PROVINCIAL PUBLIC HEALTH NURSING

IN BRITISH COLUMBIA FROM 1939-1959:

A SOCIAL HISTORY

By

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ABSTRACT

This study was designed to examine the status of public health nursing in British Columbia's Provincial Health Service during the period from 1939 to 1959. Based on the social history approach, the focus of the study was public health nursing and influences on its evolution during the selected period. The historical method was used to collect and analyze data from various primary and secondary sources; these included annual reports of provincial health units, annual reports of the Division of Public Health Nursing, journal articles, and oral histories.

Data were subjected to content analysis to reveal themes relevant to the topic. Several important factors were identified that had affected the development of public health nursing during the selected period. Data were categorized according to the various influences and research notes were written as a basis for the historical account. The presentation of findings included descriptions of the organization of public health services in the province and the role of the public health nurse. This was followed by a discussion of the forces and their impact on public health nursing. The study's conclusions were drawn from the analysis of the historical data within the social context of the time.

During the 1939 to 1959 period, some of the major

influences on provincial public health nursing were basic education for public health nurses, staff development on the job, the demand for services, and the supply of qualified personnel. Other factors were the social and political forces of the time, the health care system, and the role of voluntary agencies in public health care. Although public health nursing faced a number of problems, these were overcome to a large extent through creative strategies that promoted collegiality among staff and enhanced job satisfaction. Public health nurses had a strong sense of identity and were respected because their work contributed to improving the health of the communities they served.

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CHAPTER ONE

Background to the Problem

Community health nursing in Canada today has its roots in the public health movement that began early in this century (Allemang,1985). This link with the past is often overlooked in current discussions about the problems associated with the changing role of the community health nurse in a complex society. There is a need for a critical examination of the forces that have shaped this branch of the nursing profession in various regions of the country. The focus of this study is the history of provincial public health nursing in British Columbia during the period from 1939 to 1959.

Contemporary writings about community health nursing, as it is now known in Canada, present a common theme of a specialty area in a state of crisis (Chavigny & Kroske, 1983; Dreher, 1982; Gebbie, 1986). Problems cited are the lack of a clearly defined role; fragmentation and confusion about service priorities; an unwillingness to take a proactive stance on behalf of client groups; and the continuing focus on the individual and family rather than on the community as a whole. Although such articles are provocative, the authors rarely look to the past for explanations that could illuminate the present. Knowledge of the past is useful for broadening our perspectives on

current matters of concern to the profession.

Historical research in nursing is a field of inquiry that has received little attention until recently (Notter, 1972; Palmer, 1986). Over twenty years ago, Newton (1965) wrote of the need for research into the profession's past; she made a case for the importance of the study and recording of nursing history. Historiography is more than a simple listing of dates, facts, and significant events. According to Newton, researchers must look beyond the facts of the past; they need to search for relationships among events, recurring patterns, and influencing forces. What is important is the meaning of certain events within the social context of the time. Nurses' perspectives on the present and visions for the future are constrained by an incomplete understanding of the factors that have influenced the profession over time.

A change is occurring in the way in which nursing history is being studied by a new generation of scholars with increasing evidence of a shift away from the traditional approach to one that embraces the principles of social history (James, 1982; Lagemann, 1983). Traditional accounts of nursing history are characterized by an emphasis on the "progress" of nursing through time and a lack of attention to some of the controversies and problems of the past. Critics of this approach (Davies,1980; Melosh, 1982; Rosenberg, 1987) decry its congratulatory tone and

preoccupation with nursing leaders. Many of these historical accounts cover large periods of time but offer little interpretation of the past.

Although it is acknowledged that chronicles of key figures and landmark events have merit for the profession, historical study has the potential to reveal other realities in nursing's past. The application of the social history methodology gives rise to critical analyses of specific aspects of nursing within relatively short time periods. An example of this is found in the work of Melosh (1982) who places nursing within the contexts of women's history and labour history. Her emphasis is on the training and work culture of ordinary nurses rather than on the elite. A growing interest in the human experience of ordinary people, previously invisible in historical accounts, is emerging in the field of social history (Rosenberg, 1987).

Public health nursing has a rich and varied history around the world yet published accounts of the day-to-day experiences of public health nurses are lacking. There is evidence that this, too, is changing as social historians and nurses are becoming interested in the history of this unique branch of nursing. Heinrich (1983) found that American public health nurses of the nineteenth century were involved in providing services to immigrants, factory workers and poor families; this compelled them to advocate for social reform. Gradually, nurses working in public

health nursing agencies shifted their emphasis to health teaching and preventive measures and spent less time on bedside nursing care of the sick. Heinrich suggests that problems arose from the early twentieth century trend towards specialization within public health nursing as school, home, and maternal-infant nursing became separate services. The resulting fragmentation of service delivery led to a state of divisiveness in what could have been a strong, cohesive occupational group.

Buhler-Wilkerson's (1983) assessment of early twentieth century public health nursing in the United States is congruent with the situation described by Heinrich. At the turn of the century, it was a promising movement that was expanding to meet health needs of the time. By the late 1920s, however, it was in decline with the work of the public health nurse being "relegated to an increasingly marginal role in the health care system" (Buhler-Wilkerson, 1983, p.90).

A similar situation is described regarding the declining prominence of the work of the health visitor (public health nurse) in Britain during the first half of this century (Lloyd, 1986; Robson, 1986). Health visiting's focus on the poor and on women and children contributed to it being viewed as a low status activity in British society.

In Canada there has been a lack of critical inquiry into the history of public health nursing in this country.

A study of the emergence of public health nursing in early twentieth-century Halifax is a rare exception to the usual chronologies (McPherson, 1982). There are, however, several references that provide informative accounts of the roots of Canadian public health nursing (Allemang, 1985; Emory, 1953; Gibbon, 1947; Gibbon & Mathewson, 1947). A history of the district nursing service in Alberta contains many personal accounts of the experiences of rural public health nurses over a fifty year period (Stewart, 1979). An historical work that is specific to British Columbia is Green's book on provincial public health nursing from the turn of the century until the 1970s.

This study will contribute to the exploration of this topic by focussing on the official public health nursing service administered by the Department of Health of the British Columbia government. To delimit the topic, the time period from 1939 to 1959 has been selected. This choice is deliberate: 1939 marked the beginning of an era in public health nursing in this province with the establishment of the Division of Public Health Nursing within the Provincial Board of Health (Green, 1984). Furthermore, the historical significance of the date is noteworthy: the beginning of the Second World War had a great impact on the people of this province (Ormsby, 1958). The societal change that occurred during this period and in the immediate post-war era had an influence on public health nurses and their

practice. By examining developments through the decade of the 1950s, it will be possible to assess the impact of social change on public health nursing practice. The 1950s were characterized by improvements in the domestic economy and in international politics. The fifties were also a time of population growth due to increases in both the birthrate and immigration (Torrance, 1981). Scientific advances brought changes in the control of communicable diseases; mass immunization programs against poliomyelitis and improved treatment for tuberculosis had a major impact during this period (Green,1984). Thus, the decade of the 1950s was a period of change and expansion for public health nursing. For the purposes of this study, 1959 is chosen as the end point, marking the close of the decade. This study of public health nursing, therefore, will be circumscribed by a time frame of twenty years.

Problem Statement

A critical examination of a specific branch of nursing during a limited time period has the potential to reveal new insights on the past. Developments in public health nursing are related to various social, political, and scientific forces. The intent of the study is to examine the ways in which public health nursing was influenced by selected external and internal forces over a period of two decades. Therefore, the central research question is: What was the

status of provincial public health nursing in British Columbia during the 1939 to 1959 period?

Some of the specific questions explored in this study are as follows:

-What was the influence of nursing education on public health nursing practice?

-In what ways did political and social factors affect public health nursing?

-What was the relationship between the official public health nursing service and other agencies (such as the Victorian Order of Nurses) that provided similar services?

-Did public health nurses have any informal organizations during the period?

Definitions

Public health nursing - nursing service concerned with the prevention of community health problems through home visiting to families, school health programs, communicable disease control, and health education of the public.

Public health nurse - a registered nurse employed by the Division of Public Health Nursing, Department of Health, of the British Columbia government.

Study Objectives

The objectives of the study are set forth as follows:

1. To identify the factors that shaped the development

of public health nursing in British Columbia during the selected period.

2. To examine the responses of public health nurses to a time of social change.
3. To communicate the findings to Canadian nurses in order to increase awareness of one aspect of nursing's heritage.

Limitations

The nature of historical research presents several limitations. Chief among these are potential difficulties with availability of source material, authenticity and accuracy, and generalizability. The difficulty in making generalizations from the findings of historical research must be recognized. Although many common threads run through nursing history, it is important to remember that each era has its unique set of circumstances. Thus, the conclusions of this study will not necessarily apply to other periods in history or to public health nursing in other provinces.

Organization of Thesis

The organization of the remaining sections of this thesis is as follows: Chapter Two contains an outline of the methodology used in carrying out the study. This is followed, in Chapter Three, by the presentation and analysis

of the findings in relation to public health nursing and the influences on its evolution during the years from 1939 to 1959. The conclusions and implications of the study are presented in the fourth and final chapter.

CHAPTER TWO

METHODOLOGY

Given the problem chosen for investigation, this study utilized the methodology of historical research. The historical approach has several features which distinguish it from other forms of research: the nature of data sources, principles of historical criticism, and methods of analysis and synthesis (Christy, 1975). These factors were taken into account in the design that was followed, as outlined below.

Sources

Historical documents are categorized as either primary or secondary materials. A primary source is original material based on first-hand information (Polit & Hungler, 1987), whereas a secondary source is at least "once removed" from the original experience (Kruman, 1985, p.113). Material based on the observations of a person who actually witnessed or participated in an event is the most direct link with the facts. Therefore, although secondary sources are useful in research, primary sources are considered to be of greater value because the possibility of distortion of the truth is minimized. In this study both primary and secondary sources were used.

The initial phase of the data collection process

involved identification of sources and determination of their location. Primary sources used in this study are listed as follows:

1. Annual reports of provincial Health Units
2. Annual reports of the Division of Public Health Nursing
3. Minutes of the meetings of the Public Health Nursing Council (1955, 1956)
4. Files of the Personnel Practices Committee, Public Health Nursing Council (1952-1959)
5. School of Nursing collection, University of British Columbia Archives
6. Oral History collection, Registered Nurses Association of British Columbia

In addition, several secondary sources were used to supplement the findings from primary sources. These included articles published in issues of two national journals, the Canadian Nurse and the Canadian Journal of Public Health (some primary sources were found in these journals, also). Several articles and books on the Canadian health care system and the history and politics of British Columbia were consulted. It was not possible to locate two sets of materials that might have added other perspectives to the account. In proposing the study, the researcher anticipated having access to certain materials generated by the Division of Public Health Nursing during the forties and

fifties, namely, the minutes of the Public Health Nursing Council and the monthly newsletter, "Public Health Nursing News and Views." Apart from the years 1955 and 1956, the Council minutes were not saved, nor was it possible to locate any copies of the newsletter. This drawback was compensated for, in part, by finding several useful sources that were unanticipated at the outset. Although the Council minutes were unavailable, a number of other documents (committee reports and correspondence) pertaining to the Council were located. Other useful sources were the taped interviews with public health nurses who had practised during the 1939-1959 period, available through the Registered Nurses Association of British Columbia Library.

In collecting and organizing the data, many documents were photocopied from the original sources and arranged chronologically in three-ring binders for future reference. Four such data sets constituted the main content for the study. These were (a) annual reports of the Division of Public Health Nursing, (b) annual reports from eight provincial health units, (c) articles from the Canadian Nurse, (d) articles from the Canadian Journal of Public Health.

The reports of the Division of Public Health Nursing are contained within the reports of the Provincial Health Department and are available for all the years of interest to this study. They provide considerable information on

programs, staffing, continuing education, and organizational changes. Documents that supply rich data on public health nursing practice are the annual reports from the local health units. These reports contain detail about nursing activities and provide profiles of the communities they served. Many of the provincial units were not established until the 1950s; therefore, these reports are only available for certain years within the period under study. When combined, the reports provide substantial data on public health nursing for the years from the late forties through to the end of the fifties.

The selection of relevant materials in the journals involved going through each volume for the twenty year period. It was necessary, also, to review the journal volumes for one to two years preceding 1939 and following 1959 in order to gain a more comprehensive view of the period. Journal items--editorials, original articles, and news items--were selected on the basis of relevance to public health nursing. For example, articles that appeared in the Canadian Nurse included "Maintaining Standards of Public Health Nursing" (Chodat, 1942), "The Use of the Volunteer in a Public Health Nursing Service" (Barr, 1947), and "The Public Health Nurse Looks at Civil Defence" (Walker, 1957). In the Canadian Journal of Public Health the following articles were representative: "Desirable Qualifications for Public Health Nursing" (Emory, 1942),

"Professional Growth in Public Health Nursing Service" (Tate, 1946), "A National Health Program for Canada" (Martin, 1948), and "Newer Trends in the School Health Program" (Brown, 1956). The titles of the journal articles were indexed chronologically; there were 77 articles from the Canadian Nurse and 46 found in the Canadian Journal of Public Health.

Historical Criticism

Once data were collected, they were evaluated before beginning the analysis. As outlined by Christy (1975), data must be subjected to two types of historical criticism to establish reliability and validity. External criticism is concerned with the authenticity of a document. Written materials, such as letters and reports, must be examined for determination of authorship and the validity of the source itself. Once a document is considered to be valid, its reliability must be ascertained through the process of internal criticism. This involves the evaluation of the accuracy of statements within the document. As Polit and Hungler (1987) point out, the purpose of internal criticism is the determination of the worth of a piece of evidence. Content must be examined for the author's competence and biases. Corroboration of evidence assists in the establishment of reliability (Kruman, 1985).

In examining the evidence assembled for this study, the

researcher was aware of the potential for bias in many of the official reports. Authors of annual reports had a tendency to project a positive image of the department or health unit and, thus, there was little criticism. Official reports overlooked difficulties experienced by public health nurses in their everyday practice or working conditions. This bias was offset by more forthright accounts found in some of the journal articles and the oral histories.

This phase of the historical research process must be well executed before embarking on the next step. As Christy states, all sources "are not of equal value" (1975, p.190). This was taken into account as various sources were located and evaluated.

Analysis and Synthesis

The critical aspect in the analysis of historical data is the systematic search for meaning in the available evidence. This calls for selectivity regarding which data to include in the analysis, being certain to consider all material relevant to the problem (Fox, 1982). The process of selection of data, already referred to in the previous section, involved several reviews of all the available data in order to be clear about what to include and what to disregard. On several occasions, material surfaced that was of interest to the researcher; however, further examination showed that it was not pertinent to the study topic so it

was not used.

The process used to analyze the evidence began with review of all the assembled data sets. In particular, the health unit reports and the annual reports of the Division of Public Health Nursing were subjected to detailed content analysis. Key words and colour coding were used to identify the various categories. Some of the categories selected were education, social and political forces, supply of PHNs, funding, and volunteers. This part of the process enabled the researcher to review the data in a systematic fashion and develop thematic categories for further analysis. It was then possible to write research notes on individual topics, drawing upon the four main data sets and other secondary sources as necessary.

Analysis gave rise to the synthetic part of the process as the research notes were organized into an historical account. Direction for this stage came from the themes that emerged and the researcher's judgment about their relative importance. Several guides to historical thought and writing were consulted in this regard (Barzun & Graff, 1977; Shafer, 1974). At this point it was necessary to pay close attention to the art of historical writing (Allemang, 1973). It is important to present the findings in a logical sequence with explanatory comments incorporated in the text. As Shafer notes, the arrangement of historical evidence is an important part of the final synthesis. In this thesis

the major level of arrangement is by topic with the accounts presented chronologically.

Ethical Considerations

The ethical aspects of the study were reviewed and approved by the University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects. Throughout the study the researcher was guided by issues of confidentiality regarding documents in archival files and data related through personal communication. Copies of the completed study will be made available to the nursing profession through the libraries of the Registered Nurses Association of British Columbia and the Canadian Nurses Association (CNA).

Summary

In this chapter the steps in the historical research process were outlined. The way in which the process was applied in this study was described: data sources were located and selected, these were subjected to historical criticism, and content was analyzed. Finally, the findings were integrated into an historical account from which conclusions were drawn. This account is presented in the following chapter.

CHAPTER THREE

PUBLIC HEALTH NURSING AND INFLUENCES ON ITS DEVELOPMENT

A description of public health nursing practice in British Columbia and some of the influences on its evolution during the 1939 to 1959 period are the topics for discussion in this chapter. An overview of the organizational structure within which the public health nurse (PHN) worked is presented as background to this discussion. The latter part of the chapter contains an analysis of certain forces that influenced the status of provincial public health nursing.

Organization of Public Health Services

Provincial Health Structure

The history of the organization of public health services dates back to the Public Health Act of 1893 and the subsequent establishment of the Provincial Board of Health. From 1907 to 1946, the Board of Health fell under the auspices of the Provincial Secretary's Department. It gained departmental status in 1946 when the Department of Health and Welfare Act was passed. In 1959 another change occurred with the separation of the Health and Welfare branches into two ministries, the former becoming the Department of Health Services and Hospital Insurance. The jurisdiction of the Provincial Health Department was the

entire province apart from the cities of Victoria and Vancouver where public health services were administered by the civic authorities.

Nursing services were delivered in the early years by nurses operating within public health nursing districts and reporting to local boards of health. At the Provincial Board of Health level there was no senior nursing official, a circumstance that created problems for the nurses who felt the need for an advisor (Kilpatrick, 1938; McMillan & Law, 1938). The growth of the nursing service at that time also created the need for an administrative structure for nursing. This need was met in 1939 with the establishment of the Division of Public Health Nursing and the appointment of its first director the following year (Board of Health, 1940).

Several individuals helped to shape the province's public health system during its developmental period. Dr. Henry Esson Young was Provincial Health Officer from 1916 to 1939; under his direction public health nursing services and the first health units were organized (Board of Health, 1939). Dr. Young's early career included medical practice in northern British Columbia before he entered political life as the elected representative of the Atlin constituency in 1903. He served twelve years in the Provincial Legislature: from 1907 to 1915 he held the portfolios of Provincial Secretary and Education. His knowledge of the

conditions in the outlying areas contributed to his vision for the distribution of health services throughout the province. Widely respected as a public health authority, he held office in a number of Canadian and American professional organizations and received many honours for his achievements in the field.

His successor was Dr. Gregoire Amyot, a public health physician who had worked in Saskatchewan and British Columbia prior to an appointment at the University of Minnesota (Board of Health, 1940). As Provincial Health Officer from 1940 to 1962, he oversaw the restructuring of the Board of Health into a full government department in 1946, at which point he became Deputy Minister of Health (Department of Health and Welfare, 1946). According to Monica Green (1984), who worked closely with him, Dr. Amyot believed in the importance of local health services and, as a strong promoter of public health nursing, was instrumental in obtaining funds for preventive services. In summarizing his contribution, Green noted that "his continued support and encouragement kept the morale of the public health nurses high" (p. 125).

During Dr. Amyot's tenure in the Health Department, leadership within the Division of Public Health Nursing was provided by the three women who served as Directors. The first to hold the position was Heather Kilpatrick, a graduate of the University of British Columbia, who had

worked as a PHN in Duncan (Board of Health, 1940). In preparation for her appointment, she had been sent to the University of Toronto to study public health supervision. She provided "capable" leadership (Green, 1984, p. 53) and opened ten nursing districts from 1940 to 1944. In order to improve communication, Heather Kilpatrick started a monthly newsletter for PHNs and also initiated regular nurses' meetings. Following her resignation in 1944 (to work for an overseas relief agency), another member of the Division was appointed as her replacement: Dorothy Tate, also a University of British Columbia alumna, served as Director until 1948 (Department of Health and Welfare, 1948). She had a broad background in public health and knew the province well because of several years spent with the travelling Tuberculosis Clinic (Slaughter, 1988). She is remembered for her accomplishments in bringing in a uniform salary scale for PHNs, developing in-service education, and producing the first procedure manuals (Green, 1984).

The third Director was Monica Frith (later, Green) who served from 1948 to 1975. Her career with the Provincial Service spanned 35 years, beginning with rural public health placements in the Okanagan and the Kootenays in the early forties (Board of Health, 1944). As Director, she guided the Division through many changes including its expansion during the fifties. Her contribution to public health was recognized with honours presented by both the American

Public Health Association and Canadian Public Health Association. After she retired, Monica Green authored the first book to chronicle the history of public health nursing in British Columbia: Through the Years with Public Health Nursing was published in 1984.

When the Division of Public Health Nursing was created in 1939, the staff consisted of 44 nurses in various parts of the province. In the early forties two additional senior staff were hired to provide supervision to the field staff and to assist with administrative functions. Based in Victoria, the consultants (as they were known) made regular field visits, but were not available to deal with daily problems. As the Division grew from a staff of 44 to 111 over the period from 1939 to 1949, a great need arose for supervisors and senior nurses at the local level. As the Director of Public Health Nursing stated in her Annual Report for 1949, "supervision is necessary to ensure a quality of service which will meet acceptable standards" (Department of Health and Welfare, 1949, p. 53). The first such appointment was made in 1947 and others followed as the budget and availability of suitable candidates permitted. By the end of the fifties, 13 health units had supervisors; each supervisor had responsibility for a staff of from 15 to 20 PHNs, depending on the location. On Vancouver Island, for instance, the supervisor in Nanaimo had responsibility for 17 PHNs in the sub-offices of Lake Cowichan, Duncan,

Ladysmith, Parksville, Port Alberni and Nanaimo (Central Vancouver Island Health Unit, 1959). Although staff numbers were small, it is apparent that this type of supervision required considerable travel and a good understanding of the needs of the various communities. In 1959 the Division had a complement of 191 nurses, including the administrators in Victoria, local supervisors, and staff PHNs.

Health Unit Development

The health unit concept came into being in British Columbia as the most efficient means of organizing the delivery of public health services within a geographic region. Although part of the provincial health structure, each health unit had "regional autonomy, authority, and responsibility" (Department of Health and Welfare, 1952b, p. 44). A health unit's headquarters was designed to serve the largest population centre in a region and sub-offices were established in several other rural districts and municipalities. In the East Kootenay area, for example, the health unit had its main office in Cranbrook with smaller offices in Creston, Fernie, Kimberley, and Invermere serving these communities and their surrounding rural districts (East Kootenay Health Unit, 1954). Each sub-office was staffed by one or two PHNs and a part-time clerk; supervision was provided by the senior PHN in Cranbrook. When health units were developing in the forties, the personnel consisted of a medical officer of health, a

sanitary inspector, the PHNs, and clerical staff. Later, specialists such as dental consultants and nutritionists were added as services expanded in these areas.

The 1950s were a time of tremendous growth in the development of local health facilities and services. Until that time staff occupied office space in municipal buildings with the result that the health department lacked a distinct physical presence in the community. The availability of federal funding, through the National Health Grants, acted as a catalyst to a major building program under which local health centres were constructed (Department of Health and Welfare, 1952a). These new buildings, known as community health centres, were designed to meet the particular needs of public health programs. A typical health centre built in the 1950s was a free standing, one-storey building consisting of a reception area, staff offices, storage area, library, and clinic rooms. Some of the larger centres had meeting rooms for use by community groups and auditoriums for health education sessions (Green, 1984). In looking back at the impact that these health centres had at the time, Monica Green noted:

> At long last, public health nurses had suitable working quarters of which they could be proud. . . . It was a joy to have adequate space for child health conferences where counselling could be private and space for mothers' classes including room for exercise classes. . . . The health centres were at last visible and attractive and helped raise the morale of the staff and the prestige of the service in the community. (1984, p. 109)

As depicted above, the advent of community health facilities provided improved working environments for the nurses and enhanced program delivery at the local level. In total, 43 new community health centres were constructed during the period from 1951 to 1959; funding was based on a three-way cost sharing scheme (federal, provincial, and municipal) with additional assistance from the voluntary sector in some cases (Department of Health and Welfare, 1953; Department of Health Services and Hospital Insurance, 1959). Throughout this period staffing also increased to meet the demands of a growing population. By 1959 there were 16 provincial health units that, along with the two metropolitan units (Greater Vancouver and Victoria), provided public health services to the people of British Columbia (see Figure 1). Funding for the provincial units was based on an annual levy of 30 cents per capita at the local level (paid in conjunction with the school taxes) and was supplemented by operating grants from the Department of Health and Welfare.

Public Health Nursing Practice

Basic Programs

The public health nurse had a variety of responsibilities regarding the health of the community during the 1939 to 1959 period; the predominant aspects of the role were school nursing, communicable disease control, maternal-infant care, and visiting nursing (Board of Health,

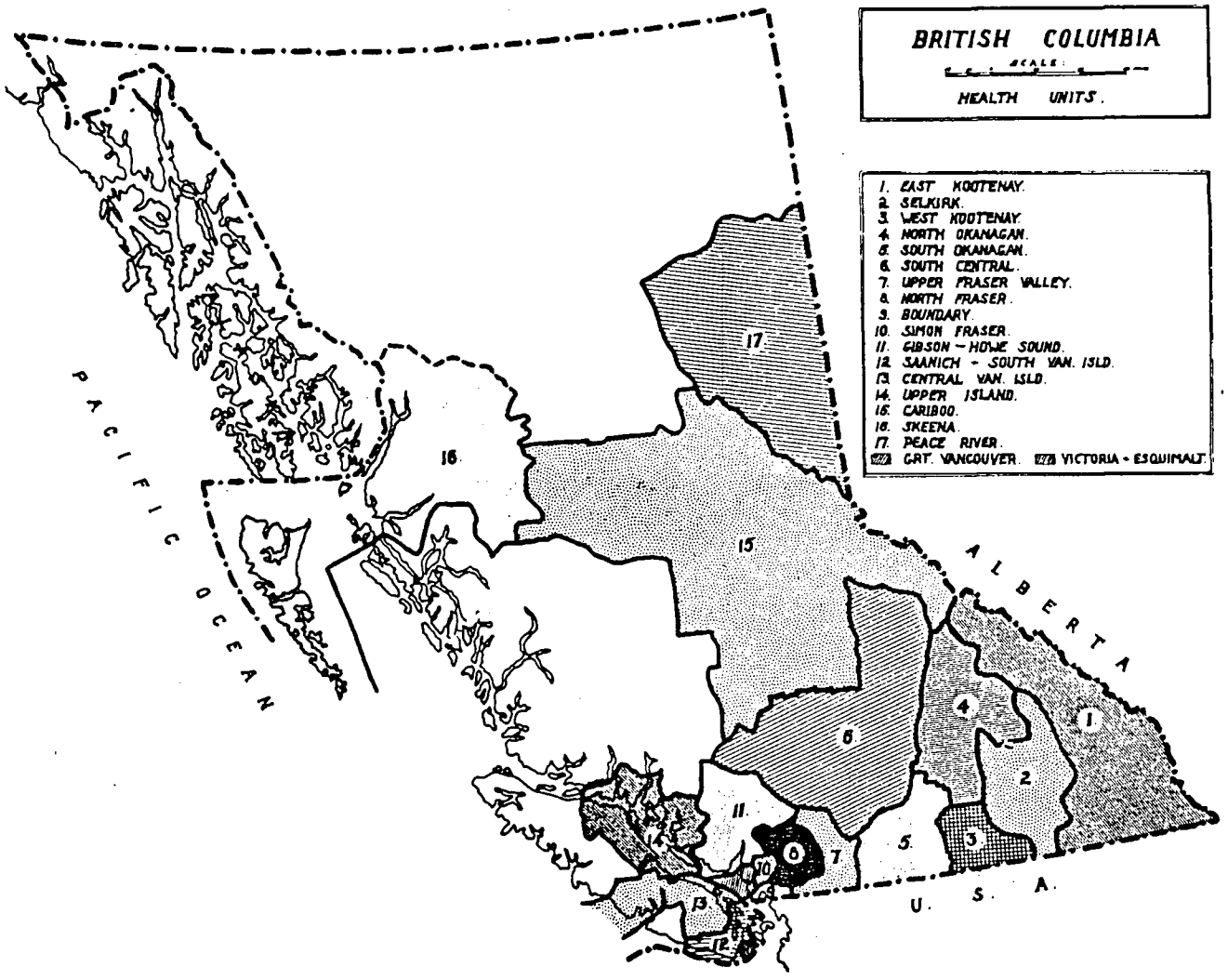

Figure 1. British Columbia Health Units in 1959.

From Taylor, J. A. (1962). The Health Branch of the British Columbia Department of Health Services and Hospital Insurance. In Canadian Public Health Association (Ed.), The federal and provincial health services in Canada. Toronto: Author.

Note. Gibson-Howe Sound became a health unit (Coast Garibaldi) in 1964.

1944). During the early years of public health nursing, services had been specialized so that a nurse carried out duties related to one program area only (e.g., school nursing and tuberculosis nursing). By the 1930s the Board of Health had moved to a generalized nursing program in which each PHN carried out all parts of the role (Board of Health, 1940). Beginning in 1944, all provincial public health nurses wore a distinctive uniform--a tailored navy blue suit over a white blouse with a hat and coat for outside wear (see Figure 2). Typically, a PHN served a population of 5,000, covering a geographic area within 20 to 50 miles from the health unit (Department of Health and Welfare, 1948).

School Nursing

As part of the generalized program, PHNs provided health supervision to all the school children in their districts. School-related duties centred around immunizing, screening for health problems, and controlling the spread of communicable diseases. In addition, the nurse acted as a resource for the teachers regarding health or behavioural problems observed in students. PHNs participated in the annual routine examinations carried out by physicians in the schools. Provincial legislation, the School Medical Inspection Act of 1911, made provision for every school child in the province to have a medical examination once a year. By the 1940s this was modified to the extent that all

Figure 2. Public health nurses in uniform, 1950. Chilliwack office, Upper Fraser Valley Health Unit. Photo courtesy of Nan Kennedy. Used with permission.

children in specified grades were seen by a physician, whereas the remainder were screened by the PHN (Board of Health, 1942). Lavinia Crane, who began as a Provincial PHN in 1951, describes the benefit of the examinations in the era before universal medicare:

> We used to do medical examinations on every child, every year. There weren't the resources; people didn't have medical plans and so on, so that even if they perhaps wanted to, it was difficult for them to get the money to get care. (Crane, 1987)

Sometimes a child living in a remote area had to go away for extended treatment in a major centre. Lavinia Crane recalls that the nurse made arrangements for any necessary financial assistance and also supported the family in coping with the separation. The nurses did much of the organizing for the medical inspections and the necessary follow-up of students' health problems (Board of Health, 1942; 1944). The 1944 Board of Health Report specified the nurse's responsibilities in this regard:

> Contact with the home--
> To follow up and explain defects discovered through physical examination of pupils.
> To assist in the control of communicable disease and to give advice concerning other public health problems in the home. (pp. 28-29)

The PHN's school role extended into the home; she provided information and explanation about health matters and was concerned with the health of the whole family.

School nursing also involved efforts to improve the poor nutritional status of the school population as revealed by the physical examinations (Department of Health and

Welfare, 1946). To offset this problem, some districts organized school lunch programs. According to an account by Margaret Little, PHN, in the 1938 Public Health Nurses' Bulletin, the school lunch program fulfilled a definite need in schools in Revelstoke. In that community, a school milk program was subsidized by a local service club; children were charged a nominal fee of 50 cents per month for half a pint of milk at lunch time, but no child was excluded:

> Those who cannot afford to pay receive this service free. . . . This service has proven a boon to the poorer children. I like to think that the added sparkle in their eyes and a slight bloom on the cheek is due to the daily milk service at school. (Little, 1938, p. 21)

Health teaching about dietary needs was seen as another way of bringing about improvements in nutritional status. In 1951 the Nutrition Service of the Department of Health conducted a dietary survey of 4,000 school children. The PHNs collected data in their schools; results showed that the majority of children had diets that were deficient in citrus fruits and other sources of vitamin C, milk, and vitamin D; moreover, many children were consuming large quantities of sugar in the form of candy and soft drinks (Department of Health, 1951). As a result of these findings, the Health Department initiated a novel method of demonstrating the principles of good nutrition through "rat-feeding experiments" (Department of Health and Welfare, 1951, p. 58). Schools received laboratory rats that were placed in classrooms and fed by the students. The

experiment involved feeding one group of rats according to Canada's food rules, while the other group consumed a diet of sweet foods. The dramatic differences between the groups of rats in terms of growth, activity, and stamina served to reinforce the message of the benefits of a balanced diet. This was a creative way to make health education come alive in the classroom and was, undoubtedly, one of the few times when public health personnel looked favourably upon the rat!

Communicable Disease Control

Communicable disease control in the general population outside the school was also a function of the PHN. It involved prevention of disease through immunization and health education. Tuberculosis was "a major public health problem" that demanded attention at the local level to bring it under control (Department of Health and Welfare, 1948, p.48). Throughout the forties, tuberculosis took its toll: in 1946, it ranked fourth as a cause of death in all age groups and was the leading cause of death among young adults (aged 20-39); that year there were over 2,500 cases of tuberculosis and treatment services were severely strained (Department of Health and Welfare, 1946). During this period, PHNs were involved in tuberculosis control and supervision of patients and their families; this included tuberculin testing, follow-up visits, and contact tracing. An important aspect of their work involved teaching patients and families precautions against the spread of infection

(Department of Health and Welfare, 1946). After the war, the advent of chemotherapy brought a major change in treatment: patients could be treated at home rather than in sanatoria and the PHN served an important function by administering streptomycin injections to patients in the community. In the late forties each PHN had approximately 20 tuberculosis patients receiving regular visits for follow-up care (Department of Health and Welfare, 1948). Although tuberculosis was responsible for deaths of nurses in previous decades, Health Department documents for the forties and fifties did not mention it as a major threat to the health of PHNs during this period.

Another health concern was venereal disease; in 1946 there were 4,618 cases of gonorrhea and 2,126 cases of syphilis, making the incidence the highest of all reportable diseases in the province (Department of Health and Welfare, 1946). Public health nursing duties in this regard centred around case finding and community education to prevent the spread of infection. Nurses received guidance for this aspect of their work from the Health Department's Division of Venereal Disease Control (Department of Health and Welfare, 1950).

A number of other communicable diseases posed a threat to the population of British Columbia during the forties and fifties. Statistics for 1946, for instance, showed that there were 63 cases of diphtheria, 17 cases of typhoid

fever, 597 cases of scarlet fever, and 167 cases of whooping-cough, all preventable diseases at the time (Department of Health and Welfare, 1946). Building up a high level of immunity in the general population was the best way to prevent their spread. The shortage of physicians during the war created a need for immunizations to be done by another group of workers and that authority was given to PHNs by the Provincial Board of Health (Board of Health, 1941). The importance of maintaining a province-wide immunization program during the war is shown in the Board of Health's 1943 Report:

> An extensive increase has taken place in the immunization of persons in British Columbia, particularly children. By this method of protecting children against diphtheria, scarlet fever, whooping-cough, smallpox, typhoid fever, and tetanus it is possible to prevent widespread epidemics of these diseases which would seriously tax and disrupt already overloaded hospital, medical, and nursing services in a period of war. Such immunization procedures, though always of great importance in peace-time, are a real war measure at the present time. (p. 14)

Carrying out a generalized immunization program involved more than the task of administering the injection; it required considerable organization by the nurses to set up clinics and keep accurate records. Further, nurses had to prepare their own supplies, often sterilizing syringes and needles over a hot plate in a community hall or a school. PHNs had to have current knowledge about dosages and spacing of immunizing agents and were required to exercise independent judgment in conducting these programs. It is

noteworthy that British Columbia's provincial PHNs were the first in Canada to take responsibility for all aspects of these programs as opposed to acting as assistants to physicians doing immunizations (Green, 1984). Born out of wartime necessity, public immunization programs remained as part of the PHN's role after the war. As a result of the distribution of PHNs throughout British Columbia and their ability to travel to the smaller communities to hold immunization clinics, the level of coverage increased and incidence rates declined over time. By 1956, 70% of the school population had been immunized against diphtheria; in that year there was only one reported case in the province (Department of Health and Welfare, 1956).

A major effort on the part of the nurses concerned the fight against polio in the 1950s. Polio outbreaks occurred in the early fifties, causing panic in local communities because of the serious consequences (Department of Health and Welfare, 1952). The incidence of the disease rose from 6.4 to 49.6 per 100,000 between 1950 and 1952 (Department of Health and Welfare, 1952). With the availability of the Salk vaccine, beginning in 1955, the Health Department undertook a major immunization campaign that lasted for several years. Protection was achieved through a series of three injections; therefore, it was a massive task to create a high level of immunity throughout the province. Health unit reports for this time showed that the PHNs put forth a

tremendous effort to conduct the immunization program; the following excerpt from a 1956 report presents a typical situation:

> The Salk vaccine program was very time-consuming. Besides the work of actually giving the injections it was necessary for our nurses to devote much time to the cleaning and sterilizing of syringes and keeping careful records which are required for a statistical evaluation of the vaccine.
>
> It has been necessary for us to cut back on some of our regular work to accomplish the polio vaccine program but we have been very glad to do this in view of the encouraging evidence of the high degree of protection afforded against the dread disease of poliomyelitis. (South Central Health Unit, 1956, p. 9)

Figures for the 1958/59 school year showed that over 86% of all school children had been immunized against polio; the incidence rate declined accordingly to 0.8 per 100,000 in 1958 (Department of Health and Welfare, 1958).

Maternal-Infant Care

The provision of preventive health services to mothers and infants was another major focus of the public health nursing program. During the forties, prenatal teaching took place in the woman's home and included instruction about nutrition, hygiene, the physiology of pregnancy, as well as preparation for the baby. After a baby's arrival, several visits were made to demonstrate infant care techniques and to monitor the new mother's health. Following the postpartum period, the home visiting usually ended and the mother was encouraged to attend the child health conference in her neighbourhood.

Child health conferences (also known as well baby

clinics) were adopted in the province, beginning around 1928, as the primary mode of delivery of public health services to the infant and preschool population (Board of Health, 1928). They were held at regular intervals in strategic community locations: church halls, community centres, and health unit offices. A typical set up involved an afternoon clinic to which women would bring their infants and young children (Boundary Health Unit, 1952; Skeena Health Unit, 1953). The PHN monitored growth, counselled mothers, gave immunizations, and made referrals to physicians when health problems were presented. At these sessions the nurse provided advice about common concerns of mothers in respect to child development, skin care, and behavioural problems.

Visiting Nursing

The provision of a bedside nursing service in the home was offered on a limited basis during this period. In the generalized nursing program followed by the Provincial Public Health Service, each nurse had a limited amount of time available to give bedside care to individuals who were ill at home. In situations where home care was required, the PHN made several visits in order to demonstrate home nursing techniques to family caregivers. In this way the patient's daily care was handled by the family and the nurse visited as needed to monitor progress or to carry out certain procedures such as injections and dressings

(Department of Health and Welfare, 1957). Some communities, including Trail, Surrey, Gibsons, and Oliver had a more extensive visiting nursing service provided through the Victorian Order of Nurses (Board of Health, 1943; Boundary Health Unit, 1957). During the fifties several experimental home care programs were launched and studied by provincial health authorities preparatory to establishing an official home care program (Department of Health and Welfare, 1951, 1958). The provincial Home Care Program was not implemented until 1974 (Green, 1984).

Program Development in the 1950s

As described above, the public health nursing program revolved around work with school children, mothers and infants, communicable disease control, and visiting nursing. There was considerable overlap among these program elements and, in all work, the family was the focus of service. In the fifties public health nursing added new programs to meet the needs of the time.

Around 1950 attention was focussed on the state of public health practice in Canada with the release of a major report commissioned by the Canadian Public Health Association: Report of the Study Committee on Public Health Practice in Canada (Canadian Public Health Association, 1950). Members of the committee were prominent nurses and physicians in public health; the field staff and authors of the report were Dr. J. H. Baillie, Executive Director of the

Association, and Lyle Creelman, who was on leave from her position as Director of Public Health Nursing in the Metropolitan Health Service of Vancouver. The Baillie-Creelman Report, as it was known, was based on an extensive study of official and voluntary agencies from coast to coast. The authors found considerable variation in programs around the country and noted serious deficits in some areas. They found that many agencies provided routine services year after year without ever examining their effectiveness. In regard to school services, they recommended that nursing time could be better spent on health education programs rather than on routine work of questionable merit (such as visiting all absentees). The Baillie-Creelman Report advocated a move toward more group work in health education; for example, it suggested that one-to-one prenatal instruction be replaced by group prenatal classes. The report was important because it presented, for the first time, a detailed account of actual public health organization and practice in Canada and gave constructive suggestions for ways to improve service delivery. Certain program modifications suggested in the Baillie-Creelman Report were already in place in British Columbia. Nevertheless, according to Monica Green who was Director of Provincial Public Health Nursing at that time, the guidelines had a "positive effect" on public health nursing (1984, p. 98). Much of the program development that took

place in the 1950s was guided by the progressive direction of the report.

Prenatal Programs

The 1950s brought the introduction and general acceptance of prenatal classes in the provincial public health program. In some areas it was necessary to introduce this idea cautiously to gain physician support. The following excerpt from the East Kootenay Health Unit Annual Report for 1954 indicates the rationale for prenatal education and shows that the nurses were aware of potential sources of resistance to this new program:

> This fall the first series of Prenatal Classes was held in Cranbrook , adding to a service that had been confined to home visiting.
>
> We feel that expectant mothers should be under the care and guidance of their family doctors throughout their pregnancy. However, busy doctors cannot discover and answer each mother's unspoken questions and doubts and we hope, through these classes, to lend our assistance. We feel that more understanding and knowledge increases the mother's sense of confidence and makes the whole experience happier and more satisfying to the mother. The series of classes includes information about the growth of the baby, good nutrition, prenatal care, labour and childbirth, as well as instruction on bathing the baby and the baby's care after he is home from the hospital. (p. 8)

The following year the report from this health unit indicated that the classes were gaining popularity and were being offered throughout the district. Consumer support seems to have been a critical factor in their acceptance. After the first classes, the participants were asked to complete an evaluation questionnaire; 100% of the women found the classes of value to them and their recommendations

for content were incorporated into subsequent classes. For instance, participants suggested that greater emphasis should be given to breathing exercises for labour and delivery and the importance of daily exercise. The Annual Report for the following year states that the nurses "revised the lectures in preparation for the pre-natal programme in 1955, putting more emphasis on the points which the participants in former classes found of greatest value" (East Kootenay Health Unit, 1955, p.8). Furthermore, the health unit staff consulted the maternity ward nurses at the local hospital and received a favourable response. By the late fifties, all health units were providing prenatal classes as the primary mode of prenatal education (Department of Health and Welfare, 1957). Although the PHN was concerned with expectant mothers, some units offered one or two evening sessions for fathers-to-be (Central Vancouver Island Health Unit, 1952).

Mental Health

Annual reports for the early fifties indicate that mental health or mental hygiene, as it was called at the time, was becoming a topic of concern. In the 1951 Annual Report of the Division of Public Health Nursing it was announced that a new mental hygiene program was being introduced, the purpose was "to promote mental well-being in all age-groups and to help prevent mental disorders and emotional disturbances" (p. 52). Mental hygiene principles

were introduced to the staff through in-service education programs at both the local and provincial levels. In 1953 all the senior nurses were sent on a two-week course at the University of Washington where the topic was covered in detail (Department of Health and Welfare, 1953). Rather than developing this as a specialized service, the Division's philosophy was the integration of mental hygiene into the generalized public health nursing program. This was consistent with the recommendations of the Baillie-Creelman Report that the generalist PHN was the appropriate field worker to carry out preventive mental health work. The PHN's work with young families was seen as highly conducive to promoting mental health:

> By relieving anxiety and building up the mother's mental security, the public health worker in contact with the mother and child at the child health conference has an opportunity to do more for the mental health of the community than in any other way. (Canadian Public Health Association, 1950, p. 47)

This basic approach to the prevention of mental health problems had merit within the context of the time and illustrates one way in which the PHN's role was broadened in the fifties.

Civil Defence

Another phenomenon of this decade was the concern over civil defence, clearly a reaction to the horrors of the atomic bomb and the development of biological warfare techniques. Public knowledge about their effects led to a movement to prepare Canada for the aftermath of possible

attacks. A federal department of Civil Defence was created to coordinate local efforts in disaster planning; this included plans for emergency hospitals, fallout shelters, and mobilization of volunteers.

Public health nurses were involved with educational programs focussed on nursing and civil defence and many nurses added their expertise to local planning endeavours. In 1951 the Public Health Nursing Section of the Canadian Public Health Association (CPHA) devoted its entire meeting to the subject. By the late fifties, however, interest had waned because the "threat of imminent disaster" had decreased and it was impossible for the civil defence movement to maintain its legitimacy (Nikitiuk, 1978, p. 47).

The Public Health Nurse's Role

As described above, the role of the PHN in the Provincial Service was varied: the work required a solid background in nursing as well as knowledge of epidemiology, nutrition, growth and development, and infection control in the home and community. The role included health teaching and counselling of individuals and families from all backgrounds (Creelman, 1941). PHNs were a source of information to members of the public in an era when lay people did not have easy access to health material (McArthur, 1952). As generalists, the nurses provided a broad public health program in their communities; this required excellent organizational abilities in order to

deliver an efficient and effective service. Although there was a central administration, PHNs at the local level functioned quite autonomously. The nurses planned their own daily schedules and spent many hours travelling around their districts (see Figure 3). Several PHNs who practised during this period recall that one of the chief attractions of the Provincial Public Health Nursing Service was the independence it allowed (George, 1987; Kennedy, 1987; Slaughter, 1988). Public health nursing was demanding in the forties and fifties, but it was worthwhile because the nurses knew that their work was important and "made a difference" to the health of the community (Norma Clark, personal communication, July 12, 1988). The nurses themselves and the public they served recognized the value of public health nursing.

Influences on Public Health Nursing

A number of factors shaped the direction of the Provincial Public Health Nursing Service during this period; some of the influences that were of particular significance are described in the remainder of this chapter. They include the impact of social and political forces on the development of provincial health services and on nursing practice. Basic education for public health nurses and staff development on the job affected the status of public health nursing. Other important factors, during the period

Figure 3. Norma Tucker (Clark), PHN, on the old Hope-Princeton Road en route to a clinic. 1948.
Photo courtesy of Norma Clark. Used with permission.

under consideration, were the demand for services and the supply of qualified PHNs to meet that demand. Also, the involvement of voluntary agencies in public health work had an impact on public health nursing services.

Social Influences

The evolution of public health nursing during the forties and fifties was influenced, to a certain extent, by the social climate of British Columbia at the time. Many factors, including population characteristics, politics, economics, living conditions, and societal attitudes acted as influences on aspects of public health nursing.

During the 1939 to 1959 period, British Columbia experienced a population boom: in one decade (from 1941 to 1951) the population expanded by 42%. According to census figures the population grew from 817,861 in 1941 to 1,165,210 ten years later; by the 1961 census it had reached 1,629,082 (Urquhart, 1965). This growth was considerably above the national average for the period. As pointed out by J. T. Marshall (1958), Assistant Dominion Statistician at the time, British Columbia's rate of natural increase had always been low compared to other provinces, a phenomenon attributed to the excess of males in the resource-based economy. Following the Depression, however, the situation began to change as the birth rate increased. The birth rate for the 1950-1954 period was three times greater than for the 1935-1939 period. This change also had an impact on the

age structure of the population: the under 15 age group doubled between 1941 and 1956. Factors thought to have been responsible for this situation were higher marriage rates and a trend toward earlier marriages and childbearing, as well as the social acceptability of larger families (Marshall, 1958). Migration continued to make a significant contribution to population growth as the economic activity of the forties and fifties attracted a large labour force (Ormsby, 1958). Adding to the migration figures was the steady influx of retirees from the prairies and elsewhere due to the favourable climate that made British Columbia "a haven for elderly people" (Marshall, 1958, p. 66).

While the demography of the province was changing, British Columbia also experienced a period of political change. The Liberal government of T. D. Pattullo dominated the political scene in the 1930s (Jackman, 1969). Although Pattullo had plans for grand schemes such as health insurance and major public works projects, they were not realized in his political lifetime due to the continuing depressed economy. A key member of the Pattullo cabinet was Dr. G. M. Weir, Provincial Secretary and Minister of Education, who gained a reputation as a reformer (Ormsby, 1958). Formerly the Head of the Department of Education at the University of British Columbia, he authored the 1932 Survey of Nursing Education in Canada (the Weir Report), which was widely circulated and formed the basis for many

subsequent changes in nursing education. Weir advocated the upgrading of nursing education and wider use of public health nurses. Pattullo's leadership of the Liberal party was contested and won in 1941 by his former Minister of Finance, John Hart. After the Premier's resignation, Hart formed a coalition with the Conservatives and led the province through the remainder of the war and into the post-war period. Hart's background in finance served the province well; his policies contributed to reducing the government's financial difficulties (Jackman, 1969). As a wartime Premier he is remembered for his part in the internment of the Japanese Canadians, "a blemish on the good name of Canada, British Columbia and John Hart" (Jackman, 1969, p. 239).

The Liberal-Conservative coalition continued through to 1952 with B. I. Johnson succeeding Hart as Premier from 1947 to 1952. Johnson brought in "progressive and constructive legislation" (Ormsby, 1958, p. 489), but party politics became turbulent in the early 1950s. Divisiveness within the coalition cleared the way for the entry of a new political party: the Social Credit party spearheaded by W. A. C. Bennett. First elected to power in 1952, Bennett appealed to the electorate with the promise of "middle of the road free enterprise government" (Ormsby, 1958, p. 489). Bennett took advantage of the improved economic climate to embark on major undertakings such as highway construction

and hydroelectric projects. Bennett's 1956 budget was, to use his description, a "great prosperity budget" (Mitchell, 1983, p. 233) in which civil service salaries were raised, additional grants were earmarked for municipalities, and a major road construction project was financed. Social spending, however, was kept under firm control. The government's stance on social policy was ruled by its opposition to the concept of the welfare state; this was supported by the voters who urged politicians to curtail welfare spending. The Bennett government's attitude to health and welfare was summarized as follows: "the Social Credit government provided the basic services for a relatively enlightened social policy, but the financial controls Bennett exercised as minister of finance ensured that frills and government-sponsored social experiments were almost nonexistent" (Mitchell, 1983, pp. 356-357). In spite of this, public health made certain advances during the fifties, probably due to the influence of the Deputy Minister of Health, Dr. Amyot, and the rising expectations of the public for health services in their own communities. As the 1950s came to an end, the government of W. A. C. Bennett was well established and had begun to put its mark on the province's political history.

The political and demographic changes of the period were closely connected to the province's economy. The Second World War marked the beginning of a growth phase in

the British Columbia economy (Ormsby, 1958). By 1941 the shipbuilding industry in Victoria and Vancouver was in full production as were other industries that manufactured items for use in the war. The west coast attracted workers from across Canada; at one point 30,000 workers were employed in the shipyards alone (Ormsby). The needs of the war industries stimulated other aspects of the economy throughout the province. On the northern coast, for instance, Prince Rupert became a supply base for the American forces stationed in Alaska and its population doubled. The province's natural resources were in demand: spruce trees were used in the manufacture of lightweight planes and minerals were needed for military purposes. Furthermore, the world-wide demand for agricultural products increased the value of cattle ranches, farms, and orchards. The economic activity was not confined to the urban areas but, rather, touched most parts of the province. British Columbia was fortunate to sustain this growth after the war. Capital from Eastern Canada, the United States, and overseas was invested in forestry and mining. Large company towns were created around new pulp and paper mills, aluminum smelters, and energy projects (Ralston,1982). In turn, service industries developed to meet the needs of an expanding population base throughout the province.

The new prosperity of the era, however, did not cause living conditions to improve overnight. Communities faced

problems with inadequate sanitation, housing shortages, and lack of public health services (Selkirk Health Unit, 1956; Skeena Health Unit, 1953). Public health workers were well aware that living standards affected health and that overall improvements in the community's health depended on adequate environments (Provincial Board of Health, 1941, 1942). This was recognized by Paul Martin, the Minister of National Health and Welfare, in a speech to the Canadian Public Health Association in 1948:

> Canada is among those countries where public health is shifting its emphasis and broadening its outlook to embrace all that affects human life. . . . In those wider applications of public health, full weight is now being given to environmental hygiene. Nutrition, housing, sanitation, recreation, economic and working conditions--all are now part of our ever-widening field of public health interest. (1948, p. 225)

One of the challenges of post-war reform was the improvement in general living conditions in order to decrease ill-health. Action on the causes of poor health and social problems was needed at the national, provincial, and municipal levels.

At the national level, a number of steps were taken toward the development of a public health insurance scheme. During the 1940s, the federal government sought to come to an agreement with the provinces to adopt a publicly administered health insurance plan (Torrance, 1981). The Liberal government of Mackenzie King envisioned that the plan would be financed by a 50-50 cost shared arrangement with the provinces; however, a major federal-provincial

conference in 1945 failed to come to an agreement on restructuring the tax system (Taylor, 1978). It was not until 1957 that a national health insurance scheme became a reality but, in the meantime, the federal government was under pressure to finance health and social programs. In 1948 the National Health Grants Program was launched to provide funding for specific needs in health services. This program had a major impact on public health around the country: public health agencies were able to draw on grant funds for programs, facilities, and professional training (Martin, 1948). The availability of the training funds, which were available from the late forties through to the sixties, boosted the ranks of public health nurses by enabling nurses to obtain public health training (Department of Health Services and Hospital Insurance, 1960). Thus, federal contributions to provincial health delivery systems aided the development of public health nursing in the post-war period. The interrelated forces of economics and politics influenced all aspects of life and public health nursing was affected by the conditions of the time. Closely related to these factors is another variable that must be considered in this discussion: the role of societal values of the forties and fifties.

Societal attitudes were influenced by and, in turn, had an influence on the circumstances of the period. The new prosperity led to an optimistic atmosphere around the

province as new housing and public facilities were being constructed in record numbers (Ralston, 1982). The return to peace created a feeling of stability that set the stage for the "baby boom" of the post-war years. In studying British Columbia census data, Marshall (1958) attributed increased fertility in the forties and fifties to changed attitudes regarding fashionable family size and a return to family values.

In discussing the characteristics of Canadian society in the post-war years, historian Donald Creighton (1976) noted that, although economic restraints had been lifted, Canadians did not indulge themselves: "The work ethic still sturdily confronted the pleasure principle" (p.247). Leisure time, according to Creighton, had a negative connotation and social life revolved around family life, church, and service clubs rather than pleasure pursuits.

Writing about American society of the 1950s, Miller and Nowak (1977) offer a critical examination of the decade that differs from the glamorization of the "fabulous fifties" (p. 3) as portrayed in popular culture of the seventies and eighties. Viewed with a certain amount of nostalgia, the fifties represented "a golden age of innocence and simplicity" (Miller & Nowak, p. 5) and marked the beginning of a higher standard of living and the promise of a better life in the suburbs. These authors point out that beneath the surface all was not well: the conformist mentality,

which prevailed in social life, politics, and education, masked serious problems and inhibited creative solutions. The dream did not materialize as expected; the emptiness of suburban life, especially for women, led to a discontent that was expressed openly in the 1960s (Friedan, 1963, 1981). This analysis can also be applied to British Columbia because of its connection to American culture. Suburban growth, for instance, was a noticeable feature of the fifties--by the end of the decade 68% of the population lived in urban areas and "bedroom communities" had sprung up around Vancouver (Taylor, 1962).

Public health nursing, as a profession dominated by women, was surely influenced by societal attitudes regarding the status of women. Although women made gains in the first half of the twentieth century, it was still "a man's world" in politics and the economy. The Second World War precipitated changes in women's involvement outside the home: the participation of Canadian women in the workforce rose from 24.4% in 1939 to 33.5% in 1944 (Pierson, 1986). In addition, almost 50,000 women served in the Canadian armed forces. The urgent need for women as workers in the war industries led to a remarkable set of supports and favourable working conditions for female employees. These included government-supported child care facilities (open 12 hours/day), after-school programs, part-time work, and "housewife shifts" (evening hours) at factories (Pierson).

Another incentive took the form of changes in the income tax legislation to encourage married women to enter the workforce. Pierson points out that these concessions were removed abruptly as soon as the war ended; the gains diminished as rapidly as they had occurred. The vital contribution of women to the war effort, at home and overseas, was recognized but "did not translate into an equal place for women on the post-war councils of the nation" (Pierson, p. 61). Women were expected to return to the home to leave room for the (male) veterans to re-enter the workforce. Although some women struggled to retain the wartime benefits (such as the day nurseries), attitudes toward working women undermined these attempts. The immediate post-war period saw the majority of women return to home duties; it took another twenty years for their participation in the paid workforce to equal that of the wartime peak (Pierson). Societal attitudes regarding working women had a definite impact on the supply of public health nurses. During the forties and early fifties, marriage was the chief reason for public health nursing resignations from the British Columbia Health Department (Department of Health and Welfare, 1946, 1950, 1952).

Education

From its beginnings public health nursing required specialized knowledge and skills beyond what was acquired through diploma nursing education in hospital schools. This

need was recognized prior to 1920 and led to the establishment of special courses at several Canadian universities to prepare qualified public health nurses. The impetus for these programs is thought to have come from increased awareness about the critical lack of public health measures in Canada in the wake of serious influenza epidemics in 1918 and 1919 and the need to bring about improvements in the health of the population (Gray, 1932). The most expeditious method of producing the type of person needed for generalized public health work was to provide public health training for graduate nurses through short-term courses. Early public health nursing courses, lasting from fourteen weeks to six months, were initiated at Dalhousie University, McGill University, and the Universities of Toronto, Western Ontario and British Columbia around 1920 (Gibbon & Mathewson,1947; Gray, 1932). Dr. H. Esson Young was the driving force behind the inauguration of the public health course for nurses in British Columbia; during the 1919-20 academic year it lasted fourteen weeks and expanded to nine months the following year (Gray, 1942). Initial funding for this course and those offered in other provinces came from the Canadian Red Cross (Porter, 1960).

At the same time, another influence on the development of public health nursing was the establishment, in 1919, of a degree program in nursing at the University of British

Columbia. The Department of Nursing and Health offered a combined university and hospital training course leading to the degree of Bachelor of Applied Science (in Nursing), as depicted in Figure 4 (Gray,1932). The purpose of the university course as explicated in the 1944-45 calendar was:

> The University offers courses in Nursing to students who desire to receive a broader education than can be secured in a hospital school of nursing alone, and who wish, at the same time, to prepare themselves for teaching or supervisory positions in schools of nursing or for Public Health Nursing service. (University of British Columbia, 1944, p. 241)

Students enrolled in the degree program spent two academic years at the University where they took arts and science courses along with other undergraduates. They then embarked on a 28-month period of nursing training at the Vancouver General Hospital from which they emerged as graduate nurses. A final year was spent back at the University (see Figure 5) where the students had two options for their course of study: teaching and supervision in schools of nursing or public health nursing. Starting in 1954 these options were merged into a generalized final year for the degree students. During the forties and fifties these courses were also available as certificate programs for graduate nurses meeting university entrance criteria (Gray, 1942). The public health nursing certificate course took ten months to complete and included practical experience in public health agencies.

The university calendar for the 1944-45 session

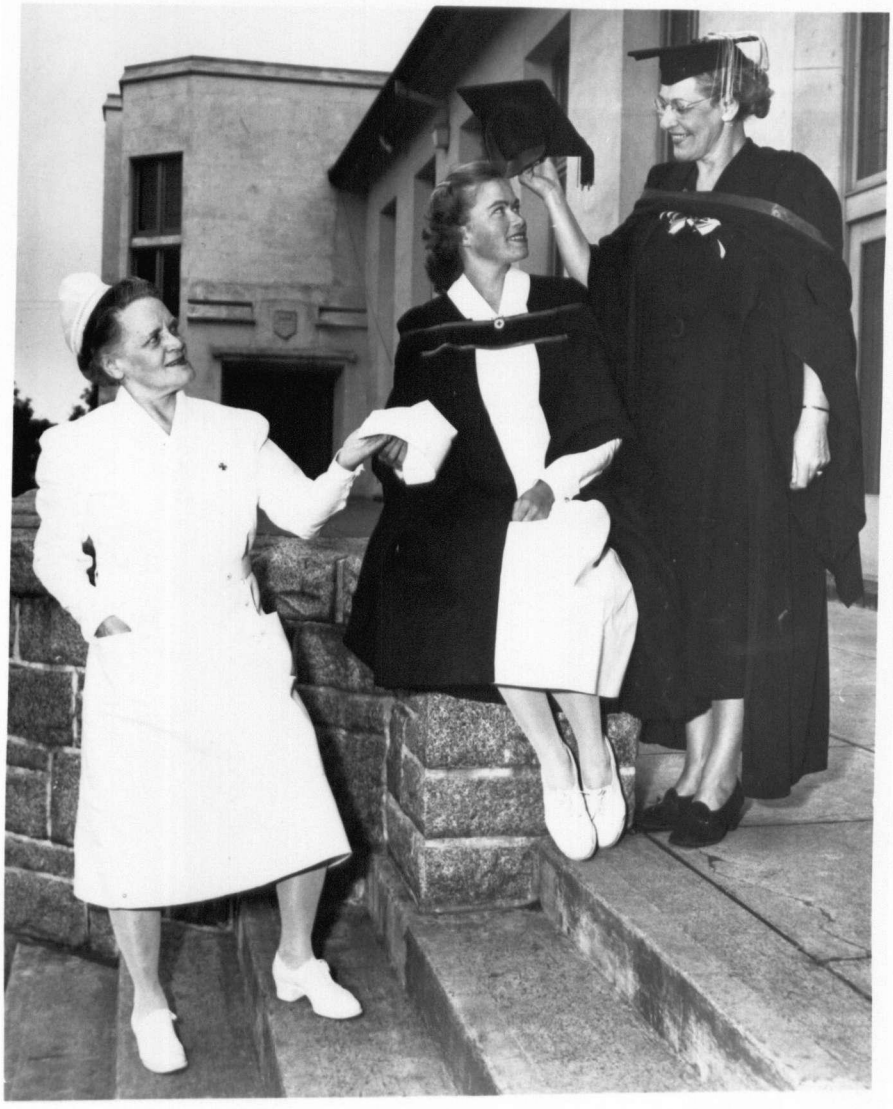

Figure 4. Graduation Day at the University of British Columbia, 1950. From left to right, Elinor Palliser, Director of Nursing, Vancouver General Hospital; Sheilagh Wheeler, Head of the Nursing graduating class; Ruth Morrison, Assistant Professor, University of British Columbia School of Nursing. Photo courtesy of UBC Archives.

Figure 5. Students in the Reading Room, University of British Columbia School of Nursing (Wesbrook Building) 1953. Photo courtesy of UBC Archives.

provides information on the public health nursing curriculum at that time; courses covered were preventive medicine, mental hygiene, infant and child health, sanitation, vital statistics, public health organization, principles of public health nursing, methods in health teaching, current nursing problems, principles of teaching, social case work, and sociology. This varied program shows that public health nursing knowledge was derived from a blend of public health science, education, sociology, and nursing. The calendar for 1944-45 offers a glimpse into the content of these courses. For instance, the course in sanitation was described as "a study of community sanitation and of relevant legislative measures" (p. 284). It involved one hour of instruction weekly and included field visits. Two hours per week were devoted to methods of health teaching which covered "the application of the principles of teaching to health instruction as carried out in the home, the school, and the community" (p. 285). Although preventive medicine was given the greatest emphasis (four hours per week), the students also spent much of their time on the social and health aspects of public health nursing (see Figure 6).

During the forties and fifties nurses taking the certificate course outnumbered the degree students. In the early 1940s, for instance, there were about eight degree graduates per year who specialized in public health nursing

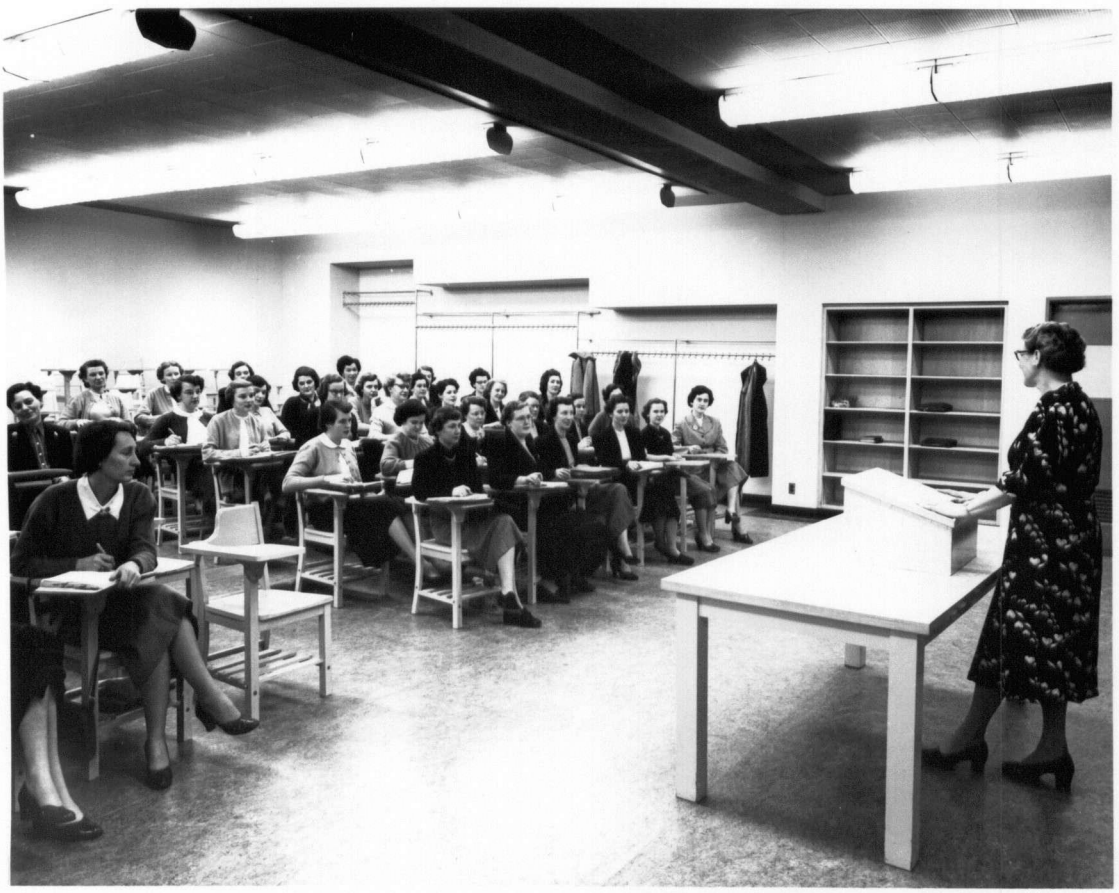

Figure 6. Final year students having a lecture in public health nursing, 1953. Photo courtesy of UBC Archives

in contrast to the 15 to 25 nurses who completed the certificate course. By the 1950s, the university program was attracting more students so that there were 25 degree graduates and 28 public health certificate recipients per year on average (School of Nursing Report, 1961).

Fieldwork was an important component of public health training and was provided in blocks of two to six weeks at selected times during the year. It is apparent that public health placements involved students in a different work environment from that of a hospital. One such difference is highlighted by the advice given in the calendar that "candidates for admission to Nursing B [the Public Health Nursing certificate course] are urged to obtain instruction in driving a motor car and to secure their driver's licence" (University of British Columbia, 1944, p.248). Norma Clark, a graduate of the degree course in 1947, recalls having a total of three months of public health fieldwork during her final year (personal communication, July 11, 1988). She spent one month each with the Victorian Order of Nurses, Metropolitan Health of Vancouver, and the Provincial Health Department; in all cases staff nurses provided orientation and field supervision. Students were given considerable independence and freedom; for example, they made home visits on their own and counselled mothers at child health conferences. Opportunities for field experience were provided by the following agencies: Children's Aid Society

of Vancouver, Provincial Health Department, Metropolitan Health of Greater Vancouver, Family Welfare Bureau of Greater Vancouver, Provincial Mental Hospital, Provincial Division of Tuberculosis Control, and the Victorian Order of Nurses. The following passage describes the role of the Provincial Health Department in this regard:

> Student field experience is provided for students from the University of British Columbia in selected areas throughout the Province to provide a period of orientation to the public health nursing program in rural communities, and to provide definite experience in the various phases of generalized service. (Department of Health and Welfare, 1946, p. 41)

Reports from individual health units indicated a supportive attitude toward the student program, although there are no accounts found of what the students actually did. This excerpt from the 1957 Annual Report of the Selkirk Health Unit is typical:

> We were privileged to have three students in Public Health Nursing from the University of British Columbia visit us for a period of one month for the purpose of having field-work experience. (p.23)

At provincial health units the students were supervised by experienced public health nurses who introduced them to rural public health. The 1956 Report of the Division of Public Health Nursing reveals that 29 students were assigned to various communities for fieldwork; these included Vernon, Kamloops, Kelowna, Chilliwack, Nakusp, New Denver, and Port Alberni (Department of Health and Welfare, 1956, p. 51). The Provincial Health Department subsidized the students' transportation to fieldwork locations; this was of

considerable benefit because of the distances involved. During that year the Cariboo Health Unit provided placements for two students from the University of Saskatchewan. The diversity of field experiences available to the students gave opportunities to apply content from their classroom learning to the practice situation.

From the preceding account, it can be seen that the theoretical and clinical aspects of the university program contributed to a comprehensive nursing education. There is, however, a question that merits further consideration in this regard: Did the nursing education of the time provide appropriate preparation for a career in public health nursing? As discussed above, there were two educational paths to becoming a qualified PHN: a one-year certificate course following nurses training and a degree program that included public health courses. On first glance these options appear dissimilar, but on closer examination it is apparent that the same amount of public health content was included in both programs. For the degree students, the public health content was not covered until the final year at which point they took the same courses as the nurses enrolled in the certificate course. Thus, for both groups of students, public health concepts were added on to a basic nursing education; the students had to shift their thinking from the sickness and curative orientation of the hospital to the wellness and preventive outlook of public health.

It can be argued, however, that the degree route to public health nursing gave students the advantage of knowledge and academic skills that would prove beneficial in their professional careers. Moreover, the first two years of university study (and involvement in university life) may have served to broaden the students' outlooks on life, clearly an asset in public health work. Nevertheless, the fact remains that hospital training had a significant socializing effect on these women; in no way was it conducive to preparing nurses for work that required independence in thought and judgment (Kennedy, 1987; Russell, 1933; Wallace, 1946). This was a fundamental weakness in the approach to educating public health nurses.

At the time certain leaders in Canadian public health nursing questioned the adequacy of this type of training. One of these was Florence Emory, President of CNA from 1930-1934 and the Associate Director of the School of Nursing at the University of Toronto. In an editorial in the Canadian Journal of Public Health, she stressed the importance of sound qualifications for public health nursing and the need to attract "young women of intelligence" (1942, p. 525) to fill leadership positions in an expanding field. Emory believed that PHNs had a significant role as professionals in the community and, as such, required a professional education of a high standard (1946). In her authoritative textbook, Public Health Nursing in Canada (1953), she

devoted a chapter to the issue of public health preparation about which she wrote:

> The validity of adding one academic year of specialized work to a basic training in nursing and calling the product a qualified public health nurse is gravely questioned. However, for financial and other reasons this type of preparation is likely to continue to be the chief source for providing staff workers for the field. This being so the certificate course should be made as rich as possible within the limitations imposed. (p. 83-84)

An alternative method of education that integrated preventive and curative aspects of nursing in an independent nursing school was considered by some as a more appropriate way of preparing PHNs. In Canada the first university program of this nature was initiated in 1933 under the direction of E. Kathleen Russell at the University of Toronto (Russell, 1933, 1938). The program grew from Russell's conviction that the preparation of nurses should be based on sound educational principles and a curriculum that had health as its focus. An important feature of the University of Toronto program was its independence from any one hospital; students received clinical experience in a variety of community and institutional settings. In 1942 a four-year course, leading to the Bachelor of Science in Nursing degree, was established to replace the three-year program. It provided generalized preparation for public health, hospital, and home nursing through the integration of relevant theory and clinical practice throughout the four years. The University of Toronto program served as the

prototype for "generic baccalaureate nursing education" (Allemang, 1985, p. 25) in Canada. Notwithstanding the advantages of this method, the predominant approach to preparation of PHNs during the forties and fifties was the one year certificate course (Canadian Public Health Association, 1950; University of British Columbia School of Nursing, 1961).

Another matter closely associated with basic education for those entering the public health nursing field was funding. Grants to universities from organizations such as the Rockefeller and Kellogg Foundations made it possible for courses to be offered in all aspects of public health (Canadian Public Health Association, 1942). Scholarships to nurses undertaking public health courses were also provided by these philanthropies. The need for training funds was a common theme in articles and editorials that appeared in the forties. In 1942, for instance, articles published in the Canadian Nurse, contributed by the Public Health Nursing Section of the CNA, called for greater funding for schools of nursing (Chodat, 1942) and stressed the need for scholarships and loans to encourage nurses to take public health training (Kerr, 1942). At that time Margaret Kerr (from the Department of Nursing and Health at the University of British Columbia and, subsequently, Editor of the Canadian Nurse) was the chairman of the Public Health Section. Under her guidance an extensive set of

recommendations for minimum qualifications was drawn up and presented to CNA. According to the Report of Studies Regarding Minimum Requirements for Employment in the Field of Public Health Nursing (Kerr, 1942), an integral part of any plan to raise standards was the availability of funding.

In 1948, the federal government embarked on the National Health Program to combat some of the major health problems in Canada; one part of this scheme involved the allocation of funds for professional training (Martin, 1948). Each year approximately 10 to 15 nurses working for the Provincial Health Department in British Columbia were awarded these grants to take the one year public health course after promising to serve for two years as provincial public health nurses upon completion of the program. The terms of these grants were considered "most generous," according to the 1955 Annual Report of the Division of Public Health Nursing (p. 51); bursaries covered tuition fees ($240 for the certificate course at the University of British Columbia), books, and provided $100 per month for living expenses. At that time there was a scarcity of housing on campus, but room and board were available in the adjacent residential district for a monthly rate of $55-$60 with light housekeeping rooms in the $25-$30 range (University of British Columbia, 1955). Grant recipients had the freedom to attend the university of their choice; some chose the programs at McGill, University of Western

Ontario, and University of Saskatchewan while others remained in the province at the University of British Columbia. There is no mention in the departmental reports about funding for travel to out-of-province universities; presumably this expense was the responsibility of the individual.

Over time, these grants were received by nurses who made a substantial contribution to increasing the number of qualified public health nurses in the provincial nursing service. During the twelve year period from the inception of the National Health Grant bursary program in 1948 to 1960, 91 nurses received public health training; over 80% remained with the Health Department for three years or longer (Department of Health Services and Hospital Insurance, 1960).

It is evident that the availability of both short-term courses in public health and training bursaries greatly expanded the supply of PHNs. This was an efficient and effective way of preparing a large number of public health workers for the Health Department's purposes. It should be pointed out that, although these women held a certificate from a university, they had not received a university degree; this constrained their opportunities for advancement within the Health Department and elsewhere. Thus, the bursary program can be viewed primarily as one that benefited the employer with a secondary benefit to the

employee. It is possible that continuing support for short-term training for PHNs hindered the advancement of public health nursing as a professional entity because it delayed making the baccalaureate degree a requirement for practice.

As the public health service expanded, the need arose for qualified people to take on supervisory and administrative functions. By providing study leaves and procuring funding, the Division was able to send potential leaders for advanced education. In the 1940s several nurses were recipients of Rockefeller and Commonwealth scholarships; they used these to study at institutions such as the Johns Hopkins School of Public Health and the University of Michigan. A number of the Division's leaders received their preparation in this way. For example, in the early forties Dorothy Tate was a staff member who was awarded a Rockefeller Fellowship to attend Columbia University from which she earned a Master of Arts degree in public health nursing administration. By 1944 she was appointed as Director of the Public Health Nursing Division. Her successor in 1948, Monica Frith, was another PHN who had been sent for graduate studies at an American university. She was a recipient of a Commonwealth Fellowship which financed her studies at the University of Michigan and a Kellogg Fellowship which gave her the opportunity to have field experience in five states before returning to British Columbia (Provincial Board of Health, 1944). Other senior

staff attended the University of Toronto and McGill where postgraduate programs in supervision and administration were offered.

In examining the outcomes of these efforts to prepare specialists and administrators, it is noteworthy that several potential leaders who were sent to Eastern Canada or the United States for advanced education did not remain in the province for their entire careers. It may be that their exposure to people and places outside their home province instilled in them the desire for greater challenges or a more cosmopolitan life. Margaret Cammaert and Lucille Giovando were two Consultant PHNs in the Health Department who left to join the World Health Organization (WHO) in the mid-fifties. In addition, several leaders who held senior positions in provincial and metropolitan public health nursing were part of this exodus. They included Lyle Creelman who left her position as Director of Public Health Nursing in Vancouver to work for a war relief agency, United Nations Relief and Rehabilitation Administration (UNRRA) and, later, to become Chief of the Nursing Division of WHO); Heather Kilpatrick, the first Director of PHN for the Provincial Board of Health who resigned in 1944 to do UNRRA work overseas; and Nan Kennedy, Senior Nurse in the Upper Fraser Valley Health Unit, who became a nurse tutor in Pakistan and Iran with WHO. Although public health nursing in British Columbia lost some of its leadership, these

individuals made an important contribution internationally. In some instances, after several years overseas, they returned to their home province with a world view that undoubtedly enhanced their practice. Likewise, British Columbia benefited by importing talent from other provinces and countries during this period. In 1948, for example, the Provincial Health Department hired PHNs from Manitoba, Ontario, Oregon, Missouri, and England (Canadian Nurses Association, 1948). Overall, funding for leadership development was useful because it facilitated the preparation of a collective resource from which the Provincial Health Department was able to draw certain individuals for executive positions.

To summarize this section: the scope and nature of public health nursing required educational preparation beyond that of a graduate nurse. In British Columbia this need was recognized in the 1920s and every effort was made by the Department of Health to secure and retain well-qualified staff members (Board of Health, 1941; Department of Health and Welfare, 1950). Beginning in 1928, the British Columbia Health Department required a public health nursing certificate or a nursing degree for permanent appointments to the Public Health Nursing Service (Department of Health and Welfare, 1950). The access of provincial nurses to the degree and certificate programs at the University of British Columbia facilitated this process

as did the availability of scholarships. In 1951, 38% of new appointees to PHN positions lacked the desired qualifications (Department of Health and Welfare, 1951); by 1959, however, 94% of the nursing staff were qualified PHNs (Department of Health Services and Hospital Insurance, 1959). During this period there was controversy over what constituted a suitable educational background for public health nursing practice; although some leaders called for higher standards and a movement into integrated university programs, the one year certificate courses for graduate nurses attracted the most candidates. During the 1939 to 1959 period there was an increase in the number of nurses prepared for both staff and administrative positions. As shown in the preceding paragraphs, education was a major influence on the development of public health nursing during the forties and fifties.

Staff Development

Once on the job, PHNs were able to avail themselves of opportunities for continuing education. The Provincial Health Department provided staff development, the scope of which ranged from local study groups to provincial meetings and national conferences (Department of Health and Welfare, 1956).

The most basic part of the staff development program took place at the local level and began with the orientation of new staff to the health unit. The amount of orientation

and initial supervision required depended on the background of the new employee. The shortage of qualified PHNs necessitated the hiring of temporary nurses who lacked public health preparation; these nurses needed an extensive orientation to district nursing. According to the Director's Report for 1949, the senior nurses were responsible for arranging this "time-consuming" (p. 53) orientation. In cases of qualified PHNs, orientation was less problematic; it usually involved familiarization with the district while the outgoing PHN was still present. New employees from other provinces received an orientation to the organizational structure of the Health Department (Department of Health and Welfare, 1949).

In a paper presented at the 1946 Conference of the Canadian Public Health Association, Dorothy Tate (Director of the Division of Public Health Nursing at the time) described the various opportunities for professional growth available to Provincial PHNs. She pointed out that the provision of a variety of experiences was an important aspect of the staff development program:

> To assist the nurse to maintain an 'alive' interest, she is given the opportunity of a transfer to a different type of district where she may have more responsibility. It is our policy to offer inducements to public health nurses to transfer every two, three or four years. (Tate, 1946, p. 497)

Health unit reports for this time certainly reflect this policy--there were frequent transfers of staff from one unit to another, sometimes after only one year. For example, the

reports from the South Central Health Unit (1952, 1953, 1954, 1955) show frequent turnover from year to year: a comparison of the staff lists for this period revealed that there had been a complete changeover in public health nursing staff from 1952 to 1954. Although this policy was justified on the grounds of adding variety and breadth to nurses' experiences (Department of Health and Welfare, 1946), there were several drawbacks. Transferring after one or two years in a health unit prevented nurses from getting to know any one community well. Loss of staff due to transfers and resignations within short periods may have led to lack of continuity in health unit programs. On the personal side, it is possible that it interfered with nurses forming strong relationships with colleagues and limited their social life in the community. Further, it must have been upsetting to members of the public to face numerous changes in health unit staff. Nevertheless, there was merit in having a systematic plan for staff advancement within the Division. PHNs who were judged to posses leadership potential were encouraged to accept new challenges and were gradually given more responsibility (Tate, 1946). As mentioned previously, potential leaders were given funding to pursue advanced education and were expected to take on senior positions upon their return.

In-service education was most appropriately carried out at the local level; therefore, time was set aside for

monthly meetings and study groups for all the nurses in a region. Topics were chosen according to the needs identified by the PHNs: in 1951, for instance, some of the groups studied prenatal care, civil defence, and the Baillie-Creelman Report (Department of Health and Welfare, 1951). Sometimes an expert was invited to speak on a topic; at other times the nurses held informal discussions or did some planning for a new program (South Central Health Unit, 1952). It is likely that these monthly meetings were appreciated by staff because many of them worked in one-nurse offices and were separated by a drive of several hours from their nearest colleague. Another aspect of staff development came in the form of a monthly newsletter, Public Health News and Views, produced by the Health Department staff in Victoria, to which field staff contributed (Department of Health and Welfare, 1946). The newsletter, containing book reviews, information updates, ideas from study groups, and personnel items, was distributed to every unit. Apart from its educational value, it was an important communication link for the PHNs around the province (Board of Health, 1943).

From time to time, opportunities were made available for staff to attend conferences or short courses. In 1948, the need to equip senior nurses for supervisory positions led the Department to offer a two-week course in public health nursing supervision (see Figure 7). In 1954, all

Figure 7. Provincial PHNs attending the first supervisory course in Victoria, 1948.
Photo courtesy of Nan Kennedy. Used with permission.

senior nurses, supervisors, and PHNs with seniority attended a pediatric refresher course, funded by a National Health Grant, in Vancouver (Department of Health and Welfare, 1954). Jointly sponsored and planned by the Public Health Nursing Division and the Department of Pediatrics at the University of British Columbia, the two-week course covered prenatal care, common childhood complaints, emotional development, and also included visits to several pediatric facilities. On several occasions the Division organized continuing education courses and brought in experts to meet particular program needs. One such course was held in Nanaimo in 1957 on the subject of prenatal services; 35 senior nursing staff attended this two-week session conducted by a Consultant from the Maternity Centre in New York. After completing this program, the participants were responsible for sharing the information with the field staff and for updating the materials and approaches used in prenatal education and home visiting.

The following year, ten staff nurses were selected locally to attend the Annual Conference of the Canadian Public Health Association in Edmonton. According to the 1955 Annual Report, these nurses benefited by obtaining information about new programs and by meeting public health staff from all parts of Canada. During 1955, also, a PHN participated in a nursing exchange program and spent the year working in England (Department of Health and Welfare,

1955). Although little detail is available on how the arrangements were made, the idea of such exchanges was viewed favourably by the Director of Public Health Nursing who expressed her hope that "the experience gained with this type of health agency will justify the extension of an exchange plan for public health nurses to other countries" (Department of Health and Welfare, 1955, p. 52). This was a novel method of job enrichment, but there was no mention in reports for the latter part of the fifties that this experiment was ever repeated.

Beyond local study groups and special courses, described above, there was another major event that contributed to staff development: the annual "Public Health Institute" (Board of Health, 1941). The Institute came into being in 1941 and was an expanded version of refresher courses that had been offered in the past. Its purpose was to bring together all the Board of Health employees--sanitarians, medical health officers, and public health nurses--for a continuing education program (see Figure 8). National and international authorities in the public health field were brought in as speakers and there were also sessions on policy changes and program reviews. The benefits for PHNs were outlined in the Director's report for 1950:

> The Annual Institute remains one of the most popular and effective methods of staff education. Here members of the staff have the opportunity of discussing their health problems in an objective manner in relation to

> similar problems throughout the Province, away from the immediate demands of the district. (Department of Health and Welfare, 1950, p. 42)

It is apparent that one of the chief advantages of the Institute, apart from its educational value, was the chance it afforded PHNs to meet, exchange ideas, and build bonds (see Figure 8). In particular, the nurses who worked alone in remote areas must have appreciated the group support. The venue, during the forties and fifties, was another attractive aspect: it was held at the Empress Hotel in Victoria during the Easter holiday period. A week in Victoria in the Spring was undoubtedly a bonus for the nurses from the interior and north of the province. Participants paid for their accommodation and meals and the Health Department financed the program, transportation, and a banquet. According to Monica Green (1984), who was a staff nurse in the early forties and then became Director in 1948, the social component served as a morale booster for staff. The highlight of the social program was the annual banquet where staff performed skits satirizing their work situations.

As the Health Department expanded and acquired more specialized staff members, the need arose for separate sessions at the Institute for the various disciplines (Department of Health and Welfare, 1951). In 1952, for instance, the nurses had one full day of strictly public health nursing content. Papers were presented on trends in

Figure 8. Public health staff on the steps of the Parliament Buildings, Victoria, at the time of the Annual Institute, 1949. Photo courtesy of Norma Clark. Used with permission.

maternal care, vision-testing, and the family of the tuberculosis patient; the day concluded with a panel discussion on nursing supervision (Department of Health and Welfare, 1952, p. 40). Thus, the program was geared to the practice needs and current interests of the staff nurses.

It is evident that the Provincial Health Department offered a staff development program that was designed to meet the continuing education needs of PHNs. As detailed above, there were various means of stimulating the exchange of ideas among the nurses and facilitating their professional growth. In particular, the annual Institute made a significant contribution to continuing education and served to raise morale and engender loyalty within the Health Department. The monthly study groups and the newsletter helped to combat isolation during this period. It is difficult to find fault with this comprehensive program, but one of its shortcomings may have been that some of the educational events were limited to senior staff. From the point of view of the staff nurse this may have been resented; on the other hand, it may have served as an incentive to attract PHNs to senior positions. Overall, these efforts had a positive influence on the professional development of public health nurses and enhanced their work in the community.

Supply and Demand in Public Health Nursing

The war years and their aftermath focussed attention on

the issue of supply and demand in relation to public health nurses. As communities became more aware of their unmet health needs, there was an increased demand for public health services:

> Indicative of this increasing health consciousness is the request from various centres for information concerning the establishment of a Public Health Nursing Service. At the present time, and for some months now, the demand for Public Health Nurses has far exceeded the supply. (Board of Health, 1941, p. 87)

Thus, pressure from municipal governments was brought to bear on provincial authorities to extend services to more communities. Even in places where public health nursing was established, there were periodic difficulties in keeping positions filled. In 1942 several nursing districts were closed temporarily due to unavailability of PHNs (Board of Health, 1942).

Another factor that influenced demand was the rapid population growth of the 1940s. The population of British Columbia increased by 42% during the period from 1941 to 1951 (the greatest percentage increase of any province for that census period), with the northern and interior regions of the province experiencing the greatest growth (Department of Health and Welfare, 1951). Naturally, this placed considerable strain on health services particularly in the areas undergoing unprecedented settlement. The existing supply of nursing and medical personnel was inadequate to meet the demand.

The Second World War had an indirect effect on the need

for public health nurses in British Columbia. The issue of the shortage of health professionals was made explicit by a major survey on health services in Canada conducted during the war under the auspices of the Canadian Medical Procurement and Assignment Board (1945). This Board was established in 1942 by the federal government to "secure physicians for the armed forces and at the same time to endeavour to preserve adequate medical services for the civilian population" (Canadian Medical Procurement and Assignment Board, 1945, p. xix). In 1943, the Board conducted the National Health Survey to determine the existing supply of medical personnel and the current status of health services in each province. With respect to public health, the report indicated that services were strained due to enlistment of public health physicians and administrators. Conditions in British Columbia were reported by Dr. G. F. Amyot, Provincial Health Officer at the time, who stated that the Board of Health had been "seriously depleted" (p. 118). Dr. Amyot's description of the situation and its impact on public health nursing was reported as follows:

> Owing to the reduction in the number of medical men in all areas of the Province, the medical practitioners remaining were overloaded to the extent that those who had been carrying out duties as medical officers of health and school health inspectors have had to curtail their work to a very large extent....To offset this, the public health nurses were performing duties not formerly permitted of such a group. Four public health nurses were urgently needed and any curtailment in this service would constitute a serious menace to the

public health work. (p. 119)

In British Columbia and elsewhere in Canada, public health services had been reduced to a minimum and PHNs filled the gaps left by physicians who were engaged in military medical service. For this reason public health nurses were urged to remain on the "home front" to serve the civilian population (Board of Health, 1941).

The National Health Survey also contained a report prepared by the Canadian Nurses Association, on the nursing situation in Canada. Based on data obtained in 1943 through registration of all civilian nurses by National Selective Service and a separate survey by the CNA, the report showed the existence of a nation-wide shortage of nurses in all types of institutions and public health agencies. At that time there were 52,483 civilian nurses, of whom only 22,136 (42.2%) were employed in nursing. There were 25,298 non-practising nurses whose reason for inactive status was marriage. Of the 7,216 nurses who left the profession between 1939 and 1943, 84% did so because of marriage.

The seriousness of the nursing supply problem was discussed by N. D. Fidler (1947) in an article published in the Canadian Journal of Public Health. Fidler, a nurse-educator, was the Director of the Metropolitan School of Nursing in Windsor, Ontario. In examining the 1943 CNA statistics and several later reports, she concluded that the shortage was caused, not by a lack of people undertaking

training, but rather, due to the loss of qualified nurses to marriage. Fidler also pointed to other factors that compounded the problem: high wastage of student nurses due to poor conditions in nursing training and improper use of nurses to perform non-nursing duties. She felt that measures to conserve the existing supply were needed and stated that it was important to "use nurses for nursing" (p. 514). The complex issue of the supply of nurses was created by forces both external and internal to the nursing profession.

It is apparent from the above that the nursing supply problem was experienced nationally and that all areas of nursing practice were affected. Public health agencies across Canada were beset by difficulties in recruitment and retention of PHNs; the need to remedy this situation was one of the motivating forces behind the Baillie-Creelman Report (McArthur, 1951). The findings described in the Report of the Study Committee on Public Health Practice in Canada (Canadian Public Health Association, 1950) revealed several problems that were common to most agencies across the country. These included inadequate salaries and lack of annual increments, underutilization of support personnel and volunteers, and decreased job satisfaction due to routine duties and lack of room for creativity. Moreover, serious understaffing placed a heavy burden on existing staff to carry out essential programs. Another factor closely

related to working conditions was the quality of the office space occupied by public health agencies. The report's authors were critical in their appraisal of the facilities they visited as part of the study:

> With few exceptions, health departments are unattractive places to which the average mother would hesitate to take her children or herself for health services, and the average tax-payer would certainly not be impressed by the appearance of the housing of the health agency.
>
> The generally poor housing facilities allocated to health agencies are another indication of the "poor relation" status of public health in the minds of governments and the public generally. If the public is to be attracted to the excellent services that public health can offer a community, surely the centres at which these services are offered should at least be clean, attractive, centrally located and large enough to permit the full functioning of a good program. (p. 24)

The above comments were written from the perspective of improving the image of public health agencies, but it is apparent, also, that inadequate work environments must have had a negative effect on staff morale. Other suggestions were made to agencies to enhance working conditions, namely: to raise salaries and provide benefits, to offer continuing education on the job, to provide regular staff evaluations, and to arrange for more clerical assistance for PHNs. The message of the Baillie-Creelman Report was clear: the shortage of PHNs was linked to serious inadequacies within health agencies; the situation could be improved if agencies (and the various governments) responded to the recommendations for improved working conditions.

Public health nursing in British Columbia was not

immune to the problem of retention of staff to meet the demand of the period. In 1949 there were 111 public health nurses, 67 (63%) of whom had been on staff for less than three years (Department of Health and Welfare, 1949). Turnover was high: that year there were 28 resignations and 41 new appointments. Resignations continued at a rate of 26% per year into the early fifties (Department of Health and Welfare, 1952). The problem of recruitment and retention of staff was of particular concern in light of the needs of the province's population at that time. The high birth rate in the post-war period created a great demand for maternal-child services in local communities and, as this cohort moved into school age, additional demand was produced. The difficulty of meeting the demands brought about by population changes was evident in the 1958 Annual Report of the South Central Health Unit (Kamloops Region): "We have had the addition of only one nurse to our staff in the past five years though the school population has increased by nearly 3,000 in that period" (1958, p.4). Solutions were required to conserve the supply during a period of increased demand; in British Columbia's Provincial Health Service several steps were taken to minimize this difficult situation.

The issue of personnel policies was central to maintaining an adequate supply of PHNs. This was recognized by Heather Kilpatrick, the first Director of Public Health

Nursing, who wrote:

> Although some progress has been made, complete adjustments in salaries have not been accomplished as yet and there is no uniformity in the provision of cost of living bonuses. Work is still going on with regard to formulating a pension plan, but as yet establishment of this desirable factor in working conditions has not been attained. These matters are of vital importance to the workers and efforts to bring about satisfactory conditions are being continued. (Board of Health, 1942, p. 74)

Concerns about such issues led to the formation, in 1943, of an organization through which the PHNs could discuss common problems and make their views known to the Director of Public Health Nursing. Known as the Public Health Nursing Council, it convened each year at the Institute to deal with matters such as uniforms, policy changes, and employee benefits. The Council elected a president and voted on resolutions brought forward from the regional study groups. It served as a "unifying" force for the nursing staff (Department of Health and Welfare, 1950, p. 42) and was considered to be "a very democratic organization," according to Nan Kennedy, a Council president from 1950-1952 (personal communication, May 19, 1988). On occasion, the group chose delegates to represent the public health nursing staff at national and international meetings, including a meeting of the International Council of Nurses in 1949 and the 1950 CNA Convention (Department of Health and Welfare, 1949, 1950).

In 1951 the Nursing Council agreed to form a Personnel Practices Committee to make representation on behalf of the PHNs to the Civil Service Commission. This was their first

step in collective bargaining for improvements in salaries and benefits. Low salaries for PHNs in the Provincial Service were a barrier to recruitment throughout the forties and fifties, according to the Director of Public Health Nursing (Department of Health and Welfare, 1953, 1954). In 1953 the Personnel Practices Committee presented a brief to the British Columbia Civil Service Commission recommending a revised salary schedule more in line with that of the Metropolitan Health Service of Greater Vancouver; this was granted the following year (Public Health Nursing Council, 1954). The Committee continued its activity through the decade, securing further salary increments from time to time, but always lagging behind the Metropolitan Health Service. Figures for 1957, for instance, show a monthly starting salary of $318 for a PHN in Vancouver, whereas a Provincial PHN received $290. This was well below the $315 minimum PHN salary recommended by the Registered Nurses Association of British Columbia (Public Health Nursing Council, 1958). The frustration with salary levels remained a concern for the nurses, as shown in the following excerpt from a letter to the Civil Service Commission prepared by the Personnel Practices Committee:

> The members of the Public Health Nursing Council of the Department of Health of the Province of British Columbia were pleased to receive a salary increase in April 1959, bringing the starting salary for Public Health Nurse Grade I to $324.00 per month.
>
> Previous to this salary increase there had been a deterioration in morale amongst the public health nursing staff and much difficulty was experienced in recruitment

> of qualified nurses....The public health nurses employed during this period of low morale hope never to experience again the lack of advancement, and even curtailment, of needed programs....Many of our experienced nurses remained in the service only through a sense of loyalty to the public and through a satisfaction felt in serving their communities. (Public Health Nursing Council, 1959)

The letter went on to request, once again, an additional increase to bring salaries into line with those received by their counterparts in Greater Vancouver whose salaries were a full 10% higher in 1959. The wording of this brief highlights the persistence and determination on the part of the nurses to achieve their goal of reasonable compensation for a demanding job. The Nursing Council's accomplishments in salary negotiations and other aspects of working conditions yielded some positive results that helped to raise morale and develop a strong identity within the Public Health Nursing Division. It should be pointed out that, despite the efforts and achievements of the Council in the fifties, there remained many issues regarding working conditions that were carried over to the next decade.

As described above, the nurses themselves took action to alleviate some of the problems in public health nursing. There were also several measures taken by the administration within the Health Department to deal with the supply problem. One of these was the establishment of a trainee or internship program, beginning in 1948, to compensate for the lack of qualified PHNs in the province (Department of Health and Welfare, 1948). Under this scheme a limited number of

nurses who lacked a public health diploma or a nursing degree were hired and provided with some on-the-job training to equip them to perform a modified public health nursing role. After a period of satisfactory performance, they were awarded bursaries through the National Health Grants to enable them to take the certificate course. Upon completion of their studies they were expected to return to the Health Department for at least two years. This was certainly a pragmatic way of combatting the problem of the PHN shortage through the fifties; once this program was underway, the Health Department had a guaranteed supply of ten to fifteen newly qualified PHNs each year.

The Provincial Service found another solution in the employment of married nurses. Although not as mobile as single women, they were a valuable resource from which vacancies were filled. For the most part, they were qualified PHNs who had worked for several years before resigning to be married. During the forties when their services were in demand, many of these experienced PHNs returned to work in their home communities and were viewed as an asset (Department of Health and Welfare, 1948). By 1953, married PHNs accounted for about 20% of the Division's staff (Green, 1984). In this way, the shortage of trained PHNs had a favourable impact on those married nurses who either wished or needed to work. Prior to the forties, many agencies did not hire married women; the increased demand

during the war and afterwards forced a reversal in employment policy. In this regard it is noteworthy that the following resolution was passed at the 1944 Annual Meeting of the Canadian Public Health Association:

> Whereas discrimination against the married public health nurse with reference to employment has existed in the past, and
> Whereas married nurses have contributed substantially to the maintenance of essential services during the war emergency, and
> Whereas some of these nurses may wish to continue in the field of public health nursing, therefore
> Be it resolved that the Public Health Nursing Section of the Canadian Public Health Association recommend to employing agencies that, in the future, applications from married nurses be considered on the same basis of qualifications, experience and individual circumstances as those from unmarried nurses. (CPHA, 1944, p. 489)

The utilization of married public health nurses during the war and the continued need for their services in the late forties and early fifties led to their acceptance by peers and administrators. Although the idea of married women having independent careers was not generally accepted in Canadian society at that time (Pierson,1986), it seems that within the milieu of public health nursing this idea was more favourably received.

Another measure to retain staff and maximize their effectiveness was the utilization of lay support staff to assist the PHN. This idea was one of the recommendations of the Baillie-Creelman Report (CPHA, 1950). Time studies conducted by the Public Health Nursing Division in 1950 showed that the nurses were spending over 10% of their time on clerical work, preparing supplies, and cleaning equipment

(Department of Health and Welfare, 1950). On the strength of these studies, clerical assistance was provided at certain health units. Progress in this regard was somewhat slow, however, and nurses continued to spend considerable amounts of time on non-nursing functions. Finally, in 1957 the first health unit aides were hired to free the PHNs from some of these tasks. In units where this type of help was available, it allowed the nurses to use their skills to the fullest and presumably enhanced job satisfaction.

Although the Provincial Health Service experienced difficulties due to the shortage of PHNs, it managed to avoid some of problems that were common elsewhere in the country (Kerr, 1941). As shown by the Baillie-Creelman Report, British Columbia's Health Department had the highest percentage of trained PHNs of any provincial agency (Canadian Public Health Association, 1950). The report also showed that the Provincial Health Service had one of the best rates of PHN coverage in Canada: one nurse for every 4,000 people. Other provinces had ratios of 1:6,000 (Manitoba) and 1:10,500 (New Brunswick), and the ratio for Canada as a whole was 1:5,200. Furthermore, as discussed previously, the Health Department had an extensive program of continuing education, something that many other agencies lacked at the time. The findings of another study carried out around the same time also cast a favourable light on the administration of public health nursing services in British

Columbia. This was a 1949 study of the Provincial Public Health Nursing Division conducted by Lucile Petry, Assistant Surgeon-General of the United States Public Health Service, as part of a larger examination of health services in the province (Department of Health and Welfare, 1949). Her comments were quoted in the department's report for that year:

> The Health Branch of the Department of Health and Welfare has an exceedingly well-conceived plan for public health nursing service in the Province and has succeeded in implementing the plan extensively. . . . The nurses in this service are generally well prepared and receive expert and dynamic leadership. A stimulating permissive atmosphere pervades the service, and co-operative planning is evident both among the nurses themselves and between nursing service and the administration. (Department of Health and Welfare, 1949, p. 55-56)

All things considered, the endeavours of the Provincial Health Service to maintain a high standard during a time of great demand were successful. The increased demand began during the war and continued with the population boom of the post-war era. A combination of factors led to a severe shortage of qualified PHNs; chief among these were low salaries, poor working conditions, and loss of nurses to marriage. By taking action on some of the causative factors, the PHNs themselves played a part in bringing about improved working conditions. Administrative initiatives to deal with the situation were also responsible for advancing public health nursing in the province.

Influence of Other Agencies

The voluntary organizations and various community service groups played a part in public health nursing during this period. Most notable were two agencies with a history of involvement in Canadian public health: The Victorian Order of Nurses (VON), and the Canadian Red Cross Society. In addition, local service clubs provided financial assistance and the services of volunteers.

Branches of the VON existed in Victoria, Surrey, Greater Vancouver, Oliver, Gibsons, and several other communities (Board of Health, 1943). As a voluntary agency, the VON was only active in those communities that had requested its services; its work was viewed as being "supplementary to that of the official agency" (Creasy, 1939, p.321). In the early years VON staff, most of whom were trained PHNs, carried out a varied program of bedside nursing, newborn visits, and prenatal instruction. A nurse with the VON in Victoria during the forties recalls being sent to the Maternity Centre Association in New York to study a prenatal exercise program that she incorporated into their classes (Short, 1987). In 1950 the VON and the official agency combined forces and began offering one prenatal program in the Victoria area (Department of Health and Welfare, 1951). In other communities, the health unit staff concentrated on the preventive part of public health and the VON took responsibility for the visiting nursing service (the forerunner of home care). This arrangement

worked satisfactorily because each group of nurses had clearly delineated functions within the community and there was little chance for duplication of service (Empey, 1948).

In British Columbia, the Canadian Red Cross was a pioneer in the field, having placed Red Cross public health nurses in isolated districts during the early 1920s (Hiltz,1967). Lack of funds forced this service to be discontinued; however, by the next decade the Red Cross responded to the critical need for health services in remote communities by opening outpost hospitals and nursing stations (Porter, 1960). Eventually, 18 outpost hospitals were established with the nurses providing outreach services including home visiting, immunization, and child health services.

In addition to the provision of nursing care, the Red Cross played a catalytic role in the development of public health services in two significant ways. It was a major force behind the establishment of public health nursing programs at Canadian universities. Provincially, it is credited with providing the funding for the first three years of the diploma course in public health nursing at the University of British Columbia (Gray, 1942). The first graduates of this course served in outpost hospitals and provincial nursing districts. Later, when health units were being developed during the forties and fifties, grants from the Red Cross and other agencies were used for the

construction of modern health centres from which the official programs were delivered.

At the local level, community organizations also contributed to the advancement of public health. As health units developed, various service clubs donated funds for equipment and promoted the work of the health department. In some communities, service organizations provided capital funding for health centre construction. In 1955, for example, the Ladner Kinsmen's Club raised funds and spearheaded the community's effort to build a centre from which the public health program could operate (Department of Health and Welfare, 1955).

Another form of assistance was provided by health unit volunteers; these were lay people who regularly helped the PHNs with tasks such as weighing babies at child health conferences or acting as receptionists at immunization clinics. The Central Vancouver Island Health Unit had formalized Women's Auxiliaries associated with its programs in Duncan, Nanaimo, and Port Alberni (Central Vancouver Island Health Unit, 1953). Their purposes, as outlined in the 1953 Annual Report were:

1. To act as a liaison between the Public Health Unit and the general public.
2. To assist by giving voluntary help in public health projects.
3. To assist financially in worthy projects. (p. 1)

Some examples of the material aid given by the Women's Auxiliaries at that time included office furnishings, a film

projector and screen, and other equipment. It is evident that numerous hours of volunteer time went into these projects over the years and this was acknowledged in annual reports.

The 1959 Report from the same health unit indicated that volunteerism was still strong at the end of the decade:

> We would like to express our gratitude to the many volunteers who have helped us during our Polio Clinics and to the faithful group who help us at Child Health Conferences and other clinics every week of the year. We think that the contribution these women make to the community is considerable. It receives very little publicity but is quietly and conscientiously given and helps our service run the smoother. (p. 29)

The excerpts cited above contain some key words that help to explain the phenomenon of volunteerism in public health work at that time. There was the notion that certain projects were "worthy" of financial aid and, also, that there was merit in donating time to these projects. Many aspects of the program were viewed by the public as useful and important; hence, the contribution made by the volunteer to such programs was valued. These women were described as "faithful" and "conscientious," an indication that they took their volunteer work seriously. Certainly, efforts to prevent polio and to protect the health of children had a major impact on the population and this seems to have been recognized at the community level.

The Central Vancouver Island Health Unit was not alone with respect to involvement of active volunteers in several aspects of the program (Department of Health and Welfare,

1952, 1953; Selkirk Health Unit, 1956, 1957; Skeena Health Unit, 1953). Throughout the province service clubs were gaining popularity and were able to mobilize support for local improvement projects; this was reflective of the growing community mindedness of the post-war era. Public health programs were among the beneficiaries of these charitable endeavours. The high degree of voluntary participation in nursing programs indicated general awareness of the importance of public health nursing at that time. In turn, the health unit staff acknowledged the value of the services rendered by volunteers and thereby sustained interest and commitment.

From these accounts of local and provincial voluntary efforts, it can be seen that a positive attitude toward community service prevailed during this period. Agencies such as the Red Cross and the VON played a formative role in health services development. At the local level, the post-war community spirit created support for public health programs and, in particular, public health nursing benefited from the involvement of the voluntary sector.

Summary

In summary, this chapter began with an overview of the organization and administration of public health in British Columbia during the 1939 to 1959 period. The role of the public health nurse was illustrated by describing the

various aspects of practice during the same period (see Figure 9). As discussed in the latter part of the chapter, a number of factors had an impact on the development of public health nursing. The social and political context of the time, the education of nurses, and programs for staff development were forces that affected public health nurses and their practice in the community. The issue of supply and demand in the field was presented; this included a discussion of the measures taken to alleviate the shortage of PHNs. Finally, the part played by voluntary health agencies and community service organizations was described as the last of these influences.

Figure 9. Norma Tucker (Clark), PHN, in front of the Port Alberni office, Central Vancouver Island Health Unit, 1950. Photo courtesy of Norma Clark. Used with permission.

CHAPTER FOUR

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS FOR FURTHER STUDY

Summary

This study of public health nursing in British Columbia was designed to examine one aspect of Canadian nursing history within a circumscribed time frame. The central research question was: What was the status of public health nursing in British Columbia during the 1939 to 1959 period? The historical method was used to collect and analyze data from various primary and secondary sources; these included annual reports from provincial health units, annual reports of the Division of Public Health Nursing, journal articles, and oral histories.

Data were subjected to content analysis to reveal themes relevant to the topic. During this process it became evident that several important factors influenced the evolution of public health nursing throughout the selected period. Data were categorized according to the various influences and research notes were written as a basis for the historical account. The presentation of findings included descriptions of the organization of public health services and the role of the public health nurse; this was followed by a discussion of the impact of each of the forces on the status of public health nursing.

Conclusions

Public health programs in British Columbia evolved within a well-planned organizational structure in which the Provincial Public Health Nursing Service provided strong leadership. A centralized system for public health service delivery throughout the province created consistency in programs and ensured accessibility for the majority of the population. Public health nurses were the first public health personnel in most areas and were responsible for nursing districts before the advent of health units. Once health units were established in the thirties and forties, public health nurses maintained their high profile through their involvement in schools, immunization clinics, and homes. They were respected health professionals because their work "made a difference" in the lives of the families with whom they came in contact and in the community at large. Their distinctive uniform added to their visibility and identity in the communities they served.

Public health nursing was characterized by a strong teaching component in most aspects of practice. PHNs were a source of health information to members of the public; they instructed parents in infant care, conducted health education classes in schools, and taught families how to care for ill members at home. This differentiated public health nursing from hospital nursing at that time and has remained an integral part of practice. Public health

nursing was, and continues to be, a unique branch of nursing.

Although much of the PHN's work was based on a standardized program (such as school health), there was room for variation depending on the needs of individual communities. Thus, programs were introduced in accordance with the needs and readiness of each community. For instance, prenatal classes were introduced over a ten-year period as PHNs responded to consumer demand at the local level. When a PHN had implemented a new program successfully or modified an existing one, this information was shared with other nurses through newsletters and regional study meetings. The 1950s saw the beginning of program evaluation at the local level; for example, PHNs evaluated the effectiveness of prenatal classes in terms of outcomes and consumer satisfaction. Individual nurses and health units played a significant part in shaping the direction of public health nursing.

In addition, outside forces were responsible for influencing the evolution of provincial public health nursing. Although funding for public health nursing was a problem due to government fiscal restraint, British Columbia's Public Health Nursing Service fared well in comparison to other provinces. The provincial government's progressive health and social policies, developed over the first half of the century, created a strong foundation for

the delivery of public health services at the local level. As a result, public health nursing flourished during this period; it was a time of program expansion and growth in numbers.

The period from 1939 to 1959 was one of significant social change for British Columbians. During the war years the role of the PHN expanded due to the shortage of physicians. Public health nurses responded to the changes of the post-war period by adapting their programs to meet the needs of the growing population. Through study groups and continuing education, PHNs were well informed of changes in the field.

Education for public health nursing was another important force that had an impact on its status. During the forties and fifties the issue of the most appropriate preparation for public health nursing remained controversial. Leaders in Canadian public health nursing called for a generalized degree program, independent of any one hospital school of nursing, that integrated health and illness concepts. In British Columbia two paths to public health nursing existed: a one-year certificate course for registered nurses and a degree program. The certificate course was the most popular; the baccalaureate program in nursing at the University of British Columbia produced a relatively small number of graduates per year. Although the certificate program was an efficient method of meeting the

demand for trained PHNs, it had may have inhibited the advancement of public health nursing in the long run because it obviated the need for a degree. Later, when other related professionals (such as social workers, nutritionists, and mental health workers) began to be employed in health units and community agencies, it may have been difficult for PHNs to work on an equal footing with members of these other disciplines. This may explain, in part, the decline of the role of public health nursing in recent decades.

The supply of graduate nurses with public health preparation barely met the demand for their services. In attracting new graduates, the Provincial Health Department had to compete with the Metropolitan Health Service of Greater Vancouver, a favoured employer among many nurses because of its location and higher salaries. This forced the Division of Public Health Nursing within the Provincial Health Department to adopt some strategies to attract and retain staff. One such measure was the trainee plan whereby nurses were offered funding to take the public health nursing certificate course and had the security of employment following its completion. Throughout the forties and fifties a number of creative actions were taken to increase job satisfaction and to keep morale high. Staff nurses were able to participate in continuing education events, conferences, and regional study groups. The annual

Institute and the monthly newsletter facilitated on-going communication among PHNs and between administrators and staff. It is evident that the administration recognized the problems of PHNs working in isolation from other colleagues; providing opportunities to socialize and study with other PHNs was essential to the maintenance of staff morale. According to PHNs who practised during the forties and fifties, there was a tremendous camaraderie among the provincial PHNs and many lasting friendships were formed at that time.

The Public Health Nursing Council brought all the nursing staff including supervisors, consultants, and the Director together in an organization to deal with the concerns of the PHNs. Through the strength of group decision-making and collective action, it was possible to institute a number of improvements in working conditions.

It is apparent that the creative strategies employed by the Health Department to ensure a favourable working environment helped to offset some of the problems inherent in the nature of public health nursing. PHNs worked in relative isolation and faced many difficult situations in their daily practice: outbreaks of communicable diseases, families living in poverty, parents adjusting to the birth of a handicapped child. They needed support from colleagues and relief from the stress of their demanding work--this was provided through study groups and gatherings of public

health nurses.

Despite the problems experienced by public health nurses, their work was rewarding because they knew that it was worthwhile. This was validated by the voluntary support received by health units during the 1939 to 1959 period. Local communities valued public health nursing endeavours as demonstrated by many instances of fund raising and publicity for public health programs. The values of public health nursing were congruent with society's values at that time; this created a positive atmosphere in which public health nursing developed and prospered. Public respect and knowledge of the importance of their role in the community, contributed to public health nurses' strong identity during this time.

Recommendations For Further Study

A number of questions for further research arose from this historical study. The focus of this study was British Columbia; it would be useful to examine the evolution of public health nursing in other Canadian provinces and other countries. Due to the existence of separate metropolitan agencies in this province, it would be interesting to compare their development over the same period with the findings of this study.

Education was shown to be a major factor in the development of public health nursing. What impact have

changes in nursing education since 1960 had on this branch of nursing? In what ways have public health nursing courses at Canadian universities changed since their inception in the 1920s? What is the history of graduate programs in public health nursing in the United States and Canada and how have they shaped the direction of practice?

Specialization within public health nursing is another area for further study. There is a need to document the development of official home care and long term care programs and the resulting fragmentation of public health nursing. What is the history of home care and long term care in the province and what impact have these programs had on public health nurses? What other health policy changes have influenced nursing in the community?

A number of PHNs left their positions to work in the field of international health with the World Health Organization and other agencies. It would be interesting to study this group of nurses in terms of their motivation and preparation for overseas work. What impact did they have on the countries in which they worked? What impact did they have on Canadian nursing when they returned?

At the national level, public health nurses had two organizations during the forties and fifties. These were the Public Health Nursing Section of the Canadian Nurses Association and the Public Health Nursing Section of the Canadian Public Health Association. Reports of the

activities of these sections within the larger bodies of the CNA and CPHA are found in the national journals, the Canadian Nurse and the Canadian Journal of Public Health. In light of the current interest in the formation of specialty groups at the national level, an examination of the history of these two groups could be helpful. How did these organizations develop and what led to their decline? What were the purposes of the two groups and what did they achieve for public health nursing? To what extent did the existence of two similar groups divide public health nursing?

Public health nurses were among the first community workers in the province. It would be useful to compare the development of public health nursing with the experiences of other occupational groups in the community. For instance, how did social work and community mental health evolve in British Columbia?

Finally, in looking at developments in practice, it would be interesting to trace the beginnings of research into public health nursing problems. What types of problems were identified? What research methods were used? How were results used and communicated to others?

It is apparent that the area of public health nursing history is rife with questions for study. The identity of future public health nurses will be strengthened by knowledge of the past.

In conclusion, this study has highlighted the importance of paying attention to nursing's collective past. When problems are encountered in current situations, knowledge of the past can illuminate and provide solutions. Indeed, many lessons are hidden in our history; it is the responsibility of today's nurses to ask questions that will lead to a greater understanding of our heritage.

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