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### **Social Policy, 'Deviant' Children, and the Public Health Apparatus in British Columbia Between the Wars**

Recently I finished a study that described how, over the years from the 1880s to the 1920s Anglophone Canadians developed a cluster of social policies that, by and large, still govern their treatment of their children.<sup>1</sup> I am now pursuing two closely-related lines of research that flow out of that study. First, I am trying to find out how the mass of Canadians moved (or were moved) from the old forms to the new; how it was that they came to apply the new notions of child-rearing, the new health practices, and the new schooling to an ever-increasing proportion of their youngsters. Second, I am trying to find out how families and children actually lived their lives under the new arrangements. This paper outlines some of my early discoveries in response to my first topic.

An obvious initial question is whether I really have a research topic at all. I have argued that the social dynamics engendered by the modernization of Canada—its transformation from a rural, resource-based economy to an urban and industrial one—produced the new policies. In this framework one could perhaps claim that the whole process of “socializing” parents and children to new ways of behaving was almost a mechanical and even mindless enterprise; as more and more Canadians came to live in a “modern” society then, naturally, its norms would govern the lives of more and more parents and children. When one looks at the evidence, however, one sees that the shift from one way of life to another involves much teaching and even more learning. Many urban parents had grown up in farm, fishing, or workshop settings where the economic success, or even the day-to-day survival of their families depended on the intensive use of their youthful labour. The new cities and their industries had much less need of child labour. Family and household chores and longer and more regular periods of schooling took up some but not all of the slack time. Parents had to find other ways of organizing their children's time. Each parent and each child had to learn to behave or misbehave in ways appropriate to his or her place in the new order.

I am particularly interested in this matter because I want to find out how parents and children actually learned what they wanted or needed to know. Who taught those whom the state did not need to coerce? What methods, other than providing models of the correct ways, did they use? In addition, how much teaching was imparted by those who were not really aware of their role? We know from autobiographies and novels, for example, that youngsters sometimes learned appropriate behaviour by carefully watching their relatives, friends, neighbours, and teachers. One can hypothesize that parents who had to take their children in the midst of their upbringing from a setting in which their work was required to one in which it was not, found learning the new ways a difficult task. On the other hand, those young people who had themselves grown up under the old system but

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who moved to the new as young adults and then formed their families, found it much easier to learn and apply the new notions of child-rearing. While my work so far has provided me with no very complete answers to these questions, it has convinced me that they are answerable. There is, in short, enough evidence to suggest that the shift from one way of life to another was anything but mindless; parents and children had to and did make many conscious choices.

To make the initial stages of my work reasonably manageable I decided to put two sorts of limits on it. What follows will show that I have had much greater success in keeping within one set of boundaries than within the other. First, I focussed on events in British Columbia in an effort to create what I hope will turn into a case study for Anglophone Canada. Second, I tried to limit myself to examining the experiences of "deviant" children and parents. I sorted this group out for early attention because I had already been able to make extremely practical use of the notion that, when people talk about, define, or try to control misbehaviour they tell us most clearly not only what they see as good or suitable conduct but also what they will tolerate in terms of minimally acceptable behaviour. Thus, because both theory and practice regarding neglected, dependent, and delinquent children changed so radically between the 1880s and the 1920s I was able to use what happened to them, and particularly what happened to delinquent children, as a basis for examining changes that affected a very broad range of Canadian youngsters. However, as I have argued elsewhere, the last half century of both theory and practice regarding juvenile delinquency in Canada is best characterized by the cynical statement: *plus ça change, plus c'est la même chose*.<sup>2</sup> In turn, therefore, the experiences of delinquent children provide too narrow a base for coming to sound conclusions about children generally.

Since I am not yet prepared to abandon the device of learning something about everyone's experience through that of the deviant, I tried to look at a different sort of deviancy. By the early 1920s, British Columbia had enacted enough legislation affecting children and parents to provide a legal framework for much of the new consensus. In later years this structure was both extended and made more elaborate. I could therefore slightly widen my focus and define deviants as those to whom the law was applied in some way or another. Indeed, even this reasonably limited application of the term can, in theory at least, take in a far larger proportion of both parents and children than might at first appear to be the case. Public health agencies acquired surprisingly broad legal powers that they could apply to homes, families, and children. Children's Aid societies could apprehend youngsters as "neglected" for a very wide range of generally loosely-defined activities. As Diane Matters has shown, the charge of contributing to juvenile delinquency and the enforcement of certain bylaws provided plenty of scope for those who wanted to sanction certain ways in which parents or other adults treated children.<sup>3</sup> However, despite the latitude that a definition based in law would give me, I will define deviancy in a non-legal way; I will apply the term "deviant" to youngsters whose upbringing was sharply at odds with the new social norms.

Two aspects of this definition require immediate comment. First, although it focusses on the child, the question as to who was the active agent of the deviancy depended very much on circumstances. Often, of course, it was the youngster, either alone or with his companions, who defied the norms or the law and would find both parents and the state arrayed against him. Much—although not all—juvenile law-breaking, such as truancy, petty thieving, and vandalism, fell into this category. Sometimes parents and children would work together against society and

the state. With the encouragement of their parents, for example, many boys and girls willingly entered the labour force before they were of legal age to do so. Finally, and perhaps more often than one might initially assume, parents defied norms to which their youngsters would gladly have adhered. Thus many children were acutely embarrassed by their parents' refusal to permit them to attend school regularly, to be vaccinated, or to receive other aspects of preventive health care.

Second, ideas of what was or was not "deviant" in the sense of this definition have changed considerably over the last half century. However, the era from the end of the First World War until the 1960s can best be described as one in which British Columbians gradually tightened the press on themselves to conform to the new norms. There were three facets to the way that they did this. First, parents and children increasingly committed themselves to behave in new ways. Second, the province elaborated its mechanisms of persuasion and compulsion to the point where they could reach almost all parents and children. Finally, those who made and implemented policy both differentiated more sharply and clearly between acceptable and deviant ways of behaving, and extended the boundaries of the latter. It became more and more difficult not to conform.

How British Columbians went about the task of improving the health of their children provides us with a reasonably clear example of how these ideas worked out in practice. In their most optimistic moments those who put together the new ways of bringing up children tended to think that the merits of their ideas were so self-evident that they merely had to make them widely known to ensure that most people would adopt them. Ideally, parents, teachers, health and welfare workers, and the children themselves, would each take up his or her appropriate task in the creation of the new society through the new childhood. As I have already suggested, an increasing proportion of parents—both middle- and working-class ones—did so. However, in a less-than-perfect world, reformers knew that they had to intervene in the lives of others; they had to persuade or coerce many people to learn the new ideas. In the area of child health care, for example, public health workers and their allies believed that they had to cut the present from the past: to break the traditional pattern by which most members of each new generation learned the elements of pre-natal, infant, and child health care from the previous one. Thus they felt they had to intervene in family life at some of its most intimate and sensitive moments. In the name of science, they attempted to substitute their new and sometimes scientifically-based practices for the customary ones passed on by parents, grandparents, friends, and neighbours. As one of the early public health nurses explained, she had not only "to wear down one set of ideas, but to build up others in their place."<sup>4</sup>

In the 1920s and 1930s health workers generally tried to make fairly obvious and fairly simple changes in people's ideas and behaviours. Pregnant women would not visit the doctor: "it is," one said for nearly all, "so foolish going to him when I feel quite well." Parents too lightly regarded the consequences of such common communicable diseases as measles, whooping cough, mumps, and scarlet fever; so often their attitude was: "let them have it while they are young, and then it will be over and done with."<sup>5</sup> However, as the years passed and the body of the new wisdom grew, society tended to push further and further into the ways in which mothers and fathers treated their youngsters. Health and welfare workers came to discover and sort out "battered children" from the far larger group of boys and girls whose parents used corporal punishment as a regular method of disciplining them. Health and welfare workers began to give more than lip-service to their

long-held concerns for the emotional as well as the physical environment provided by the home.<sup>6</sup> In common with their compatriots in welfare and education, public health workers couched their rhetoric in language that suggested their practices came right out of modern science. Of course they based some aspects of what they recommended—such as immunization—on careful scientific research. In others they extrapolated scientific data beyond accurate limits. Other things being equal, for example, it was clear that breast-feeding was a safer method of feeding infants than the bottle. Other things, however, were not always equal. If the mother had to leave the work-force in order to breast-feed, and thus reduce the family income to a point that her health and that of her children was threatened, then bottle-feeding was clearly a more appropriate choice for her to make. This condition particularly applied after the milk supply was improved and protected.<sup>7</sup>

The public health movement—health professionals, their amateur supporters in women's and other community groups, and some members of hospital and school boards and of local boards of health—employed a wide variety of devices and techniques in its efforts to change parents' thoughts and practices. At the outer edge of its work, in the most diffuse but most far-reaching form of it, the movement used most of the means by which popular culture was communicated and transformed. Health care became a regular subject for articles in newspapers, magazines, church bulletins, and of broadcasts on the new radio stations. The annual round of community fairs and expositions regularly featured beautiful baby contests, well-baby clinics, and public health displays. While probably not often persuasive enough in themselves to prompt most parents into taking active steps, these messages did help set the stage for the more direct and personal approach when it came. Newspapers and later radio broadcasts were particularly effective during serious outbreaks of infectious diseases. To cite but one example, in the fall of 1927 a relatively mild epidemic of infantile paralysis broke out in the Kamloops area.<sup>8</sup> The *Kamloops Sentinel* kept its readers informed not only about the extent of the outbreak, but also carefully instructed parents in such preventive measures as keeping their youngsters away from public gatherings, describing the characteristics of the disease, and so on.<sup>9</sup>

In a more direct but, so far as the audience actually reached was concerned, far more limited way, health workers and their allies also conducted more formal modes of educating parents in scientific child-rearing. As they went on their regular rounds, life insurance agents promoted health care and distributed booklets. By providing a baby scale, health literature, and advice as well as commercial baby products, many druggists conducted informal but widely used well-baby clinics. Many physicians in private family practice advocated new modes of infant care to their patients. Nurses, doctors, and sanitary inspectors searched out audiences. In the late 1920s, a public health nurse working in the rural districts around Kelowna reported that, in addition to all her other work, she had given "some twenty-seven addresses . . . to meetings of Women's Institutes, parents, and ratepayers on health subjects and public health organization."<sup>10</sup> In these activities, health professionals reflected provincial policy. In 1928, the politically powerful Provincial Health Officer, Henry Esson Young, reported that he did not allow "any opportunity to pass of holding meetings and distributing literature" and his department distributed no less than an average of 30,000 pamphlets a month.<sup>11</sup> Young viewed Women's Institutes, of which there were then 119 in the province, as a particularly suitable organization through which to conduct parent education.

These broadly educational efforts provided a supportive context out of which

the public health apparatus made its most direct and its most effective efforts to replace traditional lore with its own ideas. The public health staff itself took on the main task of intervening in the families of the current generation. In turn, it assigned to the school the task of preparing the next generation for proper parenthood. Since this is not the place for a thorough examination of either of these enterprises I shall roughly sketch in just enough detail to tie them in with my earlier comments on deviancy.

Although she often had the support of the family and the public health physician, the sanitary inspector, and sometimes the welfare worker, the public health nurse assumed most of the front-line duties with parents. In an effort to help the nurse organize the enormous range of tasks assigned to her, researchers analysed data on maternal, infant, and child mortality. In June, 1949, for example, Helen G. McArthur, the Canadian Red Cross Society's Director of Nursing Services, used evidence collected by the then on-going Canadian Public Health Association's Study of Public Health Practice in Canada to examine the role of the public health nurse in maternal and child care and to rank-order her duties in relationship to the mortality patterns.<sup>12</sup> The evidence—such as that which showed that over half the cases of infant mortality took place in the first month of life—made it clear that the nurse's two most important tasks were pre-natal and post-natal care and then, only as time permitted, the care of the pre-school and school-aged child. Thus the home visit was clearly the most important part of her work. The public health nurse was expected to call on expectant mothers and on the newly-born. As an extension of her home visits, and as one way of initiating them, she was to conduct well-baby clinics. Out of her school-based work she was supposed to prod the parents of children with chronic defects to have these corrected, and keep a watchful eye out for home and farm conditions that the sanitary inspector should examine and perhaps condemn.

As one might expect, the work with adults could be—and often was—more coercive than that with children. The public health nurse's behaviour towards her child and adult clients ranged from that of a supposedly friendly visitor through that of “nag” to that of a grim enforcer of the law. “In visiting the homes of the children,” the nurse in Vernon reported in 1924, “I find the parents are very pleased to get any advice with regard to the health of the children I am able to give them.”<sup>13</sup> Her Colwood colleague echoed this sentiment: it was, she explained, “very gratifying to note the growing confidence with which mothers will appeal to the nurse for advice regarding the slight ailments of their children, and the welcome extended when making those numerous ‘home’ visits. . . .”<sup>14</sup> During home visits, another nurse reported, “we can often persuade the parents of the necessity of having their children immunized . . . where a notice is absolutely ignored.”<sup>15</sup> I quote these nurses at some length in order to indicate the probably unconsciously meant but nonetheless clearly patronizing way that at least some of them thought about and also behaved towards the mothers they talked to at clinics or visited in their homes. There may have been reasonably cordial relations between mother and nurse but there was little possibility of the real friendship that the literature mentioned. Even the step from teaching in this way to coercing was an all too easy one to take. Consider this story told by Margaret Griffin.

On her first visit to a four-week-old baby that had been born in a hospital, Griffin found that the mother had replaced breast-feeding with canned milk. Although the mother's response was: “‘What! after all this time,’” Griffin “instructed her to put the babe regularly to the breast . . . and have cow's milk sup-

plementary feeding ready.” On Griffin’s next visit, however, the mother told her that “My neighbour says that . . . with a combination of breast and bottle it won’t ever sleep, and I’ll kill it.” Nevertheless the harassed mother, Griffin wrote, “ashamed to admit she hadn’t attempted to carry out my instructions because of her neighbour’s criticism . . . decided to try my plan.” With Griffin’s “constant supervision and encouragement”—which for a time meant daily visits—by the end of three weeks the baby was entirely breast-fed, “the mother had lost her ‘nerves’ and was getting proper rest.” To ensure that her readers got the point Griffin concluded this story by remarking that “Some that ‘can’t be bothered’ will nurse their babies, because with the nurse going in regularly they are ashamed to say they won’t.”<sup>16</sup>

Some parents, such as those who received Mother’s Pensions, that precursor to the wider welfare system, were particularly vulnerable to pressure. The paid or volunteer “visitor,” who called regularly ensured that the pension money was used properly: that is, “the providing of home care for the children under satisfactory conditions.” And, “in some cases, where the mother is found to be a poor manager, the monthly cheque has to be administered to ensure the provision of food, shelter and clothing for the children.”<sup>17</sup>

Their legal powers in relation to the control of infectious disease gave public health physicians, nurses, and sanitary inspectors their most powerful weapons of intervention in the lives of children and families. Health authorities could exclude pupils from school and, in the case of the more serious diseases, quarantine the whole family until the infection had run its course amongst its members.<sup>18</sup> In addition to fearing the effects of the diseases on their children and on themselves, parents—especially those who managed at or a little above the edge of subsistence—feared the effects of quarantines on the family economy. Only gradually did the wartime and post-war “miracle” drugs of the 1940s and 1950s banish the family and even neighbourhood disruption that followed the sanitary inspector’s searching out of the diseased and his nailing of the dreaded sign beside the front and back doors of the family home.

The public health service and the school shared the responsibility for the health care of school-aged children. Through its medical inspections conducted in the school and occasional forays into the classroom, public health nurses and physicians gave most of their attention to preventive medicine. Theoretically, the nurse should have tackled her work in schools only after she had completed all of her home visiting and conducted all of her well-baby clinics. In fact, however,—and for reasons discussed below—she probably spent most of her time on school-related tasks. A nurse stationed in Saanich in the 1920s summarized her “innumerable” school-associated duties. She had to be present at the medical officer’s annual inspection of pupils, she had to weigh and measure the youngsters regularly, she had to conduct routine skin inspections, she had to admit absentees, she had to inspect all “contacts” daily, she had to make arrangements for the dental care of those who could not afford to do it themselves, and she had to keep the pupils’ health records.<sup>19</sup> Indeed, these years were characterized by an increase in such routine duties. In the late 1920s, to cite but one example, Vancouver added to its regular cycle of pupil inspections one of all prospective grade one pupils.

In their preventive work, nurses could sometimes be as heavy-handed with children as they were with their parents. There is no doubt, for example, that malnutrition was a serious problem between the wars: the statistical report of school medical inspection by the Provincial Board of Health noted that in 1927-28

no less than 38 out of 130 high school and 227 out of 703 elementary pupils in Fernie suffered from malnutrition.<sup>20</sup> In this context, consider Jean Dunbar's account of her campaign against this condition.

After each monthly inspection I now divide the class into three groups (when necessary); all of average weight and over receive *white* tags, those from over 1 to 7 percent. underweight receive *blue* tags, and those over 7 per cent. underweight receive *red* tags. I explain to the children in the class-room what the different colours mean and have them repeat the following:-

Cards of *white all right*,  
 Cards of *blue won't do*,  
 Cards of *red, danger ahead*.

I then urge them to see how quickly they can all receive white cards and so compete with the other rooms in the school.<sup>21</sup>

It takes little imagination to re-create the dread with which some youngsters must have looked forward to this nurse's monthly visits, and the anguish that waving their little blue and red cards must have caused them.

The school gradually assumed the major responsibility of ensuring that its pupils would eventually grow up into knowledgeable adults and good parents. In contrast to the preventive work with both parents and youngsters, this educational enterprise was generally non-coercive, positive, and even up-lifting:

Onward little soldiers,  
 marching on to wealth,  
 All our young school-children  
 Know the rules of health.  
 Onward then ye people,  
 This shall be your song,  
 "Health" is now our motto,  
 Join our happy throng.<sup>22</sup>

The provincial department of education expanded the curriculum to ensure that, especially in the elementary grades, teachers gave a considerable amount of health instruction to both sexes. The Normal Schools trained novice teachers how to teach the new subject and their more experienced colleagues "avidly" attended courses in health education at the provincial Department of Education's summer school for teachers.<sup>23</sup> These efforts appear to have had an effect on the classroom practice of teachers. By the mid-1940s, for example, four out of every five British Columbia elementary teachers reported that they made a daily appraisal of the health and cleanliness of the pupils in their classrooms.<sup>24</sup>

In many classrooms Junior Red Cross clubs provided a strong and welcome supplement to the regular school work.<sup>25</sup> Customarily all the pupils in one teacher's class made up the membership of each branch of the Junior Red Cross. Although teachers varied greatly in their commitment to Junior Red Cross, many obviously used the organization as a pleasant vehicle to teach not only the rather dry notions of health and hygiene that the curriculum called for, but also to inculcate some civic skills and to supplement the pupil's geography lessons as well. The national and provincial Red Cross societies assisted teachers by providing them with a wide range of teaching materials and suggestions for their use. Perhaps most important, members received the sprightly magazine, *The Red Cross Junior*, which presented in a generally low-key way, a wide range of health information in its articles, stories, poems, and other features. The British Columbia organizer for Junior Red Cross, Ruth Witbeck, reported that by 1936, 14,000 pupils (out of a total enrollment of 95,000 in the elementary grades of the province) belonged to the organization.<sup>26</sup>

The persistence of the belief that mothers would—and should—provide most of the day-to-day care of children, ensured that most of the school's instruction of its older students was directed at girls. In the upper grades of the elementary school and increasingly in the high school as well, Home Economics as well as health courses were to give girls a broad training for motherhood and family care. In the 1920s, and 1930s, school nurses supplemented this work by sponsoring "Little Mother's Clubs" and similar organizations. In both the Home Economics classes and the clubs, the instruction was detailed and explicit. In an essay describing what she had learned in her Little Mothers' League classes, twelve-year-old Viollete Norman, of Ladysmith, wrote:

The baby should be fed from the mother's breast. God meant that the baby should be under the mother's food and the cow's milk is the calf's food. If the baby is fed by cow's milk the mother should be under the direction of a physician. The mother's milk takes no time to prepare and does not keep the mother too busy as it does when it is bottle fed. Bottle fed babies require about five bottles and nipples and washing them all through the day makes more work for the mother or nurse. It can be easily seen that breast babies are not as cranky as bottle fed babies, that is if the mother has nothing wrong with her.<sup>27</sup>

If Viollete eventually bottle-fed her own babies, then the nurse had at least ensured that she would feel very guilty as she did so!

It took British Columbia about a quarter of a century to provide a public health service that could reach most of its citizens. By 1938, the greater Vancouver and other urban areas were reasonably well-served. By 1948, the province had 105 nurses in the field who, it was estimated, could reach 94 percent of the population.<sup>28</sup> Nevertheless, it is clear that these nurses did not carry out the coercive side of their work, and especially that connected with home visits, to anything like the extent that their numbers supposedly made it possible for them to do. In 1938, the Victorian Order of Nurses, the Vancouver General Hospital, and other sources referred less than 1000 of the over 4500 births in the greater Vancouver area to the health services.<sup>29</sup> In 1949 Helen McArthur reported that, for the nation as a whole, in seven urban districts surveyed by the Canadian Public Health Association, the number of mothers supervised by public health nurses ranged from 3 to 33 for every 100 births. In ten rural areas the number cared for ranged from 9 to 26.<sup>30</sup>

I think there are three reasons for this state of affairs. First, the school service took up enormous amounts of time. Such procedures as monthly inspections, the requirement that pupils secure the nurse's permission to return to school after an absence of only a couple of days, and so on, bound nurses into an administrative framework—much of it of their own making—from which they found it hard to escape. This characteristic was strengthened by historical precedent. Since the school medical service had preceded that for infants, the routines of the latter were often grafted onto the already firmly-established patterns of the former. Indeed, over these years, the extent of the school-based work generally increased.<sup>31</sup> After its very thorough survey of public health practice in Canada, the study committee of the Canadian Public Health Association concluded that, "in far too many cases," public health agency programmes were "purely routine." The committee observed that the school service consumed nurses' time "out of proportion" to their other duties, that they involved her in an excessive amount of clerical work, and that they undertook many activities that might well be done more effectively by the teacher. Was not, the Report asked, "the actual testing of vision by use of the Snellen Chart a very practical application of a health lesson on vision?" When it included such activities, health became "a very practical subject and not a mere matter of learning factual material."<sup>32</sup>

Second, while as convinced as their predecessors of the rightness of what they did, nurses in the second generation of their new profession sometimes lacked the crusading fervour that was so central a characteristic of many of the pioneer public health nurses. While one could comfortably make the home visits that grew naturally out of an invitation by the mother or a meeting at well-baby clinic, it was more difficult, and time-consuming, to visit a home to which one had not been asked, or where one knew that one would not be welcomed. Without the daily support of colleagues in the same work, rural nurses must have felt most comfortable in their little office in the school and particularly hesitant, lonely, and vulnerable when away from it. One senses their diffidence even in the way that they found out who their infant clients were. In contrast to the elaborate discovery mechanisms that Toronto, for example, had earlier established to find and visit the infant as soon after birth as possible, many British Columbia nurses collected their list through regular—often monthly—visits to the local registrar of births. Thus a time gap created by the well-known tendency of parents to register births towards the end of, or even well past, the compulsory time period was compounded by these infrequent visits. Unregistered births—in the early 1930s in British Columbia still over five percent of the total—were not discovered by these nurses at all. The upshot was that health agencies missed a “golden opportunity”; many—perhaps most—infants had long since passed through the most critical hours, days, and even weeks before the nurse made her first visit.<sup>33</sup>

Finally, the nurses tended to hold back because they encountered substantial opposition—both by many individuals and sometimes by influential groups—to at least some of what they were trying to do. As late as 1950, the study committee of the Canadian Public Health Association reported that “most health departments were of the opinion that the extension of their program to include pre-natal classes and pre-natal supervision would be construed by the private physician as interfering with his practice.”<sup>34</sup> Further, British Columbians have a long tradition of populist opposition to the conventional wisdom of the medical and public health establishments and what follows should be seen in that context.<sup>35</sup> Before she turned to badger the children to increase their weights, the Fernie nurse mentioned above was told by the school board that “perhaps it would not be wise” for her “to approach the parents on the subject of malnutrition.”<sup>36</sup> In November 1929, scarlet fever broke out near Kelowna. The district health officer and public health nurse conducted a vigorous campaign to promote immunization against the disease. As the nurse, Anne Grindon, reported, “almost immediately every home received a warning pamphlet from the Canadian Anti-Vivisection Society, Victoria Branch, denouncing the inoculation and the Dick test” which it followed up with letters-to-the-editor in local papers.<sup>37</sup> After sending notices to all parents, the Kamloops nurse reported that she had only been able to immunize forty percent of the pupils in the two public schools.<sup>38</sup>

Clearly, this initial survey of the data uncovered no startling changes; if my findings at this stage are preliminary they are nonetheless predictable. In its effort to bring the new norms to bear on everyone, the public health establishment generally relied on an uncritical refining and elaborating of already-established practices. Few health workers questioned the validity of any aspect of the work they were doing. After all, each school brought into the net of pupil inspection for the first time replicated the story told by the pre-war pioneers; school nurses and physicians found the same wide and dramatic range of health “defects” for correcting as did their predecessors. It was not until the 1940s that managers began careful examinations of the efficiency of each part of the system in relation to the whole.<sup>39</sup>

It would take a much longer period of time before significant groups would begin to question the fundamental assumptions that underlay the work. In these and later years, public health theory cast the nurse in the role of the active, scientifically-trained expert, the mother in that of the docile but grateful recipient of her nurse's advice. If the mother did not follow the advice—if she decided to bottle-feed rather than breast-feed her infant—the nurse viewed this action as the product of stubbornness or perversity. She seldom saw that it was, perhaps, the rational outcome of a mother's careful weighing of her options and her deciding, say, that her income was more essential than her milk to the health and welfare of her family. It would not be until the 1960s and 1970s that such people would begin to feel some relaxation in what must have been an increasingly uncomfortable social press.

This last comment suggests that, in the long run, my second line of investigation may be more productive than the first. Clearly my examination of deviancy earlier in this paper, which focussed on the topic solely from the point-of-view of society, is incomplete because it leaves out those who made a rational choice to be "deviant." Thus, while it is still probably necessary for me to sketch in more detail of the ways in which Canadian society tried to apply and enforce its new consensus, I will probably arrive at a more accurate understanding of the social effects of modernization by looking at how families and children actually lived their lives under the new arrangements. In turn, I may find that my sympathies do not always lie with professional workers such as Anne Grindon. In 1937, she lamented the attitude of certain parents that was exemplified in a message that other parents must have written, and many more must have said. A father, she reported, wrote to his son's teacher to insist that she teach Antonio to "read, write, not what he should do at home."<sup>40</sup> Some such "deviant" parents may actually have known what they were doing.

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### Notes

I am grateful to Norah Lewis for her comments on an earlier version of this paper.

<sup>1</sup>This statement contains two premises that I will not try to examine or justify in this paper. The first is that, by the 1920s, Anglophone Canadians had indeed laid out a new and coherent set of policies regarding child-rearing and child care. The second is that it was this same set of policies that, by the 1970s, actually governed the care of the vast majority of Canadian children. For the first, see my *Children in English-Canadian Society: Framing the Twentieth-Century Consensus* (Toronto: University of Toronto Press, 1976); for the second, see my "The History of Canadian Children: Some Notes for the International Year of the Child," *CSSE News/Nouvelles SCEE*, VI (Nov. 1979): 3-8.

<sup>2</sup>Neil Sutherland, "'The More Things Change . . .': Social Policy and the Child in Modern Canadian Society," unpublished paper, CSSE, June, 1977.

<sup>3</sup>Diane Louise Janowski Matters, "'A Chance to Make Good': Juvenile Males and the Law in Vancouver, B. C., 1910-1915," (M.A. thesis, University of British Columbia, 1978), especially ch. 3.

<sup>4</sup>Esther Naden, "The Home School Visit, Saanich," *British Columbia Public Health Nurses Bulletin*, I (Apr. 1929): 14-16, hereafter *BCPHNB*.

<sup>5</sup>Margaret M. Griffin, "French Creek and District," *ibid.*, I (May, 1930): 22-3; Ontario Board of Health, *Report*, 1921, pp. 53-4.

<sup>6</sup>For an early statement of this concern, see Jessie Forshaw, "How Child Welfare Work Can Be Assisted in the Rural Districts of British Columbia," *Canadian Journal of Public Health*, (June, 1921): 284-5, hereafter *CJPH*.

<sup>7</sup>See M. W. Beaver, "Population, Infant Mortality and Milk," *Population Studies*, XXVII (1973): 243-59.

- <sup>8</sup>Only a very few of the 198 cases reported were paralytic. British Columbia, Provincial Board of Health, *Report*, 1927, *passim*.
- <sup>9</sup>*Kamloops Sentinel*, Sept. 16, - Oct. 28, 1927, *passim*.
- <sup>10</sup>Anne F. Grindon, "The Development of Public Health Nursing in the Kelowna Rural Districts," *BCPHNB*, I (May, 1930): 38-9.
- <sup>11</sup>British Columbia, Provincial Board of Health, *Report*, 1927-28, p. W6.
- <sup>12</sup>Helen G. McArthur, "Trends in Maternal and Child Care," *CJPH*, XLI (May, 1950): 177-82.
- <sup>13</sup>Jean A. Dunbar, "School-work in Vernon," *BCPHNB*, I (Oct. 1924): 2.
- <sup>14</sup>Helen Kelly, "Colwood," *ibid.*, I (Oct. 1924): 4.
- <sup>15</sup>Anne F. Grindon, "The Development of Public Health Nursing in the Kelowna Rural Districts," *ibid.*, I (May, 1930): 38-9.
- <sup>16</sup>Margaret M. Griffin, *ibid.*, I (Apr. 1927): 27.
- <sup>17</sup>British Columbia, Provincial Secretary, *Annual Report of the . . . Mothers' Pension Act*, 1930, p. 4; *ibid.*, 1934, p. 3.
- <sup>18</sup>The school side of this work is described in Harold White, "School Medical Service, City of Vancouver," *CJPH*, (May, 1928): 227.
- <sup>19</sup>N. Higgs, "Child Welfare in Saanich," *BCPHNB*, I (Apr. 1928): 14.
- <sup>20</sup>British Columbia, Provincial Board of Health, *Report*, 1927-28, pp. W26-W29. The current medical opinion and knowledge was summarized by the physician in charge of a clinic for malnourished children established in 1919 by Toronto's Hospital for Sick Children. See Chas. S. Macdougall, "Malnutrition in Children of School Age," *CJPH* (Jan. 1925): 25-35.
- <sup>21</sup>Jean A. Dunbar, "School Nursing in a Mining Town," *BCPHNB*, I (Apr. 1926): 17.
- <sup>22</sup>Quoted in J. Maryon Arnould, "Matsqui-Sumas-Abbotsford Demonstration Area," *ibid.*, II (Mar. 1937): 7; the popularity of such health songs—with teachers anyway—is testified to by the fact that the Junior Red Cross publication, *A Collection of Health Verses Suitable for Use in Primary Grades* (Toronto: National Office, 1945), appeared in its seventh edition in 1945.
- <sup>23</sup>British Columbia, Provincial Board of Health, *Report*, 1927-28, p. W6.
- <sup>24</sup>*A Health Survey of Canadian Schools, 1945-1946: A Survey of Existing Conditions in the Elementary and Secondary Schools of Canada* (Toronto: The National Committee for School Health Research, 1947), pp. 41-2.
- <sup>25</sup>*Ibid.*, p. 43. for an account of the origins and Canadian and world-wide development of Junior Red Cross, see Anne Anderson Perry, "A Logical Highroad to Health," *Social Welfare*, (Dec. 1929): 60-3; see also Canadian Red Cross Society, *The Role of One Voluntary Organization in Canada's Health Services: A Brief Presented to the Royal Commission on Health Services on Behalf of the Central Council of the Canadian Red Cross Society*, (Toronto: National Office, Canadian Red Cross Society, 1962), pp. 54-63.
- <sup>26</sup>Ruth Witbeck, "Practical Citizenship as Taught in Tecumseh School," *The B. C. Teacher* (June, 1936): 19.
- <sup>27</sup>Viollete Norman, "The Nursery," *BCPHNB*, I (Apr. 1927): 11.
- <sup>28</sup>John F. Murrell, "The Development of Health Units in British Columbia," *CJPH*, XLI (Sept. 1950): 390.
- <sup>29</sup>Vancouver, *Report of the Medical Health Officer*, 1938, pp. 12, 43.
- <sup>30</sup>Helen G. McArthur, "Trends in Maternal and Child Care," *CJPH*, XLI (May, 1950): 177-82.
- <sup>31</sup>See, for example, H. Cecil Rhodes and Pauline M. C. Capelle, "Venereal-Disease Education in the High School: British Columbia's Experiment," *CJPH*, XXXV (May, 1944): 181-89; Roger G. Knipe, "Experiences in Diphtheria Control in Northern British Columbia," *ibid.*, XXXV (Aug. 1944): 297-301; J. L. Gayton, Marion Bellis, and W. H. McClenahan, "A Survey of Pinworm Infection in an Elementary School," *ibid.*, XXXIX (May, 1948): 200-2.
- <sup>32</sup>*Report of the Study Committee on Public Health Practice in Canada* (Toronto: Canadian Public Health Association, 1950), pp. 7, 30-1.

<sup>33</sup>Ibid., p. 37.

<sup>34</sup>Ibid., p. 33.

<sup>35</sup>See, for example, the campaigns against chlorination and fluoridation, and the legislative efforts of Ernest Winch for the Hoxey cancer treatment and Lydia Arsens for pure foods.

<sup>36</sup>Jean A. Dunbar, "School Nursing in a Mining Town," *BCPHNB*, I (Apr. 1926): 17.

<sup>37</sup>Anne F. Grindon, "The Development of Public Health Nursing in the Kelowna Rural Districts," *BCPHNB*, I (May, 1930): 38-9.

<sup>38</sup>Olive M. Garood, "Public Health in Kamloops," *ibid.*, I (May, 1930): 28.

<sup>39</sup>For an account of parallel developments in England, see Huw W. S. Francis, "Education and Health: The English Tradition," *Public Health*, 89 (1975): 129-35; 181-90; 273-7.

<sup>40</sup>Anne F. Grindon, "The Value of an Annual School Health Cup Competition," *BCPHNB*, II (Mar. 1937): 22.