job to educate subsequent generations of doctors, many of whom will practice in rural settings. Coincidentally, in the midst of writing this essay I participated in a teaching session with a group of medical students in which we analyzed their recent first-hand experiences of rural medical practice here and elsewhere in Atlantic Canada. This is a mandatory component of the first-year curriculum. Listening to these students’ narratives I was struck by their personal discovery that rural medicine was different from its urban counterpart. The many more hours spent with patients doing clinical work, being “on-call” almost all the time, and the broad range of medical conditions and challenges encountered struck students. Moreover, students also were conscious of the porous boundary between personal and professional life (for example, doing a quick diagnosis or follow up when a doctor meets a patient in the canned food aisle of the local supermarket), the lack of anonymity and occasional need to “get away,” the high regard shown for nurse-practitioners, and the paralyzing and isolating effect that harsh weather and terrain can still have on the delivery of health care. Indeed, as these students expounded on their two-week “shadowing” exercise, my mind wandered to Noel Murphy’s reminiscences about the interactions he had with his patients sixty years earlier. Other cottage hospital doctors, nurses, and midwives from past days would probably still be able to relate to what these students said and they with them.

Perhaps, then, an audience for these books would not just be historians and those interested in “them days,” but would also include a new generation of doctors-to-be.

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Notes

¹Good examples of this genre of life writing exist for many regions of Canada and the United States, but Atlantic Canada (especially Newfoundland and Labrador) seems to be “over represented” in this regard. Perhaps one explanation lies in Sir Wilfred Grenfell’s public relations and adventure writing exercises in the early 1900s. See Ronald Rompkey, *Grenfell of Labrador: A Biography* (Toronto: University of Toronto Press, 1991), Rompkey, ed., *The Labrador Memoir of Dr. Harry Paddon, 1912-1938* (Montreal: McGill-Queen’s University Press, 2003), and Gordon Thomas, *From Sled to Satellite: My Years with the Grenfell Mission* (n.p., 1987). Other examples include: Gary L. Saunders, *Doctor Olds of Twillingate: Portrait of an American Surgeon in Newfoundland* (St. John’s: Breakwater, 1994); Robert Skidmore Ecke, *Snowshoe & Lancet: Memoirs of a Frontier Newfoundland Doctor, 1937-1948* (Portsmouth, NH: Peter E. Randall, 2000); and Brian P. Harris, *Good as the Sea: Rural Newfoundland: Medical and other Experiences, 1955-1958* (St. John’s: Faculty of Medicine, 1990). This rich and abundant medical historical source material will become the basis for a larger study that I am currently working on which will present a collective portrait of rural practice in Newfoundland and Labrador.

²As geographers have pointed out, defining “rural medicine” is not easy. See, for example, William Kamp *et al.*, eds., *Health in Rural Settings: Contexts for Action* (Lethbridge: University of Lethbridge, 1999); and especially Michael J. Troughton, “Redefining ‘Rural’ for the Twenty-First Century,” 21-38; G.W.N. Fitzgerald, “The *Canadian Journal of Non-Urban Medicine*?” *Canadian Journal of Rural Medicine*, 11(2006) 183-4; Alun E. Joseph and Peter R. Bantock, “Rural Accessibility of General Practitioners: The Case of Bruce and Grey Counties, Ontario, 1901-1981,” *Canadian Geographer*, 28 (1984): 226-39; Raymond W. Pong and Roger J. Pitblado, “Don’t Take Geography for Granted! Some Methodological Issues in Measuring Geographic Distributions of Physicians,” *Canadian Journal of Rural Medicine*, 6 (2001):103-13.

³H. Gordon Green, *Don’t Have Your Baby in the Dory: A Biography of Myra Bennett* (Montreal: Harvest House, 1973); a dramatic rendering of Bennett’s life is available in Robert Chafe’s play, “Tempting Providence.” See, Chafe, *Two Plays: Butler’s Marsh, Tempting Providence* (Toronto: Playwrights Canada Press, 2004). For a scholarly analysis, see Linda Kealey, “On the Edge of Empire: The Working Life of Myra Bennett,” in Myra Rutherford, ed., *Duty Bound Dispatch: Nursing and Midwifery in Outposts, Outports and Rural Canada, 1870-1920* (Montreal: McGill-Queens University Press, forthcoming).

⁴R.A. Vonderlehr and Roger E. Heering, *Report of a Survey on Civil Health Services as They Relate to the Health of Armed Forces in Newfoundland* (Washington, DC: United States Public Health Service, 1940) quoted in James E. Candow, “An American report on Newfoundland’s Health Services in 1940,” *Newfoundland Studies*, 5 (1989): 229. Throughout the reprinted version of the document the senior author is inaccurately identified as Vanderlehr. Dr. Vonderlehr was a noted expert in venereal diseases, was one of the archi-

tects of the infamous Tuskegee syphilis study on African-American men, and was senior author of the first published report of this “experiment” in 1936. For additional information see Susan M. Reverby, ed., *Tuskegee’s Truths: Rethinking the Tuskegee Syphilis Study* (Chapel Hill: University of North Carolina Press, 2000).

⁵Steven Cherry, “Change and Continuity in Cottage Hospitals, 1859-1948,” *Medical History*, 36 (1992): 271-89.

⁶John R. Marten, *Leonard A. Miller: Public Servant* (Toronto: Fitzhenry and Whiteside, 1998), esp. ch. 15. For background of the Scottish model (the Highland and Islands Medical Service), see Morrice McCrae, *The National Health Service in Scotland: Origins and Ideals, 1900-1950* (East Linton, Scotland: Tuckwell Press, 2003).

⁷R.R. Andersen, J.K. Crellin, and B. O’Dwyer, *Healthways: Newfoundland Elders, Their Lifestyles and Values* (St. John’s: Creative Publishers, 1998). Generally, it appears that “women’s troubles” — menarche, menstruation, and menopause — were taboo subjects in outport culture. See also, Dona Lee Davis, *Blood and Nerves: An Ethnographic Focus on Menopause* (St. John’s: Institute of Social and Economic Research, 1983).

⁸It is worth noting the Association of Newfoundland and Labrador Midwives (formed in 1983) has spearheaded a drive to reestablish midwifery in the province. Recently, Kelly Monaghan, a midwifery advocate and Memorial University doctoral candidate in the Division of Community Health and Humanities, wrote a letter to Minister of Health and Community Services Tom Wiseman. She commented that it is “quite ironic that midwifery services, once a pillar of community health in pre-confederate [*sic*] Newfoundland, is all but extinct here less than 60 years later, and at a time when the rest of the country embraces its value.” See “We urge you to reflect on this province’s rich midwifery tradition,” *Independent*, 20 May 2008. See also Sheila O’Leary’s “Time for Midwifery Legislation is Now,” *Independent*, 30 May 2008. The concept of a *doula* (Greek for “woman’s servant”) has also recently been brought to popular attention in Newfoundland. See, Christine Hennebury “The woman beside the mother,” St. John’s *Telegram*, 26 May 2008. She describes the activities of the only *doula* currently in Newfoundland. A project is underway, however, to train an additional 16 *doulas* within the province; see “Group wants medical and birth professional coordinated,” *Telegram*, 26 May 2008.

⁹For nineteenth-century Ontario, see J.T.H. Connor, ““Larger fish to catch here than midwives’: Midwifery and the Medical Profession in Nineteenth-century Ontario,” in, *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, ed. Dianne Dodd and Deborah Gorham (Ottawa: University of Ottawa Press, 1994), 103-134; for a discussion of the rebirth of this practice in Ontario, see Ivy Lynn Bourgeault, *Push! The Struggle for Midwifery in Ontario* (Montreal: McGill-Queen’s University Press, 2006). Discussions of this topic from a national perspective are available in Brian Burch, *Trials of Labour: The Re-emergence of Midwifery* (Montreal: McGill-Queen’s University Press, 1994) and Wendy Mitchinson, *Giving Birth in Canada, 1900-1950* (Toronto: University of Toronto Press, 2002). For a useful comparison to the United States, see Judith Walzer Leavitt, *Brought to Bed: Child-Bearing in America, 1750-1950* (New York: Oxford University Press, 1986) and Charlotte G. Borst, *Catching babies: The Professionalization of Childbirth, 1870-1920* (Cambridge, MA: Harvard University Press, 1995).

¹⁰Such works include Cecilia Benoit, *Midwives in Passage: The Modernisation of Maternity Care* (St. John’s: Institute of Social and Economic Research, 1991); Margaret Giovannini, *Outport Nurse*, ed. Janet McNaughton (St. John’s: Memorial University, Faculty

of Medicine, 1988); Rhoda Maude Piercey, *True Tales of Rhoda Maude: Memoirs of an Outport Midwife*, ed. Janet McNaughton (St. John's: Memorial University, Faculty of Medicine, 1992); and Janet McNaughton, "The Role of the Newfoundland Midwife in Traditional Health Care, 1900 to 1970," PhD Thesis, Memorial University of Newfoundland, 1991.

¹¹On the Notre Dame Bay Memorial Hospital, see Saunders, *Doctor Olds of Twillingate* and also J.T.H. Connor, "Twillingate," *Newfoundland Quarterly*, 100 (1) (2007): 12-15; 30-33; details of the M.V. *Christmas Seal* are available in Edgar House, *Light at Last: Triumph over Tuberculosis in Newfoundland and Labrador* (St. John's: Lung Association of Newfoundland and Labrador, 2005); and about the M.V. *Lady Anderson*, see Nigel Rusted, *It's Devil Deep Down There* (St. John's: Creative Publishers, 1987).

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