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Volunteers in Action: The Establishment of Government Health Care on Prince Edward Island, 1900-1931*

IN THE PROCESS OF PREPARING THE 1933 Annual Report of the Department of Health for Prince Edward Island, Dr. W.J.P. MacMillan wrote to Robert Wodehouse (whom he called “the real sponsor” of the health department) for a summary of the story behind the department’s creation in 1931. Wodehouse, the executive secretary of the Canadian Tuberculosis Association, briefly outlined his contributions and concluded: “I have known the Island, its people and its health work most intimately for eleven years. I have done everything in my power to improve the health work for these people, whom I like more than any others in Canada. I can only add...it is the best thing that has ever been done there”.¹ Behind these few words lay a decade of concerted effort, political lobbying, backroom bargaining, and educational programmes. Although the tuberculosis mortality rate on Prince Edward Island was the highest in Canada in 1921, the Island was the only province which lacked a health department and provided virtually no public health services. Ten years later, both political parties agreed that the government should assume responsibility for the people’s health. An analysis of the struggle to achieve this goal illustrates how well-organized and committed volunteer associations can influence and shape government actions; and provides useful insights into Island mentality in the 1920s.

During the 19th century, Prince Edward Island governments provided public health services on a piecemeal, *ad hoc* basis. When confronted with epidemics, the authorities initiated emergency measures that were later transformed into legislation. After the perils subsided, these enactments lapsed until the next contagious disease visited the Island, whereupon the legislation was resurrected. The Public Health Act of 1908, passed in response to an outbreak of smallpox, designated the Executive Council as the Provincial Board of Health, authorized the formation of local boards of health throughout the province *when needed*, and made possible the appointment of a temporary Chief Health Officer in times of crisis.² Prior to 1927, however, the only permanent government bodies concerned

* The research assistance of Helen Gill, and the comments of Margaret Conrad and Thomas Spira are acknowledged with thanks, as is the financial support of the Hannah Institute for the History of Medicine.

1 *Fifth Annual Report of the Department of Public Health for 1933* (Charlottetown, 1933), p. 10, Public Archives of Prince Edward Island [PAPEI].

2 Douglas O. Baldwin, “Smallpox Management on Prince Edward Island, 1820-1940: From

with public health were the Charlottetown and Summerside municipal boards of health, which were simply the city councils, and until 1931, P.E.I. was the only province without a health department, a medical laboratory, or a sanatorium. Since smallpox, cholera, typhus, diphtheria, and typhoid were considered preventable by relatively inexpensive vaccines, quarantine regulations, and sanitary procedures, there was little demand for permanent and costly government public health programmes. Disease management thus superceded disease prevention. The spread of tuberculosis in the 20th century, and the emergence of voluntary organizations to stem the “white plague”, played a major role in changing this attitude.

Jean Antoine Villemin made the first significant advance toward the conquest of tuberculosis in 1865 when he discovered that the disease was communicable. Seventeen years later, Robert Koch isolated the tubercle bacillus, which entered the body by inhalation or ingestion. Tuberculosis symptoms varied depending upon the part of the body infected. Early symptoms of pulmonary tuberculosis, the most common form of the disease, included coughing, expectoration, and spitting of blood. Subsequent symptoms were fever, weakness, and a general wasting away; hence the early names, consumption (from the Latin *consumo*) and phthisis (Greek for wasting away). These symptoms were not present in the incipient stage, and made diagnosis difficult before the advent of x-ray machines.

Prior to the 20th century, the general public continued to believe that the disease was hereditary. Some people ascribed consumption to such varied causes as the wrath of God, evil spirits, bad air or miasmata, restricted breathing capacity, and immorality. The 1893 *Health Reader* for P.E.I. and New Brunswick public schools attributed tuberculosis to alcohol and tight lacing.³ Since consumption was generally considered incurable, and its progression was slow and steady rather than dramatic, people adopted a fatalistic attitude towards it. Indeed, physicians could do little for their patients. Although some doctors recommended hypnosis, deep breathing exercises, or an hospitable climate, the basic treatment continued to be rest, fresh air, and wholesome and fattening food.⁴

The first official recognition that consumption was a problem in P.E.I. appeared in the Charlottetown Health Officer’s reports during the late 1880s.

Neglect to Fulfillment”, *Canadian Bulletin of Medical History*, II (Winter 1985), pp. 147-81; Baldwin, “Pigs, Epidemics, and Hospitals: The Struggle for Public Health Services”, in Baldwin and Thomas Spira, eds., *Gaslights, Epidemics and Vagabond Cows: Charlottetown in the Victorian Era* (Charlottetown, 1988), pp. 51-69.

- 3 Sheila M. Penney, “Nova Scotia, 1900-1914: A Case Study of the ‘Sanatorium Solution’ to Tuberculosis”, unpublished paper presented at the Atlantic Canada Studies Conference, Edinburgh, 1988, p. 5.
- 4 George Jasper Wherrett, *The Miracle of the Empty Beds* (Toronto, 1977), pp. 12, 16, 43, 202; Edward Playter, *Consumption: Its Nature, Causes and Prevention* (Toronto, 1895), pp. 13, 70; William G. Rothstein, *American Physicians in the Nineteenth Century* (Baltimore, 1972), p. 270.

IN CASE OF CONSUMPTION, LOOK TO THESE FOR CURE



THE DOCTOR.



SUNLIGHT.



OUT-DOOR AIR.



GOOD FOOD.

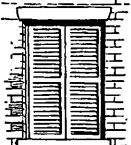


REST.

CONSUMPTION'S ALLIES—AVOID THEM AND YOU ARE SAFEGUARDING AGAINST THE DISEASE



INTEMPERANCE AND OTHER EXCESSES.



THE CLOSED WINDOW.



OVERWORK.



CROWDED SLEEPING LIVING AND WORKING ROOMS.



SMOKE AND DUST.



MOUTH BREATHING OFTEN DUE TO AGENOSIS.

CURES AND CAUSES

A CAREFUL CONSUMPTIVE,—NOT DANGEROUS TO LIVE WITH,



COUGHS, SPITS AND SNEEZES INTO PAPER OR CLOTH,—



BURNS OR BOILS IT BEFORE IT DRIES,—



OR PUTS IT INTO A DISINFECTANT,—



WASHES HER HANDS BEFORE AND AFTER EATING.—



ALWAYS USES THE SAME DISHES AND BOILS THEM IN WATER BEFORE WASHING WITH OTHER DISHES,—



AND SLEEPS ALONE

HOW THE GERMS OF CONSUMPTION ARE CARRIED FROM THE SICK TO THE WELL



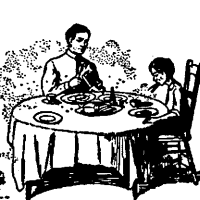
CONSUMPTIVE SPITTING ON FLOOR. FLIES FEEDING ON IT, CARRY THE GERMS OF THE DISEASE TO FOOD.



THE SPIT DRIES AND CARELESS SWEEPING, DUSTING OR DRAUGHTS CAUSE THE GERMS TO FLOAT IN THE AIR.



THE GERMS MAY ENTER THE BODIES OF CHILDREN PLAYING ON THE FLOOR, THROUGH SORES OR WOUNDS.



OTHERS MAY GET THE DISEASE BY BREATHING OR SWALLOWING THE GERMS. SPRAY GIVEN OFF IN SNEEZING OR COUGHING, CONTAINS GERMS IN A MOIST AND ACTIVE STATE.



PUTTING FOOD, MONEY, PENCILS ETC. INTO THE MOUTH AFTER A CONSUMPTIVE HAS POISONED THEM WITH HIS SPIT.

They revealed that consumption accounted for over 17 per cent of Charlottetown's mortuary statistics, and that only two Canadian cities (Sorel and London) had a higher proportion of deaths per 1,000 population.⁵ The Health Officer advocated cleanliness of home and body, better sewerage facilities, meat and milk inspection, and more efficient disease notification. Unfortunately, nothing occurred for nearly two decades, as smallpox and diphtheria, quick-striking and deadly maladies, attracted more attention. The municipal government's reluctance to continue the practice begun by the federal Department of Agriculture in 1892 of collecting mortuary statistics also served to camouflage the extent of tuberculosis in Charlottetown. Doctors were only required to report infectious diseases, not consumptive patients. Outside the capital, most people considered the benefits of rural life sufficient protection.⁶

The spark needed to kindle interest in tuberculosis prevention in P.E.I. came from the Canadian Association for the Prevention of Consumption and Other Forms of Tuberculosis (later the Canadian Tuberculosis Association). Created in 1900 through the influence of the Canadian Medical Association, Governor-General Lord Minto, and several concerned individuals, the CTA sought to combat tuberculosis by educating the general public about the disease, influencing governments to pass needed legislation (including the creation of sanatoria), and establishing local and provincial anti-tuberculosis branches throughout Canada.⁷ To this latter end, the association's secretary/organizer, retired minister Dr. William Moore, travelled about the country, delivering lectures, and disseminating anti-tuberculosis literature. With the support of two P.E.I. doctors, Moore toured the Island from Souris to Alberton in the summer of 1904, giving 14 talks on the dangers of consumption. Shocked by the lack of public health facilities on the Island, Moore addressed a four-page "Open Letter to the Medical Men and Clergymen of Prince Edward Island", urging them to form a provincial association for the prevention of consumption. The people, he wrote, must be educated about the perils of tuberculosis, and the necessity of a model sanatorium and a bureau of vital statistics.⁸ In 1905, Moore revisited the Island and helped

5 "Report of the Health Officer", *Annual Report of the City of Charlottetown* (1887, 1888), PAPEI.

6 Douglas Baldwin, "The Campaign Against Odors: Sanatarians and the Genesis of Public Health in Charlottetown, Prince Edward Island, 1855-1900", *Scientia Canadensis*, X (Spring/Summer 1986), pp. 72-82.

7 Floris E. King, "Historical Study of the Voluntary Tuberculosis Community Health Program in Canada with Projective Emphasis", Ph.D. thesis, University of North Carolina, 1967, pp. 56-9.

8 William Moore, "Open Letter to the Medical Men and Clergymen of Prince Edward Island", 11 October 1904, Canadian Tuberculosis Association [CTA], file 83, Public Archives of Canada [PAC].

establish anti-tuberculosis societies in Queens and Prince counties.⁹

During the next decade, this “philanthropic movement for the betterment of common humanity” concentrated on educating the public.¹⁰ Press Committees published articles in local newspapers on tuberculosis prevention and the role of sputum in spreading the disease. School Committees promoted better hygienic classroom conditions, regular physical exercises during school hours, and annual medical examinations of all students. Legislative Committees urged municipal meat and milk inspection, compulsory medical reports on all tuberculosis patients, and anti-expectoration laws. To arouse public interest, some physicians lectured in schools and village halls, placed leaflets and posters (provided free by the CTA) in public places, and distributed sputum cups to poor patients.¹¹ In 1908, Dr. George Porter succeeded Moore as CTA organizer and continued the emphasis on arousing public and government interest through lectures, personal visits, and pamphlets. His 1908 visit to P.E.I. coincided with the Provincial Medical Society’s decision to reorganize the anti-tuberculosis society and resulted in a division of Queens and Kings counties into organizational districts affiliated with the central committee in Charlottetown. The new society created a sanatorium committee, and established a free dispensary in Charlottetown.¹²

The executive of both the Charlottetown and Summerside societies consisted largely of ministers and physicians, but with the establishment of a free dispensary in Charlottetown in 1909, women assumed a major role in the fight against tuberculosis. The society engaged nurse Gertrude DeBlois to operate the dispensary two hours daily (in conjunction with the city’s physicians who provided free medical examinations), and to perform district work during the balance of the day. Aided by the Dispensary Committee, which identified the city’s unemployed and investigated their worthiness for help, DeBlois dispensed drugs, clothing, eggs, milk, and coal to the city’s poor. The wives of Charlottetown’s physicians, clergymen, and other prominent citizens staffed this committee, which tended to concentrate more on general health problems than on tuberculosis.¹³ In 1910, for example, DeBlois visited 805 sick patients, only 18 of whom were

9 Elsewhere, anti-tuberculosis societies appeared in Ontario (1896), Quebec (1901), British Columbia and Manitoba (1904), Nova Scotia (1905), Alberta (1907), New Brunswick (1909), and Saskatchewan (1910); King, “Historical Study”, pp. 72-3.

10 “Charlottetown Anti-Tuberculosis Society Minutes” (1909), Acc. 3414, PAPEI.

11 “Report of the First Annual Meeting of the Western Association of P.E.I. for the Prevention of Tuberculosis” (January 1907), Acc. 2594A, Item 149, PAPEI; The Canadian Association for the Prevention of Tuberculosis, *Annual Report* (1906), pp. 70-2; *ibid.* (1907), Appendix No. 42.

12 George Dana Porter, *Crusading Against Tuberculosis: The Memoirs of George Dana Porter MD* (Ottawa, 1953), pp. 13-4; *Maritime Medical News* (Halifax), 8 (August 1908), p. 315.

13 “Charlottetown Anti-Tuberculosis Society Minutes” (1909-1915).

consumptive. Two years later, the city allocated \$100 to the society contingent upon it providing food to the needy.¹⁴ That same year, the provincial society added Emeline Stewart, a graduate nurse, to educate the rural districts on the need for sanitation, hygiene, and the proper treatment of tuberculosis. Stewart visited 350 homes and 40 schools that autumn, and her work was apparently so productive that the society decided “to push this phase of education to the limit of our financial resources”.¹⁵

The anti-tuberculosis campaign gradually achieved results. Provincial school inspectors reported annually on school sanitary conditions and the growth of consumption among teachers and students. In some areas, the population was so alarmed by the fear of contracting tuberculosis (phthisiophobia) that hotels refused to admit anyone with a cough.¹⁶ Charlottetown and Summerside city councils required physicians to report all tuberculosis patients, overcame opposition from meat dealers to enforce inspection of abattoirs and all meat and milk sold within their jurisdictions, passed anti-expectoration laws, and required medical inspection of school children with tuberculosis symptoms. But despite repeated requests, the provincial government failed to enact tuberculosis prevention legislation, or erect a sanatorium.

The first recorded interest in erecting a sanatorium on the Island occurred at the July 1899 meeting of the Maritime Medical Association when three Island doctors formed a committee to consider “ways and means” of doing so. Nine years later, the Maritime Medical Association passed a resolution requesting the Island government to provide a sanatorium.¹⁷ By 1909, delegates from the anti-tuberculosis societies and the provincial medical society were appearing regularly at city council and provincial cabinet meetings to request funds to construct a sanatorium. Such an institution, they argued, would help both to prevent and to cure tuberculosis. Patients would learn how to care for themselves, and once they returned home, would educate their friends and relatives. Pressure from the well-educated segments of society, however, proved unable to convince either municipal or provincial governments to part with the needed funds.¹⁸

In 1910 the Charlottetown ATBS arranged for a summer tent hospital for incipient tuberculosis cases, but although the government added a small infirmary to the Falconwood Asylum to care for indigent consumptives, it remained reticent to commit further funds, despite a booming economy based on the silver fox industry. The public did not consider tuberculosis as dangerous as the many

14 *Ibid.* (1910, 1912).

15 Canadian Tuberculosis Association [CTA], *Annual Report* (1912), Appendix 33.

16 *Ibid.* (1910), p. 24.

17 *Maritime Medical News*, 7 (July 1908).

18 CTA, *Annual Report* (1910), Appendix 15.

epidemic diseases that frequented the Island, and consequently, exerted little pressure for preventive action. "If the significance of the scourge [tuberculosis] were brought home to the people", Charles Dalton claimed in the Assembly in 1913, "they would insist, as vigorously as if the disease was smallpox, in having an end put to it".¹⁹

The sanatorium era began in North America in 1882 when Dr. Edward L. Trudeau constructed a sanatorium at Saranac Lake, New York. The first sanatorium in Canada emerged 15 years later in Muskoka, Ontario. Others followed in Nova Scotia (1904), British Columbia and Quebec (1908), Manitoba (1910), and New Brunswick (1911). By 1914 there were 34 such institutions in Canada. These sanatoria owed their existence to dedicated and wealthy volunteers, many of whom had personally experienced the tragedy of tuberculosis. Charles Dalton was Prince Edward Island's benefactor. Dalton, a Conservative M.L.A., was a wealthy silver fox farmer who had lost two daughters to tuberculosis, and had seen his teenaged son permanently disabled by the disease. In April 1913, Conservative premier J.A. Mathieson announced that Dalton had offered the province \$20,000 to defray the costs of a sanatorium, and had pledged \$1,000 annually for ten years toward its maintenance. The government unanimously accepted his gift, which ultimately totalled \$53,000, and agreed to construct a sanatorium and finance maintenance costs. The preamble to the enabling legislation illustrated the success of the anti-tuberculosis societies' educational campaign: "Whereas modern investigation has demonstrated that tuberculosis is a preventable and in many cases a curable disease, yet the ravages from this dread scourge in our Island claims many victims and causes needless loss of life, untold grief to our people, as well as great financial loss to our Province".²⁰

The government placed the construction and operation of the Dalton Sanatorium under the control of a five-person Commission — Charles Dalton (representing the government), Dr. S.R. Jenkins (President of the Medical Council), and the presidents of the anti-tuberculosis associations in the three counties. After the fashion of the day, the Commissioners selected an isolated location in North Wiltshire, 15 miles north of Charlottetown and three miles from the nearest railway. The sanatorium was situated on one of the highest points of land in P.E.I., with a beautiful view of the countryside. The rural surroundings provided fresh air, rest, and a peaceful frame of mind, as well as avoiding possible complaints by neighbours suffering from phthisiophobia. An attached farm supplied milk and produce. The three-storey, 27-bed building and pavilions opened in March 1915, employing 50 workers, including three nurses.²¹

19 P.E.I., *Journal of the Legislative Assembly*, 12 April 1913.

20 P.E.I., *Acts of the General Assembly*, "An Act to Incorporate the Charles Dalton Sanatorium", Cap. 3, 24 April 1913, PAPEI.

21 "Minutes of the Charles Dalton Commission" (1913-1915), Acc. 2541, PAPEI.

For the next seven years the Dalton Sanatorium was the source of almost constant political bickering. In 1916, Premier John Mathieson sought to enact a \$27,000 temporary War and Health Tax, \$7,000 of which would maintain the sanatorium. The new leader of the Liberal opposition, J.H. Bell, decried this additional tax, and condemned the government's original decision to accept Dalton's offer. This institution, Bell declared, cost the Island over \$20,000 annually for maintenance and operation. Transportation expenses for coal and provisions were high, and the water supply was deficient. In addition, only incipient tuberculosis patients were admitted for treatment. Advanced cases remained at home to infect friends and relatives, while the sanatorium catered to only 27 patients out of an estimated 1,000 consumptives. It would be more efficient and less expensive, he advocated, to conduct thorough and frequent school inspections, and to employ trained nurses to visit the homes of the diseased and instruct them in the benefits of fresh air, cleanliness, and sunshine. "The legislature must look beyond the war", Bell concluded, "they must face the music and face it now. Each member must answer to his constituents this question — 'Do you favor the imposition of a special tax to enable the Government to operate the Dalton Sanatorium for all future time?'"²²

There was considerable truth in Bell's condemnation of the sanatorium. Sanatoria had little medical value until collapse therapy (pneumothorax) and x-rays became popular in the 1920s. The traditional treatment of rest, fresh air, and good food was often rendered ineffective by late detection and the patients' reluctance to be hospitalized until the disease had advanced beyond the incipient stage. In addition, the sanatorium could only house a small proportion of the infected patients, few of whom were the most needy — the poor.²³ These ideas, however, ran counter to accepted medical beliefs, which favoured institutional and "scientific" medicine. Bell's proposal, Dr. S.R. Jenkins declared, would reverse the "modern methods" of medicine and return the Island to the dark days of disorganization and home medicine. Sanatoria, he continued, were educational institutions, whose cured patients "were in reality graduates who could be of incalculable value to the country in disseminating" knowledge to others.²⁴ Sheila Penney has suggested that the medical profession preferred sanatoria to public dispensaries because they were less threatening and served to enhance the physician's prestige and income.²⁵ In addition, the public health movement

22 *Patriot* (Charlottetown), 19 March 1916.

23 Katherine McCuaig, " 'From Social Reform to Social Service'. The Changing Role of Volunteers: The Anti-Tuberculosis Campaign, 1900-1930", *Canadian Historical Review*, 61 (1980), p. 483; Darlene Zdunich, "Tuberculosis and the Canadian Veterans of World War One", M.A. thesis, University of Calgary, 1984. p. 32.

24 "Scrapbook Debates", 5 August 1916 and 21 March 1912, PAPEI.

25 Sheila M. Penney, "Tuberculosis in Nova Scotia, 1882-1914", M.A. thesis, Dalhousie University, 1985, p. 172.

stressed the role of the expert in promoting scientific medical advances, and sanatoria, which used the latest diagnostic equipment, appeared to satisfy this requirement. The sanatorium's goal of educating patients and through them society, also conformed to the ideology of the pre-war public health movement.²⁶ The underlying motives of the sanatorium's proponents on P.E.I. are difficult to discover. Rent by internal dissension and public distrust, the medical profession had been less successful in achieving professional status and prestige than doctors in Nova Scotia and New Brunswick.²⁷ Lacking a research tradition, Island physicians appeared to accept CTA statements of the merits of sanatoria without question. While we now know that early sanatoria success rates benefitted by dismissing advanced cases before they died in hospital, and by accepting only incipient patients, this was not common knowledge at the time. Since Island sanatorium opponents never mentioned these facts, it seems likely that Islanders were unaware of sanatoria's general ineffectiveness. Isolation, rest, fresh air, and diet were cures that everyone could understand, and the physical presence of a sanatorium was visual evidence that the government was concerned with the voter's well-being.

The Island government thus chose to follow accepted wisdom. The special tax passed, but in 1916 the federal Military Hospitals Commission, which had been created to care for injured and diseased soldiers, assumed control of the Dalton Sanatorium for the duration of the war and for one year thereafter. This temporary change in ownership was initiated by the provincial government, which wished to claim a share of federal monies being spent on tuberculosis prevention throughout the country. The Island even agreed, under duress, to contribute \$9,000 to assist additional construction. During the next two years, government members visited Ottawa on several occasions to insist that the federal government expand the Dalton Sanatorium in line with federal expenditures elsewhere. As a result, the Military Hospitals Commission purchased an adjoining 60-acre farm, and increased accommodations to 46 and later to 72 beds. Despite opposition by the provincial Liberal party, the federal government expended over \$366,700 in remodelling the Dalton Sanatorium.²⁸ Thus, when the sanatorium was scheduled to be returned to the provincial government in 1921, the enlarged hospital had become a white elephant.

26 McCuaig, "From Social Reform to Social Service", p. 480.

27 See Douglas Baldwin and Nancy J. MacNeill MacBeath, "Quacks, Physicians, and Opium Eaters: The Professionalization of Medicine in the 19th Century", *The Island Magazine*, 26 (Fall/Winter 1989), pp. 13-9.

28 In 1915, Canada had 32 sanatoria, with approximately one bed for every 4,400 Canadians. By the end of 1919, thanks largely to government funds, 36 sanatoria provided beds for every 2,300 people. "Department of Soldiers' Civil Re-Establishment", Canada, *Sessional Papers* (1917-21); "Military Hospitals' Commission Minutes", 31 May 1920 and Memo 1919, RG 38, vol. 287, PAC; "Scrapbook Debates", 12 April 1917, PAPEI.

Bell became Island premier in 1919 on a programme that included belt tightening to reduce the deficit. When an unidentified "Ontario specialist" estimated that the enlarged sanatorium would cost \$125,000 to operate, and \$40,000 in annual maintenance, the Premier despatched a delegation to the Department of Soldiers' Civil Re-establishment demanding either \$60,000 in compensation, or assurances that the federal government would continue to operate the institution. The federal government rejected these demands, transferred the consumptive patients to a Quebec sanatorium, and returned the Dalton Sanatorium to the Island government. The Charlottetown Anti-Tuberculosis Society (ATBS) and the opposition Conservative party both fought to save the sanatorium. The Society suggested that the building's capacity be reduced to 30 beds, the upkeep of which would not exceed \$15,000 annually. Certainly, Bell's estimate of \$125,000 for the 72-bed sanatorium seemed high, considering that similar-sized institutions in Fredericton and Kentville cost \$59,000 and \$40,000 respectively.²⁹ The premier, however, was a long-time opponent of the sanatorium, and in 1922 he returned Dalton Sanatorium to its benefactor, stating that the people "are not prepared to pay the price no matter how great the benefits derived from it".³⁰

Although the poor fitness level of Canadian soldiers in World War I had dramatized the magnitude of Canada's tuberculosis problem,³¹ the first few years of peace in P.E.I. witnessed the decline of the anti-tuberculosis movement. The provincial anti-tuberculosis society existed in name only, and the Charlottetown Society closed its dispensary for the summer months to conserve funds.³² In 1922, the Canadian Tuberculosis Association reported that although P.E.I. had the highest tuberculosis death rate in Canada (see Table 1), and the lowest tax rate per person, the premier had refused to reopen the sanatorium because increased taxes would be unpopular with the people.³³ The province still lacked a full-time Medical Health Officer, a modern medical laboratory, and a provincial health department. The nadir came when Charles Dalton dismantled all but the doctor's residence at the sanatorium, and donated the materials and furnishing to Bishop O'Leary to rebuild the Charlottetown Hospital. The loss of the sanatorium, Dr. W.J.P. MacMillan later recorded in his memoirs, "constitutes the darkest page in our history".³⁴

29 *Patriot*, 22 March 1921; Charlottetown Anti-Tuberculosis Society, *Annual Report* (1920-1922), PAPEI.

30 "Scrapbook Debates", 22 March 1922, PAPEI.

31 McCuaig, "From Social Reform to Social Service", pp. 487-8.

32 "Charlottetown Anti-Tuberculosis Society Minutes", 5 April 1922, PAPEI.

33 Text of the radio talk given at the Toronto Canadian National Exhibition, 28 August 1922, as reported in *The Canadian Red Cross* (November 1922), p. 14.

34 W.J.P. MacMillan, "Memoirs", in the possession of Dr. A. MacMillan, Charlottetown.

Table 1

Tuberculosis Mortality Rates Per 100,000 Population, 1921-1932

YEAR	PEI	NS	NB	QUE	ONT	MAN	ATLA	BC	CANADA
1921	144	134	106	123	71	69	53	78	88
1922	126	133	108	121	66	61	53	94	86
1923	107	126	113	124	66	65	62	95	87
1924	116	129	107	121	60	62	61	92	84
1925	100	113	103	115	59	61	59	92	81
1926	103	125	105	126	58	61	60	88	84
1927	83	125	103	118	56	57	63	88	81
1928	114*	111	101	118	56	60	51	99	81
1929	85	101	94	119	51	63	57	93	78
1930	117	107	97	119	53	66	58	92	80
1931	77	102	83	111	50	61	52	93	74
1932	99	100	79	102	46	56	54	80	69

* The sudden growth in tuberculosis deaths was attributed to an influenza epidemic.

Source: George J. Wherrett, *The Miracle of the Empty Beds: A History of Tuberculosis in Canada* (Toronto, 1977), Appendix 6.

The only positive signs at this time came from the Federal Department of Agriculture. In 1897 it had offered free tuberculin testing for stock owners who promised to dispose of their diseased cattle. Rather than compel uniformity, the Federal Department of Agriculture launched a series of voluntary programmes to illustrate the economic and health benefits of disease-free cattle.³⁵ By 1910 the Department's educational campaign had resulted in greater public agitation for a safer milk supply. Before long, dairymen were demanding that the cattle they purchased be free from tuberculosis, and the breeders of dairy stock realized that unless they produced healthy cattle, they could not obtain a ready market for them. In 1918, Canada and the United States adopted a plan for the eradication of bovine tuberculosis in pure-bred herds. The next year the Accredited Herd Plan provided for government testing of pure-bred cattle, the slaughter of infected animals, and compensation for those slaughtered; and in 1922, the federal government initiated the Restricted Area Plan to eradicate the disease in areas where at least two-thirds of the cattle-owners agreed to comply with government regulations. In 1924, when the cattle owners adopted the programme, Prince Edward Island became the third area, and the first province, to become tuberculosis-free.

Although bovine tuberculosis was eradicated on the Island, the province still had one of the highest consumption mortality rates in Canada, and was the only province without sanatoria, chest clinics, or diagnostic laboratories.³⁶ The provincial government also declined to support orphanages, the Children's Aid Society, the Red Cross, the Charlottetown ATBS, or establish a bureau of vital statistics and a permanent department of health. Although the early 1920s was a difficult and uncertain time, the collapse of the regional economy cannot alone account for the Island's neglect of basic public health measures.³⁷ The reasons went beyond mere funding problems.

Because P.E.I. had no public lands, large industrial enterprises, or forest or mineral wealth, its revenue depended mostly upon federal subsidies and direct taxation. The Island had been the first province to impose a direct tax in 1894, and consistently raised a larger proportion of its revenue by this means than did other provinces. Between 1913 and 1921, property and income taxes increased from eight per cent of total revenues to 21 per cent. Continuing outmigration reduced the population from a high of 109,000 in 1891 to 86,000 in 1925, resulting in a smaller proportion of wage earners and a higher ratio of those over 70 years of

35 For further information see CTA *Bulletin* (September and December 1925, June 1927).

36 John Heagerty, *Four Centuries of Medical History in Canada* (Toronto, 1928), vol. 2, pp. 227-45.

37 For a defense of the economic problems see Phillip Buckner, " 'Limited Identities' and Canadian Historical Scholarship: An Atlantic Provinces Perspective", *Journal of Canadian Studies*, 23 (Spring/Summer 1988), p. 191.

age. This placed a greater tax burden on the employed people left behind. Higher freight rates, and a reduced demand for fish and agricultural produce following the war, further hindered economic growth.³⁸

Prince Edward Island, however, seemed less affected by the regional malaise than were Nova Scotia or New Brunswick. Charlottetonians, for example, surpassed their 1919 Victory Loan target of \$2,900,000 by \$400,000, and the president of the Board of Trade stated early in 1921 that although “we cannot boast of our country being a land of Millionaires, yet the people in this province for the most part are prosperous, comfortable and happy”.³⁹ Frugal financing limited the growth in provincial interest payments between 1916 and 1925 to 69 per cent, compared to 310 and 317 per cent in Nova Scotia and New Brunswick respectively.⁴⁰ And, while it was true that Premier Bell refused to assume control of the Dalton Sanatorium as part of his belt-tightening programme, he spent over \$159,000 in 1921-22 on highway improvements as part of the federal government’s plan to encourage the construction of a connected system of highways across Canada. In this same period, provincial health expenditures totalled only \$785. Bell provided the Island with the most miles of road per capita in Canada (it also had the highest population density), and imposed a \$3.00 poll tax to finance the construction.⁴¹ The funding was available to maintain the Dalton Sanatorium, but public health was just not a priority. Two years later, the Bell government fell to the Conservative party which had campaigned against the growing costs of highway construction, that had increased the province’s debt by almost \$500,000.⁴² But the new government soon found the patronage opportunities surrounding road improvements too inviting to ignore, and embarked on its own public works programme.

Fiercely independent and relatively secure, Islanders continued to believe that a government governs best by governing the least. Both political parties concentrated on balancing the budget, and providing only those services that the people demanded, which was common North American practice in the 1920s.⁴³ Most

38 Stewart Bates, *Financial History of Canadian Governments* (Ottawa, 1939), p. 96; Frederick L. Driscoll, “The Island and the Dominion”, in F.W.P. Bolger, ed., *Canada’s Smallest Province* (Charlottetown, 1973), p. 275.

39 *Evening Patriot* (Charlottetown), 14 July 1921, as quoted in Peter E. Rider, “Coping with Hard Times: The Response of Charlottetown, P.E.I. to the Economic Reverses of the Inter-war Period, 1919-1939”, unpublished paper presented at the Canadian Urban History Conference, Winnipeg, 1985; *The Canadian Annual Review* (Ottawa, 1918), p. 669.

40 Computed from *The Maritime Provinces Since Confederation* (Ottawa, 1927), p. 121.

41 Bates, *Financial History*, pp. 44-5; Wilfrid Eggleston and C.T. Kraft, *Dominion-Provincial Subsidies and Grants* (Ottawa, 1939), pp. 44-5; Wayne E. MacKinnon, *The Life of the Party* (Summerside, 1973), p. 85.

42 *Reports of the Provincial Auditor of Public Accounts* (Charlottetown, 1921-23).

43 Ottawa reduced federal spending by 25 per cent per capita between 1921 and 1929, and allowed

Islanders, however, apparently believed that their province, especially the rural countryside in which almost 80 per cent of the people lived, was immune from epidemics.⁴⁴ The urban reform movement, which emphasized the blessings of farm life, only confirmed this belief. P.E.I. was unrepresented on the Dominion Council of Health, because, as John Heagerty explained in 1927, Islanders considered themselves particularly healthy, “so that there does not appear to have been the same urgent demand for a department of public health as in the other provinces”.⁴⁵

When Amy MacMahon arrived on P.E.I. in 1921 to organize a public health programme for the provincial Red Cross Society she discovered that the task of convincing the government to accept responsibility for the people’s health “was rather a unique one, for it was not alone a case of interesting a few important people, and converting the members of the Government. The people of the Island as a whole would have to be sufficiently stirred up” to demand that the government provide the financing, and be willing to “pay the extra tax”.⁴⁶ MacMahon’s successor, Mona Wilson, encountered similar 19th-century health views:

In about 1925 I was driving away off in the country one day and saw a girl walking ahead. She had a most peculiar gait. I slowed up to study it but couldn’t figure it out. When I got near, found she had double club feet — a girl of about 12 yrs. clumping along with one foot over the other. Picked her up, took her home, talked to the mother, the school teacher, the priest, interviewed a surgeon re correction, finally after a year broke down the attitude of the mother — that this condition was a case “of the sins of the parents would be visited unto the children unto the 3rd and 4th generation” (or whatever the correct quotation is) because the mother had married her first cousin!!!⁴⁷

Changing North American perceptions of tuberculosis and public health also played a role in the Island’s reluctance to spend public monies on preventive measures. Prior to World War I, the anti-tuberculosis campaign was part of the urban reform movement which sought to improve conditions by bettering the environment. Although tuberculosis obviously infected the individuals, its causes were believed to be rooted in the community.⁴⁸ The P.E.I. anti-tuberculosis

the Department of Health to deteriorate. John Herd Thompson and Allen Seager, *Canada, 1922-1939* (Toronto, 1985), p. 129.

44 Douglas O. Baldwin, “Smallpox Management on Prince Edward Island”, p. 170.

45 Heagerty, *Four Centuries*, vol. 1, p. 380.

46 Amy E. MacMahon, “Pioneer Public Health Nurse in Prince Edward Island, Canada”, *Johns Hopkins Nurses Alumnae Magazine* (Baltimore), 22 (February 1923), p. 15.

47 Wilson to B.A. Delaney, 5 March 1953, Acc. 3280, PAPEI.

volunteers were thus involved in a variety of reforms from impure milk to improper sewer connections.⁴⁹ Pre-1920 anti-tuberculosis work was in keeping with 19th-century charitable practices. Indeed, the creation of the Dalton Sanatorium resulted from an individual act of philanthropy, not from government commitment or public pressures. Following the war, however, perceptions of tuberculosis switched from a community disease to an individual malady. The diseased organism was now the infected person, not the environment.⁵⁰ Public health reformers turned their attention from arguing for coercive legislation to promoting educational campaigns designed to change individual habits. When this failed, and governments also proved unresponsive, insurance companies, the Red Cross, the CTA, and other volunteer organizations mounted well-financed campaigns, administered by paid specialists, designed to encourage the people to demand comprehensive medical care from their governments.⁵¹

In the absence of government concern with public health matters on the Island, the Canadian Red Cross Society took the initiative at the conclusion of World War I. In 1920, the P.E.I. Society sent a delegation to the government requesting a provincial laboratory, a full-time medical health officer, public health nurses, and the creation of a provincial health department similar to other provinces.⁵² When this attempt failed, the society hired Amy MacMahon, a graduate nurse from The Johns Hopkins Hospital, to conduct a child welfare and public health nursing demonstration.⁵³ The Red Cross hoped that the government would be so impressed by her work that it would henceforth assume the financial burden, but when the Bell government proved unresponsive, the Red Cross Society rehired MacMahon, and added a second nurse, followed by a third in 1923. These public health nurses instructed students in proper hygiene, and inaugurated dental, vaccination, prenatal, immunization, infant, and crippled children clinics. Supported by the Women Institutes, the Gyro Club, Protestant and Catholic churches, and the Charlottetown ATBS, the Red Cross Society operated as a surrogate provincial health department, enabling the government to avoid binding health commitments. Thus, when the Canadian Red Cross Society offered to grant the provincial society an extra \$5,000 conditional on the province spending a similar amount on public health, the government declined.⁵⁴ Although the nurses were appalled at the large number

48 Katherine McCuaig, "Tuberculosis: The Changing Concepts of the Disease in Canada, 1900-1950", in Charles G. Roland, ed., *Health, Disease and Medicine* (Hamilton, 1982), p. 300.

49 *Guardian*, 2 April 1912.

50 McCuaig, "Tuberculosis: The Changing Concepts of the Disease in Canada", p. 300.

51 McCuaig, "From Social Reform to Social Service", pp. 491-500.

52 "Minute Book of the Prince Edward Island Branch of the Canadian Red Cross Society" (August 1920), Acc. 3150, Item 16, PAPEI.

53 MacMahon, "Pioneer Public Health Nurse", p. 15.

54 "Minutes of the Executive Committee of the Canadian Red Cross Society", 10 October 1923,

of tubercular patients throughout the Island, anti-tuberculosis work formed only a small part of their activities.

The impetus for post-war tuberculosis prevention on the Island originated with the Canadian Tuberculosis Association, and its executive secretary Dr. Robert E. Wodehouse. Late in 1922 the CTA Executive resolved to establish a three- to five-year anti-tuberculosis demonstration in a medium-sized Canadian city to illustrate the effectiveness of diagnostic x-ray clinics, health surveys, sanatoria, and follow-up visitations. A successful programme, it hoped, would lead to “bigger things”, as had recent Ontario demonstrations in nature study, household science, and manual training. Although several executive members suggested sites in Nova Scotia and Quebec, two provinces with high tuberculosis mortality rates, Wodehouse and Dr. J.W. Robertson, the Chairman of the Canadian Red Cross Society, opted for Prince Edward Island after discovering the Island’s woeful lack of anti-tuberculosis facilities during a summer survey of the Maritimes. P.E.I.’s size, isolation, and even population density made it an ideal location to demonstrate the benefits of preventive health care. However, Premier Bell balked at the stipulation that the Island establish a permanent health department and diagnostic clinics, and the CTA selected Three Rivers as its demonstration site.⁵⁵

In 1924 the provincial government finally allocated funds to the Red Cross Society. The impetus behind this change in policy came from Dr. W.J.P. MacMillan, and Margaret Grier, the CTA Assistant Secretary. At public meetings arranged by the Red Cross and the Women’s Institutes in 1923 and 1924, Grier gave illustrated talks on tuberculosis prevention and revealed that although P.E.I. had one of the highest tuberculosis mortality rates in Canada, it was the only province lacking sanatoria, diagnostic clinics, and government preventive health work. These revelations shocked many Islanders,⁵⁶ and W.J.P. MacMillan chose this time to run for political office. As a close friend of Dr. S.R. Jenkins, the Secretary of the Provincial Red Cross Society, and as a member of both the Children’s Aid Society and the Charlottetown ATBS, MacMillan had participated in several public health delegations which had been repeatedly refused government grants. When the 1923 election approached, he decided to run and “go after it another way”. MacMillan and the Conservatives captured 25 of 30 seats. The new premier, J.D. Stewart, was MacMillan’s patient and friend, regarded MacMillan as his “first Lieutenant”, and consulted him more than any

Canadian Red Cross Society Archives, Ottawa. In fact, many people erroneously believed that this work was being conducted by the government. P.E.I. Red Cross Society, *Annual Report* (1924), Red Cross Society Archives, Charlottetown.

55 “Executive Minutes”, 28 November 1922, vol. 7, file 5, and “History of P.E.I. Full-time Provincial Public Health Service” (1932), vol. 7, file 48, CTA, PAC.

56 P.E.I., Red Cross Society, *Annual Report* (1924), Red Cross Society Archives, Charlottetown.

other party member. In 1924, MacMillan reached his “first objective” when the government granted the Red Cross \$2,500.⁵⁷

At approximately the same time, Dr. Wodehouse persuaded the Ontario government to loan its Provincial Chest Diagnostician, Dr. G.C. Brink, and its portable x-ray equipment to operate clinics throughout the Island in the summer of 1925. The CTA financed the clinics, while the Red Cross nurses, under Mona Wilson, organized them, and arranged for public meetings to be addressed by Brink and Wodehouse. Brink examined 189 referred patients, and found only 34 per cent of them free of tuberculosis. The activities of the Federal Department of Agriculture’s Restricted Area programme and its discovery that bovine tuberculosis had spread into several farmers’ homes served to make the population receptive to the doctor’s services, and many patients travelled a great distance to attend the clinics.⁵⁸ In the evenings the two physicians addressed public meetings, including the P.E.I. Medical Society, on the perils of consumption. “I can see Dr. B. now”, recalled Mona Wilson in 1964, “a tall, thin, cadaverous looking man with dark, deep set eyes — addressing these public meetings held in district halls at night lighted only by lamp light”.⁵⁹

Following the success of the travelling chest clinics, Wodehouse resurrected his earlier plan to turn Prince Edward Island, where he owned a summer cottage, into an experimental health area. After several private meetings with Premier Stewart in the Summer of 1925, Dr. Wodehouse, supported by a CTA five-year annual grant of \$20,000, offered to establish a comprehensive health department, with a provincial Health Officer, a 25-bed building for advanced tuberculosis cases, x-ray equipment, and 11 trained nurses (five with sanatorium experience) operating out of five cooperating villages across the Island. In return, Wodehouse required P.E.I. to contribute \$5,000 annually to defray the expenses of the new department, which would become a government responsibility.⁶⁰

Clearly, the CTA was following the strategies of the Canadian Red Cross Society and the Rockefeller Foundation in familiarizing the general public with the benefits of better health facilities before threatening to withdraw these advantages in hopes that the people would demand that the government provide similar services.⁶¹ After a short lobbying campaign by the provincial Red Cross,

57 MacMillan, “Memoirs”.

58 CTA, *Bulletin*, September 1925.

59 “Mona Wilson Red Cross Reminiscences”, Acc. 3028, PAPEI; G.C. Brink, “The Travelling Diagnostic Clinic for Diseases of the Lungs”, CTA *Bulletin* (1925); “Prince Edward Island Medical Society Minutes”, 8 July 1925, Medical Society Archives, Charlottetown.

60 Wodehouse to Stewart, 24 July 1925, vol. 7, file 49, CTA, PAC; “Scrapbook Debates”, 24, 27 March 1926, PAPEI.

61 John G. Reid, “Health, Education, Economy: Philanthropic Foundations in the Atlantic Region in the 1920s and 1930s”, *Acadiensis*, XIV, 1 (Autumn 1984), p. 71.

and the Canadian Red Cross Society's offer to grant its provincial body an additional \$2,500 contingent upon the provincial government making an equal contribution, many politicians responded favourably to the proposal, but the Stewart government procrastinated into January of the next year as it tried to balance the budget. Despite a spate of last-minute telegrams between Wodehouse and Stewart, Quebec received the financial aid instead of P.E.I.⁶² Through his friendship with Gordon Ramsay of the Canada Life Assurance Company, and V.R. Smith of the Confederation Life Association, Wodehouse addressed the Public Health Committee of the Canadian Life Insurance Officers Association (CLIOA) four days after P.E.I.'s rejection of his health proposal. He informed the Committee that the Maritimes had the highest tuberculosis mortality rates in the country, which resulted in "*great loss to insurance companies carrying Health and Death risk policies*", and suggested that the eastern provinces needed "stimulation" similar to the travelling chest diagnosticians in operation in British Columbia, Saskatchewan, and Ontario, and about to commence in Alberta. Such field work, combined with a three-year publicity campaign, would "create public opinion to compel a change of attitude".⁶³ The CLIOA, which represented 44 insurance companies, accepted Wodehouse's scheme, agreed to provide \$45,000 over three years to combat the spread of tuberculosis in the Maritimes, and established the Maritime Tuberculosis Educational Committee (MTEC) (with representation from the CLIOA, the three provincial governments, and the CTA) to administer the funds. Wodehouse was appointed chairman, and Dr. George Jasper Wherrett became the medical director assigned to conduct diagnostic work in New Brunswick.⁶⁴ This time, when the MTEC promised to spend \$15,000 annually on the Island for five years, to engage a fourth Red Cross nurse, and to assign Wherrett to hold twice yearly tuberculosis clinics in various Island locations, Prince Edward Island agreed to augment its grant to the provincial Red Cross Society to \$5,000.

P.E.I.'s parsimony was not due primarily to its limited financial resources. Although it had the lowest provincial revenues per capita, the Island also had the lowest expenditures. As Tables 2 and 3 illustrate, ordinary revenues usually exceeded ordinary expenditures throughout the 1920s, which was not the case in the other two Maritime provinces. Island out-migration bottomed in 1925, and thereafter the population slowly increased. Interest payments on the 1929

62 Wodehouse to Stewart, 24 July 1925, vol. 7, file 38, and January 1926 Telegrams, file 49, CTA, PAC; P.E.I. Red Cross Society", Executive Minutes", 12 February 1926, Red Cross Archives, Charlottetown; "Minutes of the Canadian Red Cross Central Council", 8 December 1925, Red Cross Society Archives, Ottawa.

63 Wodehouse to V.R. Smith, 23 January 1926, File 49, CTA, PAC.

64 The New Brunswick government had recently recruited Dr. Wherrett from the Fort Qu'Appelle Sanatorium to conduct provincial chest clinics.

Table 2

**Ordinary Revenues, Expenditures, and Liabilities
on Prince Edward Island, 1920-1930**

	Ordinary Receipts \$	Ordinary Expenditures \$	Surplus Revenue (Deficit) \$	Total Liabilities
1920	740,970	660,770	80,200	-
1921	769,720	694,040	75,680	1,277,800
1922	748,890	687,240	61,650	-
1923	554,300	790,050	(235,750)	1,714,900
1924	738,430	715,880	22,550	-
1925	740,080	745,340	(5,260)	2,048,500
1926	832,550	756,110	76,440	2,030,400
1927	836,750	870,430	(33,680)	2,189,600
1928	1,034,780	943,550	91,230	2,382,200
1929	1,083,570	1,033,550	50,250	2,558,740
1930	1,148,750	1,133,370	15,380	-

Source: *The Canada Year Book 1932* (Ottawa, 1932), p. 734; *Reports of the Provincial Auditor of Public Accounts* (Charlottetown, 1920-30).

Table 3

Ordinary Receipts and Expenditures Per Capita, 1916-1930

	Prince Ordinary Receipts	Edward Ordinary Expenditures	Island Surplus (Deficit)	N.S. Surplus (Deficit)	N.B. Surplus (Deficit)	Ontario Surplus (Deficit)
1916	5.59	4.98	.61	.02	.03	.41
1917	5.49	5.39	.10	(.44)	(1.60)	.64
1918	5.72	5.39	.33	(.47)	(.11)	.64
1919	5.61	7.33	(1.72)	0.0	(1.09)	(.27)
1920	8.32	7.42	.90	(.22)	.35	.03
1921	8.69	7.83	.86	(.17)	(1.39)	.63
1922	8.41	7.72	.69	(.07)	.61	.76
1923	6.37	9.08	(2.71)	.18	(.43)	(4.80)
1924	8.57	8.32	.25	(.23)	(.28)	(2.33)
1925	8.61	8.67	(.06)	(2.92)	(1.41)	(1.11)
1926	9.57	8.69	.88	(1.14)	.32	.25
1927	9.62	10.00	(.38)	(.10)	1.16	.17
1928	11.76	7.22	4.54	(1.19)	(.26)	.07
1929	12.31	11.74	.57	.20	(1.31)	.79
1930	13.05	12.88	.17	(.42)	(2.08)	(.19)
Total			5.03	(6.97)	(7.49)	(4.31)

Source: *The Canada Year Book 1932* (Ottawa, 1932), p. 737.

provincial debt were only \$75,000 (about seven per cent of total revenues), compared to \$2,270,000 in Nova Scotia, and \$1,904,000 in New Brunswick. The Island even managed to reduce its debt in 1926 by \$18,000.⁶⁵ Much of the province's economic success was attributable to agricultural production (especially field crops), which employed over 60 per cent of the male population, and contributed over 80 per cent of the net value of production.⁶⁶ Thus, while P.E.I. had one of the lowest wealth per capita ratios in the country, there were funds available for public health services if the government wished to change its budgeting policies, or reverse its priorities from roads and bridges, which steadily increased their share of expenditures from 15 per cent in 1921 to 32 per cent in 1931, to health and welfare, which declined in the same period from 17 to 12 per cent.⁶⁷ A prime example of Island financing occurred in 1927 following the receipt of an additional \$125,000 in federal monies as a result of the Duncan Commission. The provincial government immediately reduced taxes by almost \$40,000, and raised highway expenditures by 48 per cent. Thus, although the Island showed a surplus on current accounts from 1928 to 1930, the debt increased yearly.⁶⁸

Prince Edward Island was a rural province. Families generally cared for their own sick and lame. They operated small, self-sufficient, thrifty farms, and expected the government to be equally penurious. The Saunders administration, for example, had only three portfolied ministers, and the eight cabinet ministers all considered their positions part-time.⁶⁹ The people looked to their government to provide basic services, which did not include social services. As one CTA executive member stated, "What will happen in Prince Edward Island [regarding the creation of a sanatorium and a department of health] depends upon the success of our efforts to convince those thrifty prosperous people that they should assume a greater responsibility themselves. We have promised further aid so soon as this is manifest".⁷⁰

Following Dr. Brink's visit, the anti-tuberculosis campaign continued unabated. Wherrett conducted over 50 chest clinics and inspected almost 800 patients, while the Maritime Educational Committee distributed weekly health

65 *The Canada Year Book 1932* (Ottawa, 1932), p. 732; and *Reports of the Provincial Auditor of Public Accounts* (Charlottetown, 1926).

66 S.A. Saunders, *The Economic History of the Maritime Provinces* (Fredericton, 1984), p. 114.

67 Calculated from Thane A. Campbell, *The Case of Prince Edward Island: A Submission Presented to the Royal Commission on Dominion Provincial Relations* (Charlottetown, 1937), appendices.

68 Bates, *Financial History*, p. 98; *Canada Year Book 1932*, p. 743.

69 Leonard J. Cusack, "The Prince Edward Island People and the Great Depression, 1930-1935", M.A. thesis, University of New Brunswick, 1972, p. 8.

70 CTA *Bulletin* (June 1926).

articles to Island newspapers. The Red Cross nurses demonstrated the value of public health work through their school inspections, Junior Red Cross work, home visitations to tuberculosis patients, and distribution of literature to the Women's Institutes. Wherrett and Wodehouse addressed the Island Medical Society, and lectured to as many public meetings as possible. Each fall at the Provincial Exhibition the Red Cross displayed statistical charts, slides and moving pictures detailing the harmful effects of consumption, and in 1927, the Red Cross and the Women's Institutes took part in the National T.B. Christmas Seal campaign. This Seal Campaign, which was itself a promotional activity, had been expected to yield \$1,000, but raised over \$2,200.⁷¹ Many people also noticed the Red Cross posters at the provincial Exhibition, remarked on the high tuberculosis death rate, and seemed appalled at the lack of treatment facilities. In July 1927, the Island Medical Society formed a committee to discuss with the government the issue of obtaining beds for incurable tuberculosis patients.

The growing agitation finally impelled the government to act. In 1927 the Public Health Act of 1908 was replaced by new regulations similar to those adopted in Nova Scotia in 1910, which required compulsory notification of tuberculosis, disinfection of the patients' premises, and health restrictions on workers in food processing occupations.⁷² In 1928, the new Liberal administration under Summerside Lawyer A.C. Saunders required that all students entering Prince of Wales College provide proof that they were free of tuberculosis, and made office rooms available in Summerside for Red Cross nurses performing tuberculosis duties in Prince County. In March, Saunders met with Red Cross and Women's Institutes' committees. He suggested that the former devise a plan for a sanatorium and encouraged the Women's Institutes "to get together in the next year and make sufficient collections to establish" a sanatorium.⁷³ In the Legislative Assembly, Saunders acknowledged that the people's health should be the province's first consideration, but refused to act until the citizens "are willing to contribute sufficient to carry on this most worthy object".⁷⁴ Two months later the provincial Red Cross Society urged both political parties to suspend partisan politics temporarily and agree to a special tax to help erect a sanatorium.⁷⁵ The Women's Institutes also acted on Saunders' suggestion. At their annual convention in August, the 300 delegates established a fact-finding committee to determine

71 P.E.I. Red Cross Society, *Annual Report* (1927).

72 B.C. Keeping, "The Development of Public Health in Prince Edward Island", *Canadian Public Health Journal*, XXVI (1935), p. 13.

73 "Scrapbook Debates", 20 April 1928, PAPEL.

74 *Ibid.*, 21 March 1928, PAPEL.

75 "Minute Book of the Prince Edward Island Branch of the Canadian Red Cross Society", 28 May 1928, Acc. 3150, Item 18, PAPEL.

the costs of constructing and maintaining a provincial sanatorium. Later, a more representative committee was formed consisting of two members of the Women's Institutes; three members each from the Boards of Trade and the Medical Society; Justice F.L. Haszard, ex-premier and president of the Red Cross; Dr. S.R. Jenkins of the Charlottetown ATBS and Secretary of the Red Cross; and Dr. P.A. Creelman, representing the CTA.⁷⁶ Privately, Saunders attempted to use the lack of public health facilities to secure increased federal subsidies. In a confidential memorandum to Prime Minister W.L.M. King in December, the Premier wrote that "we have never been able in the history of this Province to do anything for public health. We have today over 700 cases of persons suffering from tuberculosis, with no sanatorium or other place to take care of them or give them proper treatment.... it will cost about \$3,000 per bed, and a 100-bed Sanatorium [sic] would cost our Government at least \$125,000 per annum to operate. How can this worthy institution be undertaken".⁷⁷

At this point, when the Red Cross Society and the MTEC offered to pay two-thirds of his salary, the government agreed to appoint a full-time Medical Health Officer and chest diagnostician.⁷⁸ The appointment of Dr. P.A. Creelman provided the spark needed to generate widespread public support for a sanatorium. Creelman had an extensive background in public health work, and had practised medicine in Ohio and Newfoundland before moving to the Riverglade Sanatorium in New Brunswick, where Wodehouse convinced him to relocate to P.E.I. A native-born Maritimer and graduate of Dalhousie University, Creelman had no difficulty in continuing Wherrett's work. Certainly, his appointment created a great deal of optimism, and Dr. MacMillan accurately prophesied that "once this diagnostician is at work, public sentiment in favour of a sanatorium will be so aroused that the government of the day will have to provide a sanatorium".⁷⁹ Indeed, Creelman spent most of 1929 promoting the need for a sanatorium and urging volunteer groups to become involved in fund-raising activities. In his view, the role of such organizations was to educate the people about the value of public health activities so that the government could then make the needed improvements.⁸⁰

The Women's Institute was the obvious organization to help arouse public

76 "Report of the Supervisor of Women's Institutes" (1928), in P.E.I. *Report of the Minister of Agriculture*, PAPEL.

77 Quoted in Ernest R. Forbes, *The Maritime Rights Movement, 1919-1927* (Montreal, 1979), p. 186.

78 At the request of Dr. Wodehouse, the P.E.I. Red Cross Society agreed to donate \$1,200 from its annual Christmas Seal Fund toward the M.H.O.'s salary, and the Maritime Tuberculosis Educational Committee extended its plan from three to five years.

79 CTA *Annual Report* (1928).

80 P.E.I. Provincial Board of Health, *Annual Report for 1929*, p. 9.

opinion. Tuberculosis home care fell naturally to mothers and wives, and the responsibilities of providing adequate nourishment, rest, and fresh air to tubercular relatives without endangering other members of the family must have proven a heavy burden to many women. The Red Cross nurses had already alerted local branches to the dangers of tuberculosis, and had recruited their help in promoting public health in the schools. In 1928 the Institute had 183 branches (which grew to 236 three years later), almost 4,000 members, and the largest number of branches per square mile in Canada. In addition, it published the popular *Institute News* quarterly to update its members on public health and other issues.⁸¹

Scouring the province, Creelman convinced 178 of the 183 branches to pass resolutions in favour of a sanatorium, and to write individual letters to the premier. Their petitions, with thousands of signatures, including those of many influential Islanders, were presented to the government early in 1929.⁸² Apprised of these resolutions, and in receipt of hundreds of “the most pathetic and heart-breaking letters” from tubercular patients, as well as Dr. Creelman’s first annual report which estimated that between 700 and 800 Islanders had tuberculosis, with 80 dying annually, the premier met with the sanatorium committee which had been formed the previous year.⁸³ After rejecting an 80-bed sanatorium that would cost \$50,000 annually, the government promised \$30,000 for a 33-bed establishment, plus \$12,000 yearly maintenance costs, provided the private sector raised \$60,000. When the committee accepted this compromise, the government incorporated the Provincial Sanatorium in April, and appointed seven Commissioners to operate it. Growing public support had succeeded in forcing the government to modify its position, but there remained the need to solicit \$60,000.

The overwhelming response to this challenge illustrated the immense strides the various volunteer societies had made since 1924. Led by the Women’s Institutes, Dr. Creelman, the Red Cross nurses, and the Charlottetown ATBS, the sanatorium drive was well-publicized by the press and in pulpits across the Island. They reminded Islanders that it was almost impossible to enter out-of-province institutions without paying an exorbitant fee, and that for every tubercular patient who remained at home, nine additional people became infected. The cause was now so popular that many women canvassers reported that they had never collected for any charity in which they were received so cordially and offered such excellent subscriptions.⁸⁴ Amazed by the enthusiastic

81 “Report of the Supervisor of Women’s Institutes” (1929-1931).

82 “Address by Mona Wilson to Women’s Institutes” (1931), file 71, Item 1431, PAPEI; Annie Walker, *et al.*, *Fifty Years of Achievement* (Toronto, 1948), p. 40.

83 “Scrapbook Debates”, 25 March and 12 April 1929, PAPEI.

84 “Address by Mona Wilson to Women’s Institutes” (1931), PAPEI.

support, campaign manager Charles Williams declared that it was “unusual to find a movement receiving such widespread reaction...the seriousness of our T.B. situation is realized by all classes of our citizens and they are quite evidently determined that a provincial T.B. sanatorium shall be available in the near future”.⁸⁵ By the end of 1929, almost \$63,000 had been raised, and when experts suggested that for an additional \$10,000 a 48-bed sanatorium could be built, the government agreed. The new building, situated on North River Road and McGill Avenue in Charlottetown, opened in June 1931. Ironically, Lieutenant-Governor Charles Dalton presided at the official opening.⁸⁶

As the sanatorium campaign proceeded, Wodehouse was busy once again on his pet project to create a comprehensive and centralized provincial health service. Although Premier Saunders’ promotion to the Island Supreme Court in May 1930 interrupted the doctor’s overtures, the new premier, Walter M. Lea, was a “loyal friend” of the anti-tuberculosis movement.⁸⁷ Wodehouse reminded the government that outside financial support for public health services was due to terminate in July 1931, and the government would shortly have to decide whether to discontinue these services, or set aside additional funds for them. Wodehouse also intimated to premier Lea that additional financial help might be procured if the province agreed to establish a permanent department of health. “The thing is”, he wrote, “that benefactors wishing to assist in establishing such a health unit will want to see the work organized on a permanent basis under Government responsibility before they will contribute”.⁸⁸ When the Rockefeller Foundation proved unresponsive to Wodehouse’s requests, he once again approached the Canadian Life Insurance Officers Association, which agreed to provide \$15,000 annually for five years as an “object lesson” to the other provinces “of what can be done with a modern health unit set up in each of the three provinces”.⁸⁹ In return, the Association asked the Island to contribute

85 *Guardian*, 16 September 1929.

86 The campaign raised \$70,000. The government contributed \$40,000 for capital costs and \$2,000 thereafter for maintenance. The Sanatorium was increased to 50 beds in 1932. This gave the province 56.8 beds per 100,000 population, which was well below the national average of 80, and only better than Alberta’s 31.4. P.E.I.’s provincial tuberculosis expenditures of 9 cents per capita was the lowest in the nation. CTA, *Bulletin* (September 1932).

87 Wodehouse to E. Reid (Chairman of the CLIOA), 26 May 1930, vol. 7, file 50, CTA, PAC. Premier Lea had been a member of the provincial team that failed to convince the federal government to continue support for the Dalton Sanatorium. As Agricultural Minister in 1923, Lea had encouraged tuberculin cattle testing on the Island.

88 Wodehouse to Lea, 7 April 1930 and undated follow-up letter, file 48; Wodehouse to E. Reid, 26 May 1930, file 30, CTA, PAC; “Proposal to establish a Department of Public Health and to absorb the Red Cross Public Health Nursing Work” (1930), ACC. 3028, PAPEI.

89 Quoted in the *Annual Report of the Department of Health* (1930-31), p. 15; *Fifth Annual Report of the Department of Health for 1933*, pp. 9-10.

\$13,600 annually, and establish a permanent department of health under provincial jurisdiction.⁹⁰ The proposed Health Department would absorb the Red Cross Nursing Division, and include a Chief Medical Health Officer (Dr. Creelman), who would supervise the sanatorium and all chest clinics; an assistant Health Officer (Dr. B.C. Keeping), to conduct field health work; two sanitary inspectors; a laboratory technician; five public health nurses under Mona Wilson; one part-time clinician in charge of the Charlottetown V.D. clinic; a part-time meat and milk inspector for Charlottetown; along with motor cars and an office staff of two. All health activities would be subject to the approval of an advisory committee established by the Canadian Life Insurance Officers Association. After each group assented to this plan, the Provincial Department of Health began operations on 1 July 1931, with Dr. MacMillan as the first Minister of Public Health. Six years later, when the grants terminated, the Department was able to stand on its own without outside assistance. As the Canadian Life Insurance Officers Association asserted, P.E.I. was a “concrete example of how voluntary funds can be used to advantage in initiating” public health services.⁹¹

Prince Edward Island had come a long way in just nine years. In 1922, the Island had allowed its only sanatorium to be dismantled, the various anti-tuberculosis societies had been reduced to one chronically bankrupt association, the provincial Board of Health was merely the executive council, and the Island lacked a full-time Medical Health Officer. Although the politicians were not opposed to improved health facilities, they were reluctant to lead in advance of public opinion, especially if it meant increasing taxation. The frugal, self-sufficient Island farmer believed in small, limited government. Health care was a matter for the home, not the state. Besides, everyone knew that country people were a healthy lot, and Prince Edward Island was a haven from the evils of industrialization and urbanization. In the ensuing years, the Canadian Tuberculosis Association, through the Maritime Tuberculosis Educational Committee, publicized the dangers of tuberculosis so effectively that by 1930 the government was forced to respond to public pressure generated by the Women’s Institutes, the Medical Society, and the Red Cross Society. The nurses, through their contacts with schools and homes throughout the province, performed the initial spade work by arousing public interest in health matters in general. School health inspections, infant and prenatal home visiting, the distribution of thousands of health brochures, tuberculosis follow-up visits, vaccination and diphtheria

90 Although this appeared to be a large amount of money, Wodehouse pointed out that the province already provided \$5,000 to the Red Cross, \$4,200 for the Board of Health, \$900 for vital statistics, and \$3,000 for the sanatorium; and Charlottetown contributed \$2,000 for public health services. Wodehouse to Clerk of P.E.I. Executive Council, 6 June 1931, vol. 7, file 48, CTA, PAC.

91 CTA, *Annual Report* (1933), p. 18.

immunizing clinics, crippled children's work, and countless other services had made the Red Cross known from one end of the Island to the other, and laid the foundation for the Department of Health. The success of the various volunteer societies in changing the public's attitude towards health care made it virtually impossible for any Island government to return to earlier times. When the CTA threatened to end its financial assistance unless the province took greater and permanent interest in preventive health services, the government altered its budgeting priorities and accepted responsibility for the people's health in 1931. Although tuberculosis remained an incurable disease until the discovery of streptomycin in 1944, its presence aided in the establishment of a provincial department of health concerned with all aspects of public health.