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Polio and Public Health in British Columbia, 1927-1955

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Throughout the history of public health in British Columbia, polio has presented enormous challenges to the political ministries and private organizations dedicated to social welfare. Despite the severe fiscal restraints of the Great Depression, early initiatives to monitor public health after the opening of the province's first health unit on Vancouver Island in 1927¹ led to a strong framework of public health education and the reporting of communicable disease. This essay will explore how public and political responses to polio epidemics affected health policy over time.

The bulk of the primary sources from the early period presented here comes from the files of Dr. Henry Esson Young, the province's second Provincial Health Officer, 1916 to 1937.² Young was a physician who served as MLA for the northern town of Atlin for three years before moving to Victoria to serve as Provincial Secretary and Minister of Education from 1907 to 1915.³ One of the founders of the University of British Columbia,⁴ he was responsible for much of the legislation involved in its creation, and he took a particular interest in the university's School of Nursing. Young also oversaw construction of the Riverview "Hospital of the Mind" (originally

¹ British Columbia *Sessional Papers*, 1930, p. U9.

² British Columbia *Sessional Papers*, 1940, p. CC7-8.

³ British Columbia *Sessional Papers*, 1940, p. CC7-8.

⁴ Brian J. Fraser, *The Study of Religion in British Columbia: A State-of-the-Art Review*, (Water, Ontario: Wilfred Laurier University Press 1995): p. 4.

named “Essondale” in his honour), and the provincial Normal School in what is now the Young Building at Camosun College.⁵

Young’s annual reports in the Sessional Papers of the Legislative Assembly provide ample evidence that public health was placing heavy demands upon the provincial coffers. The statistics reflect a preponderance of serious diseases afflicting the population, ranging from the ever-present tuberculosis to diphtheria, scarlet fever and other ubiquitous childhood afflictions.⁶ Perhaps one of the most important developments during his tenure as Health Officer was the implementation of a system for tracking reportable diseases. By the end of 1929, every physician in the province was provided a set of pre-stamped cards which were to be mailed back to Victoria each week, on which all cases of disease for the previous week were noted.⁷

Although polio does not appear in the annual reports quite as dramatically as did other reportable diseases, the early records of correspondence show that infantile paralysis proved to be a particularly frustrating challenge for patients and medical professionals, especially for those living in the more remote rural areas of the province in the years leading up to the Depression. Given its geography, British Columbia is no stranger to the urban/rural divide. What factors influenced the eventual concentration of medical services for polio and other epidemic diseases in the Lower Mainland? What roles did poverty and geography play in the outcomes for those who required treatment for these diseases in B.C. during this time? I will argue that the evolution of a strong provincial response was driven by a

⁵ G.P.V. and Helen B. Akrigg, *British Columbia Place Names*, (Vancouver: University of British Columbia Press 1997): p. 76.

⁶ British Columbia *Sessional Papers*, 1930, p. U6.

⁷ British Columbia *Sessional Papers*, 1930, p. U20.

combination of happy circumstance, as evidenced by a generation of extremely competent and well-connected “medical men” who found themselves in charge of setting up provincial medical health systems and formulating public health policy in the late 1920s.⁸ Without these early efforts at a provincial level, one can only speculate how these epidemics would have been dealt with.

Polio historian Christopher Ruttly argues that the 1927 epidemic galvanized the provinces to respond in a unique way:

In most provinces, and to varying degrees, provincial polio strategies expanded during serious epidemics with the development of specific preventive, treatment and hospitalization services that were freely available to all polio cases, regardless of income. No other disease generated such a broad and unconditional response from Canadian governments during this period – and with the blessing and co-operation of the medical profession. In the absence of any effective treatments for polio, the assumption of responsibility by provincial governments helped to relieve some of the extraordinary frustrations and pressures polio increasingly placed on private physicians. Bearing the brunt of Canada's worst epidemics, Alberta, Ontario, Manitoba, and Saskatchewan developed the most sophisticated and generous polio policies in this period.⁹

While most of the western provinces worked with extraordinary speed to provide a broad range of services to all polio victims regardless of ability to pay, British Columbia's early response

⁸ Christopher J. Ruttly, “A Middle Class Plague, Epidemic Polio and the Canadian State 1936-37,” *Canadian Bulletin of Medical History*, Volume 13 (1996): p. 284.

⁹ Ruttly, “A Middle Class Plague,” p. 279.

was more haphazard, and it would not be until the mid-1950s that such things as contributory hospitalization schemes and rehabilitative services would be available to all residents. By the late 1940s, the B.C. Polio Fund – the non-profit society which had been managing much of the aftercare for polio patients since the first epidemic in 1927 – was close to becoming overwhelmed by the demands of the postwar population boom.

Polio: the first wave

Poliomyelitis, more commonly known as infantile paralysis, first appeared in Canada in the late 1800s,¹⁰ but the first major epidemic did not appear in British Columbia until September 1927.¹¹ This “first wave” epidemic came to the province on the heels of a major outbreak on the east coast of the United States where it sickened 27,000 people and killed 6,000 in 1916.¹² It was initially reported as a cluster of symptoms – “upset stomach, headache, fever, rapid pulse and stiffness in the neck or back,”¹³ – which could easily be misconstrued as influenza. What set polio apart from other contagious diseases, however, was the fearsome speed with which it could ravage the nervous system, resulting in partial or complete paralysis within a couple of weeks of initial infection, assuming the patient survived the initial viral attack.¹⁴

¹⁰ Joy Jaipaul, “In the Shadows: Poliomyelitis Epidemics and Nursing Care in Edmonton 1947-1955,” *Alberta History* 53.3 (Summer 2005): p. 3.

¹¹ “Infantile Paralysis Epidemic in West: 14 Children Dead and More Than 70 Are in Hospital,” *The Globe*, September 9, 1927, p. 3.

¹² Gould, *A Summer Plague: Polio and its Survivors*, (New Haven & London: Yale University Press, 1995), p. 28.

¹³ Ratty, “A Middle Class Plague,” p. 287.

¹⁴ Jaipaul, “In the Shadows,” p. 3

Today, the polio virus discovered by Dr. Karl Landsteiner at the Rockefeller Institute in 1908, is known to have several different strains which can be transmitted by fecal-oral contact between humans.¹⁵ Until the mid-1930s, however, there was much speculation as to the methods of transmission, as it was commonly thought to be a single virus transmitted via the nasal passages.¹⁶ This theory was abandoned after some disastrous experimentation with nasal spray trials resulted in irreversible damage to the olfactory nerves of a number of test subjects.¹⁷ By 1927, however, doctors had a small weapon in the form of a convalescent serum which could be taken from the blood of a recovered polio victim.¹⁸ If the serum could be administered within the first 24 hours of the onset of symptoms, the viral invasion of the spinal fluid could be arrested and serious complications such as paralysis and death could be prevented.¹⁹

The viral infection took place in three stages: acute, convalescent and chronic.²⁰ Medical historian Daniel J. Wilson describes the progression of the disease:

In the classic case described by George Draper, the patient exhibits a period of feverishness possibly accompanied by vomiting and diarrhea. This is followed by a period of remission when the patient seems to be recovering. However, in many cases the disease then proceeds to a second phase of central nervous system

¹⁵ Christopher J. Rutty, "The History of Polio," *Health Heritage Services*, (Originally prepared for Sanofi Pasteur) 2002: p.1.

¹⁶ Gould, *A Summer Plague*, p. 65-66.

¹⁷ Rutty, "The History of Polio," p.7.

¹⁸ Christopher J. Rutty, Luis Barreto, Rob Van Exan, Shawn Gilchrist, "Conquering the Crippler: Canada and the Eradication of Polio," *Canadian Journal of Public Health*," 96:2 (Mar/Apr 2005), p. 6.

¹⁹ Gould, *A Summer Plague*, p. 22-23.

²⁰ Gould, *A Summer Plague*, p. 25.

involvement in which the fever returns accompanied by sensitivity to touch, stiffness (especially in the back and neck), and paralysis. Poliomyelitis could be confirmed by a spinal tap, though in most cases paralysis was sufficient confirmation.²¹

The patient would be quarantined during the infectious period of two weeks, which was sufficient time to monitor for symptoms of paralysis. In the worst cases where paralysis was the outcome, a convalescent period of up to two years of rest and physical therapy was to be expected. There was no simple cure for polio, however, and the complexity of the required aftercare was staggering: depending on which type of virus was involved, treatments could range from relatively simple physiotherapy with hot compresses and gentle exercise (the “Sister Kenny” method) to invasive and often horrifically unsuccessful orthopedic surgery attempting to correct deformities such as severe scoliosis.²² Thus it is easy to see why polio was viewed with such fear in the years leading into the Great Depression. The enormous fiscal costs aside, it took a great toll on caregivers and taxed the resources of communities it invaded.

The situation became even more dire when the virus shut down the respiratory system (severe bulbar poliomyelitis), placing more demands on nursing staff who were required to monitor and care for their patients around the clock, often at great risk to themselves.²³ Nurses were faced with wards filled with helpless patients in rows of iron lungs, a device invented in

²¹ Daniel J. Wilson, “A Crippling Fear: Experiencing Polio in the Era of FDR,” *Bulletin of the History of Medicine* 72:3 (1998), p. 472.

²² Sass, Gottfried and Sorem, *Polio's Legacy: An Oral History*, p. 43-48 . See also Gould, *A Summer Plague*, Chapter 5: “An Angel Abroad,” p. 85-110).

²³ Jaipaul, “In the Shadows,” p. 5-6.

1928 but so prohibitively expensive that it was not always available to all who needed one, forcing some physicians to make agonizing choices about who should live or die.²⁴

Dr. Henry Esson Young, Medical Health Officer

The early polio experience in British Columbia can be found in the records of the province's medical health officer. In May 1928, the health department of Dr. Henry Esson Young had approved the expenditure of funds to send Dr. C. Wace of the Queen Alexandra Solarium for Crippled Children in Victoria to tour the southern interior of the province "to acquaint the medical men with the facilities provided at the Solarium for the treatment of such [polio] cases and to discuss with the profession the treatment during and immediately after the attack."²⁵ In his letter of invitation, Dr. Young referred to the ferocious 1916 epidemic which had struck particularly hard in New York City,²⁶ mentioning that since that time "it has been gradually crossing the continent, and will undoubtedly be seasonable."²⁷ The doctor's itinerary would take him into the Okanagan and Kootenay regions, which had taken the brunt of the epidemic of 1927.²⁸ This particular junket, aside from being a useful tool for keeping area doctors informed about the latest treatment protocols for polio patients, was also meant to raise awareness

²⁴ Gould, *A Summer Plague*, p. 91-92.

²⁵ Letter from Dr. H.E. Young to Dr. C. Wace, Secretary, Queen Alexandra Solarium for Crippled Children, Victoria, May 2, 1928. PABC GR-2586: Box 1, File 2.

²⁶ Christopher J. Rutt, "The History of Polio," *Health Heritage Research Services* (2002): p. 3.

²⁷ Letter from Dr. H.E. Young to Dr. C. Wace, May 2, 1928. PABC GR-2586: Box 1, File 2.

²⁸ Undated report: *Poliomyelitis, Cases & Deaths, July – Dec. 1927*. PABC GR-2586: Box 1, File 2.

among the general public that the government was taking an interest in its welfare.²⁹

Meanwhile, a small crisis was being documented in Coal Creek, the news arriving in a memo from the Fernie RCMP detachment. The family of the first reported polio case of June was in dire straits and desperate for further assistance:

Re: J*** K***** B**** & Familey [sic] (Sick & Destitute) Coal-Creek.

I beg to report that the above named family where [sic] placed in quarantine on the 16th day of June upon instructions of the Medical Officer (Dr. Corson) of Fernie, B.C. for Infantile Paralysis on M***** B**** aged 16-months.

On account of the mother suffering from fits it has been found advisable to have the husband remain at home or otherwise provide a nurse to look after the children during the period of confinement. This was found to be not practical with the household equipment that they have.³⁰

The response of the Government Agent was immediate. A request was to the local general store “to supply this family with staple foods not to exceed \$30.00 per month, and I also have, in accordance with doctor’s orders, allowed a supply of fresh milk daily.”³¹

²⁹ Letter from Dr. H.E. Young to Dr. C. Wace, Secretary, Queen Alexandra Solarium for Crippled Children, Victoria, May 19, 1928. PABC GR-2586: Box 1, *File 2*.

³⁰ Memorandum *from* F.N. Emmott, Fernie RCMP Detachment, to Government Agent, Fernie, June 21, 1928. PABC GR-2586: Box 1, *File 2*.

³¹ Letter from E.T. Cope, Government Agent, to Dr. H.E. Young, Victoria, June 22, 1928. PABC GR-2586: Box 1, *File 2*.

A diagnosis of infantile paralysis in a young child was truly a dreadful thing. The “necessary precautions” were relatively simple: disinfection of living quarters and personal items, bed rest, quarantine and monitoring the fever. In the absence of a dose of convalescent serum, which was extremely difficult to obtain in such a remote area at that time, all parents could do was wait to see if the child developed paralysis. With luck, the fever would die down and the family could return to normal life. The alternative was simply too awful to contemplate: paralysis, permanent disability or death, not to mention the extreme risk of transmission of the disease to others in the house. For these reasons, there was no disease that frightened parents – and impoverished families in particular – in the early decades of the twentieth century quite so much as infantile paralysis.

Telegrams continued to arrive at Young’s office throughout the late summer and fall of 1928 from physicians in outlying areas pleading for convalescent serum. The main local source of serum was the provincial laboratory at Vancouver General Hospital, but most of that supply was designated to treat local cases. Young often had to reply “Sorry, no serum available.”³² News came from Fernie that, despite the quarantine measures taken in the first instance, two more cases had developed, one in a five-year old child and another in a man in his late twenties who rapidly developed acute anterior poliomyelitis (or “true polio,” the the most feared of the viral infections, attacking the anterior horns of the spinal cord and the lower brain, often resulting in full or partial paralysis).³³ Dr. Young, now alarmed at this new development, had to inform the

³² Telegram from Dr. H.E. Young to Dr. Corsan, July 23, 1928. PABC GR-2586: Box 1, File 2.

³³ Sass, Gottfried and Sorem, *Polio’s Legacy: An Oral History*, p. 2.

local doctor that there was no convalescent serum available, and warned against the use of commercially available remedies of dubious origin.³⁴ By now, much of his department's business dealt with securing a reliable supply of the precious serum, and the Vancouver laboratory was canvassing patients who had had the disease to step forward and donate blood, for a fee. In 1928, donors were paid between \$6.00 and \$16.50 per donation, depending on the quantity, which was ironically well in excess of what doctors were being paid to treat their patients.³⁵

As polio season wore on, with the serum shortage becoming critical, Dr. Young began urging the local physicians to do all they could to obtain a supply of blood from patients who recovered, but there was a problem. The donor was required to bear the cost of a Wassermann test for syphilis, unless the specimens could be sent to the provincial laboratory at Vancouver General Hospital, where testing was subsidized.³⁶ This factor alone must have represented a disincentive to donate among the rural population, but local businesses came up with some ingenious solutions. In Kelowna in 1934 children were offered free movie passes if they gave blood for the cause.³⁷

³⁴ Letter from Dr. H.E. Young to Dr. D. Corsan, July 28, 1928. PABC GR-2586: Box 1, File 2.

³⁵ Letter from Dr. H.E. Young to Dr. R.E. Coleman, Vancouver General Hospital, September 8, 1928. Letter from Young to Dr. W. Workman, Coal Creek, July 17, 1928. See also undated *Report on Infantile Paralysis* by H.W. Hill, Professor of Bacteriology and of Health, UBC; Director, Vancouver General Hospital Laboratories, Vancouver, BC. PABC GR-2586: Box 1, File 2, p. 7-8.

³⁶ Letter from H.W. Hill, Director, Provincial Board of Health Laboratories, Vancouver, to Dr. H.E. Young, August 17, 1934. PABC GR-2586: Box 1, File 2.

³⁷ Letter from G.A. Ootmar to H.E. Young, October 8, 1934. PABC GR-2586: Box 1, File 4.

Contagion in Schools

Apart from the almost complete absence of convalescent serum, there was the question of what to do about school closures. In the presence of an epidemic, it was thought, those at risk should be isolated from those who were contagious. As more cases began to surface throughout the southern region, word of mouth usually arrived in town before official instructions from Victoria could be issued, and over-cautious doctors often took it upon themselves to close schools at the first appearance of an outbreak.³⁸ Throughout September as new cases began to arise, Young fielded many telegrams from physicians in outlying areas reporting that they had decided to send children home and shut down schools and other gathering places as a precaution. Young firmly believed that closing the school was more of a detriment, considering that allowing children to circulate through the community increased the risk of contagion and did more harm than good.³⁹ A doctor in Vernon went so far as to consider banning students from polio-prone regions from attending the local school, and sent a telegram to Victoria to request data:

Kindly inform me what districts in Western Canada infected with infantile paralysis. Children from such districts cannot attend school here.⁴⁰

³⁸ Telegram from Dr. J.E.H. Kelso, Edgewood, BC, to Dr. H.E. Young, December 5, 1930. PABC GR-2586: Box 1, File 3.

³⁹ Letter from Dr. H.E. Young to Dr. R. Gibson, Ashcroft, BC, September 18, 1928. PABC GR-2586: Box 1, File 2.

⁴⁰ Telegram from Dr. O. Morris, Vernon, BC, to Dr. H.E. Young, September 7, 1928. PABC GR-2586: Box 1, File 2.

That a local physician would make such a unilateral gesture is indicative of the level of paranoia developing in the community regarding what was essentially a non-event. Young was quick to question the legality of the doctor's actions and informed him that the Board of Health had no intention of declaring a formal polio epidemic in this instance.⁴¹

As fall turned to winter, another heartbreaking message arrived in Young's office from the local doctor in Golden, inquiring whether a young father of three small children could be treated at the Queen Alexandra Solarium for Crippled Children in Victoria. Young wrote back:

There is no institution in the Province devoting itself to this work.

...

I ... would suggest that you try and get the man down to the Vancouver General....

He could enter the hospital as an indigent and would be entitled to hospitalization.

...

You had better have the Government Agent certify to the fact that the man is indigent.⁴²

Like the memo from Fernie in June, this exchange shows how swiftly lives could change from productivity to dependency when polio was involved. Without access to adequate hospital facilities for ongoing therapy, the misery was magnified beyond imagination. Despite the best efforts of officials like Dr. Young

⁴¹ Telegram from Dr. Young to Dr. Morris, September 8, 1928. PABC GR-2586: Box 1, File 2.

⁴² Letter from Dr. Young to Dr. Ewert, November 26, 1928. PABC GR-2586: Box 1, File 2.

and his peers, the sheer size of the province⁴³ (and the absence of a provincial hospital insurance plan) was proving to be an enormous handicap in establishing an equitable system of treatment for all who needed it.

A 1934 report from the medical officer in Kelowna gives a sense of the demands polio was making on available medical resources in a small community:

As Miss M***** had orders from me to watch all the children who were living in the area where the two children were living and watch the other children in the quarantined family I could not ask her to do more. She had her hands full, and Mrs. G***** was ill after the Clinic, in bed overworked. So I asked the Council for a nurse, which request was granted. *There are 38 houses to visit twice a day, in some are as many as 6 children.*⁴⁴ [emphasis added]

This report clearly indicates that the crisis of polio contagion (even in the absence of a formally declared epidemic) represented a significant strain on remote communities whose only access to public health resources might be a single doctor and a nurse or two at a small clinic.

Post-War Epidemics

In Young's annual report to the Provincial Secretary that year, he noted that "the lack of finances to carry on any elaborate plan of prevention has been a serious handicap."⁴⁵ Despite the

⁴³ British Columbia Sessional *Papers*, 1952, Fifty-Fifth Report of the Provincial Board of Health, p. X21.

⁴⁴ Letter from Dr. G.A. Ootmar, Kelowna, BC, to Dr. H.E. Young, September 30, 1934. PABC GR-2586: Box 1, File 4.

⁴⁵ British Columbia Sessional *Papers*, 1934, p. Z7.

fiscal restraints, his vision of a consistent, centralized system of delivering medical care and sharing information did much to quell the annual polio panic and inform the public about appropriate measures of control. However, the disease would continue to tax the resources of remote communities and health care providers even in the years after the discovery of a viable vaccine.⁴⁶ By the 1950s, it was all the province could do to keep up.

Three more serious polio epidemics struck the province, the first in 1947, with far worse situations occurring in 1952 and 1953.⁴⁷ The later attacks were particularly virulent and there was a great deal of speculation as to why this happened. Two new strains had been discovered, and the theory was that the population which had developed immunity to the first occurrence remained vulnerable to infection by the new arrivals.⁴⁸ By 1953, the two major hospitals in the province – Vancouver General and the Royal Jubilee in Victoria – were operating at capacity.⁴⁹

In Victoria, medical officials issued urgent appeals for volunteer nurses (retired, graduate or married) to come forward, and respirators were being shuttled back and forth to the mainland in order to meet demand.⁵⁰ So great was the concern that year that a federal state of emergency was considered in order to address a critical shortage of medical staff in the hardest hit areas, particularly British Columbia.⁵¹ Although a state of

⁴⁶ D. Kubryk, "Paralytic Poliomyelitis Trends, Canada, 1958," *Canadian Medical Association Journal*, 1959, August 15; 81(4): p. 228-231.

⁴⁷ *British Columbia Sessional Papers*, 1956, p. N44. Statistical table lists 421 cases for 1931, 312 cases in 1947, 584 in 1952, and 787 for 1953.

⁴⁸ *British Columbia Sessional Papers*, 1954, p. Y31.

⁴⁹ "Polio Incidence Up Over Past Six Days: 14 New Cases Tax Facilities," *Victoria Daily Times*, September 25, 1953, p. 13.

⁵⁰ "City Polio Outbreak Needs More Nurses," *Victoria Daily Times*, September 17, 1953, p. 15.

⁵¹ House of Commons *Debates*, December 3, 1953, p. 575.

emergency was never officially declared, Royal Canadian Air Force Air-Sea Rescue personnel were assigned to bring polio victims into the city from remote areas often inaccessible by road.⁵² Flights equipped with portable respirators and military medical personnel were a godsend for these patients who were transferred to iron lungs in moving vans on arrival at the Vancouver airport on Lulu Island.⁵³ These evacuations were often undertaken at great risk, often at night in dangerous weather.⁵⁴

In response to the epidemic of 1953, poliomyelitis committees were set up at both Vancouver General and Royal Jubilee Hospitals composed of physicians specializing in the various branches of medicine. Members of the Committee were assigned as consultants to polio cases referred to the hospitals by private physicians for the proper care and rehabilitation of their patients.⁵⁵ In the absence of a purpose-built facility, polio was managed on a case-by-case basis, putting nearly unbearable pressure on existing resources. Fortunately, a plan was in the works for a new addition to the Pearson Tuberculosis Hospital in Vancouver which would help alleviate the problem.

The Pearson Pavilion

On June 28th, 1955, after a series of frustrating delays due to rising costs and other issues, the Pearson Poliomyelitis Pavilion was opened in Vancouver. The Pavilion, designed as a

⁵² British Columbia *Sessional Papers*, 1954, p. Y32-33.

⁵³ Letter from G.R.F. Elliot, Assistant Provincial Health Officer, to Dr. J.L. Murray Anderson, Medical Administrator, Royal Jubilee Hospital, Victoria, June 10, 1955. PABC GR 0123: Box 28 File 8.

⁵⁴ British Columbia *Sessional Papers*, 1953, p. BB33.

⁵⁵ British Columbia *Sessional Papers*, 1954, p. Y32.

“special unit for the care of convalescing patients,”⁵⁶ was built to accommodate polio patients suffering from a variety of crippling after-effects of their disease. The new unit was quickly filled to capacity, with more patients waitlisted for the male wards in particular.⁵⁷ Prior to their arrival at the Polio Pavilion, many of these patients had spent time in acute care beds at hospitals in Vancouver and Victoria, with less acute cases transferred from the Western Society for Physical Rehabilitation Centre on West 27th Avenue in the Vancouver. The Society, incorporated in 1947, oversaw the construction of a post-war rehabilitation facility designed

...as a school for the physical rehabilitation of the orthopedically disabled, including paraplegics, polios with permanent paralysis, arthritics, leg amputees, cerebral palsied children (spastics) and kindred cases.⁵⁸

The state-of-the-art unit of Pearson Pavilion was a much more suitable environment for polio patients, featuring gender-specific lung wards (for those requiring respirators and iron lungs), a ward for paralytics, therapy equipment, an operating room, isolation unit and a “respirator park” where patients in iron lungs could be transferred in the event of an emergency. The building was also equipped with a generator to keep respirators running during a power failure. The facility was designed to provide “good food, plenty of light, and a friendly atmosphere

⁵⁶ Official programme of the *Dedication and Official Opening of the Poliomyelitis Pavilion*, June 28, 1955. PABC GR 0123: Box 28 File 8.

⁵⁷ Memorandum from Dr. C. McIver, Pearson Hospital, to Dr. H.S. Stalker, Medical Superintendent, Pearson Tuberculosis Hospital, May 18, 1955. PABC GR 0123: Box 28 File 8.

⁵⁸ Brochure: *Western Society for Physical Rehabilitation*, 1951. PABC GR 2652: Box 2 File 25, BC Polio Fund.

[to] contribute to the feeling of well-being”⁵⁹ for polio patients requiring intensive, often lifelong, medical care and therapy. The facility was not without its problems, though; growing pains included an acute shortage of orderlies who were young and strong enough to manage the demands of attending to polio patients. The fact that they were paid less than the cleaning staff at the time did not sit well. Another issue was the disparity between the comfort allowance (covering major items such as shelter and food, and minor — but no less important — items such as eyeglasses and dentures) allocated to polio victims and those enjoyed by tubercular patients.⁶⁰ It is interesting to note that the Poliomyelitis Pavilion was an extension of the Pearson Tuberculosis Hospital and reported to the Division of Tuberculosis Control.⁶¹ By marrying the two divisions, the province was able to carry forward Dr. Young’s vision of centralization of services, focusing on research, prevention, public education and outpatient follow-up. While polio was about to be brought under control, tuberculosis remained an insidious enemy yet to be conquered.

Beginnings of State Medicine

Historian Megan Davies discusses the convergence of circumstances which allowed Dr. Young’s department to

⁵⁹ Official programme. PABC GR 0123: Box 28 File 8.

⁶⁰ Memorandum from Mr. B. Elshaw, Chief Orderly, Pearson Hospital, to Dr. H.S. Stalker, Medical Superintendent, Pearson Hospital, October 3, 1955. Letter from Enid S. Wyness, Provincial Supervisor, T.B. Social Services, to Mr. C.W. Lundy, Deputy Minister of Welfare, Victoria, August 31, 1955. PABC GR 0123: Box 28, File 8.

⁶¹ Memorandum from Dr. C. McIver, Pearson Hospital, to Dr. H.S. Stalker, Medical Superintendent, Pearson Tuberculosis Hospital, May 18, 1955. PABC GR 0123: Box 28 File 8.

continue and even expand its public health work in the Depression years. She posits that the fortuitous election of forward-thinking Liberals in 1933 was a catalyst for even greater things to come, and makes note of British Columbia's "cadre of health and social welfare professionals" who

envisioned state medicine as acting in innovative and path-breaking ways, rather than merely continuing with established programs and reacting to outbreaks of disease.⁶²

The parallel role of philanthropy cannot be ignored; Canadian women's associations in particular have a prominent place in the history of health in the country, and British Columbia was no exception. The indispensable fundraising and volunteerism of women's associations, forging links between communities and their health departments in myriad ways, was formally and publicly acknowledged by the men in charge from the outset.⁶³ As early as 1929, women's groups from British Columbia and Alberta were petitioning the federal government to provide grants to permanently replace Rockefeller Foundation funding of provincial health units.⁶⁴ By the mid-1930s, however, much of the important committee work had been taken over by male professionals as the reorganization of the health department became more scientific and controlled.⁶⁵ The predominance of women in public health nursing is, of course, another topic for further exploration.

⁶² Megan J. Davies, "Competent Professionals and Modern Methods: State Medicine in British Columbia during the 1930s," *Bulletin of the History of Medicine*, 76:1 (Spring 2002): p. 62-65.

⁶³ British Columbia *Sessional Papers*, 1927, p. M9.

⁶⁴ House of Commons *Debates*, April 5, 1929, p.1328-29.

⁶⁵ Davies, "Competent Professionals and Modern Methods," p. 72.

It should also be noted that the contributions of the Rockefeller Foundation were invaluable in maintaining regional health units during the worst of times, extending funding of a quarter of the budget for two North Vancouver districts beyond its original three-year commitment in the mid-1930s.⁶⁶ The Foundation had been forthcoming with grants to the province's health department since the early 1920s, with the provincial government providing half and municipalities contributing a quarter share unless, as in this instance, the municipal budget was unable to bear the cost during the lean years. This arrangement would continue until the post-war federal program took effect.⁶⁷ As late as the 1950s, British Columbia's troubled hospitalization plan was providing care for polio patients only during the early contagious stage of the disease (a period of two weeks), after which time patients had to pay their own way, a situation which created acute hardship for many and represented an inexorable drain on charitable services. This came to light during the outbreak of 1952, and benefits were quickly allocated to match subsidies which had been in place for TB patients for quite some time.⁶⁸

Universal health insurance was clearly on the minds of many in the Depression years, as it was an obvious solution to the problems of poverty and accessibility in remote rural communities far from the urban centre. British Columbia was among the first to attempt to institute a hospitalization insurance scheme in 1935, legislation that was sidelined after an exhaustive

⁶⁶ British Columbia *Sessional Papers*, 1936, p. FF14.

⁶⁷ House of Commons *Debates*, March 3, 1930, p. 217.

⁶⁸ Letter from Mrs. Martha Allaire, Executive Secretary, BC Polio Fund, to Mr. E.L. Rimmer, Division Administrator, Region #1, Provincial Social Welfare Dept., Social Welfare Branch, Victoria enclosing outline of BC Polio Fund services to polio patients. November 20, 1952. PABC GR 2720: Dept of Health and Welfare – BC Polio Foundation.

province-wide survey in 1932 and much debate in the Legislature in the spring of 1936. Saskatchewan succeeded with its own hospitalization insurance plan in 1947, the first of its kind in Canada,⁶⁹ but comprehensive insurance schemes would not begin to become reality until the passage of the federal *Hospital Insurance and Diagnostic Services Act* of 1957.⁷⁰ Geography continues to challenge accessibility to services in many parts of the province, with regional health care in rural regions still extremely susceptible to fluctuations in fiscal policy. As services are cut, patients must still travel long distances for treatment, and a solution to this problem is still to be found. While a complete medical services plan (apart from hospitalization services), would be some time in coming, the systems and policies created by the first public health professionals constituted a viable template for modern medical care in British Columbia, and their contributions are very much a part of the fabric of the province today.

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⁶⁹ C.S. Houston, *Steps on the Road to Medicare: Why Saskatchewan Led the Way*, (Montreal: McGill-Queen's University Press, 2002): p. 84.

⁷⁰ Paul A. William, Eugene Vayda, May L. Cohen, Christel A. Woodward, Barbara M. Ferrier, "Medicine and the Canadian State: From the Politics of Conflict to the Politics of Accommodation?," *Journal of Health and Social Behavior* 36:4 (Dec. 1995): p. 305.

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