In the Picture of Health:
Portraits of Health, Disease and Citizenship
In Canada's Public Health Advice Literature, 1920-1960

By

Helen E. Harrison

A thesis submitted to the Department of History
In conformity with the requirements for
the degree of Doctor of Philosophy

Queen's University
Kingston, Ontario, Canada
September 2001

Abstract

In 1919, the Canadian government announced the creation of the Dominion Department of Health. Because health is primarily a provincial responsibility, the responsibilities of the new Department were limited to the coordination of federal health services, and the production and dissemination of public health information. Through public health education the government hoped to resolve a variety of pressing social problems, not the least of which was the apparently feeble state of Canadian citizens. The government's education work was supported by both private corporations who were interested in improving the efficiency and stamina of their work force, and by voluntary groups whose concern for the eradication of disease was more altruistic.

Between 1920 and 1960, the government produced and distributed a dizzying array of pamphlets, articles, booklets, lectures, posters, exhibitions, demonstrations, radio broadcasts, and instructional films. The subject (and quality) of the material varied widely. Topics included the avoidance of specific diseases such as tuberculosis, diphtheria, venereal disease and mental health, as well as more general material on personal hygiene, accident prevention, interpersonal relationships and the importance of good posture. Because the information was intended for a general audience, much of it was presented as a form of entertainment. Good or bad health was associated with the lifestyle choices of the characters portrayed within the material. Typically, the lifestyle choices deemed most conducive to good health were premised on pre-existing social values including the ennobling virtues of work, patriotism and domesticity. In other words, good health was shown to be a mediating factor in the definition of good citizenship.

This study explores how and why this information was produced and disseminated, and analyses the advice and assumptions implicit within the material itself. Research concentrates on the records of the Canadian Department of National Health and Welfare, and is supplemented by comparative material from the Health League of Canada and the Metropolitan Life Insurance Company. Together these three organizations instructed generations of Canadians in the intricacies of health and disease, and in the process, redefined the limits of social responsibility for a modern age.

Acknowledgements

When I first pitched this project to my then advisor, the late George Rawlyk, he asked me how on earth I would keep this sprawling topic reined in. At the time, I thought the question funny and told him not to worry, I would keep things under control. I have since discovered the naïveté of that answer. This project could never have been completed without the wisdom and support of a great many people.

Initially, my thesis began as a study of morals and medicine under the direction Karen Dubinsky and George Rawlyk. After Prof. Rawlyk's untimely death in 1995, I reconsidered the parameters of the project and asked Jacalyn Duffin to join my supervisory team. Karen Dubinsky and Jacalyn Duffin proved to be a tireless source of energy, enthusiasm and intelligence. Together they helped me to discover both practical and creative solutions to my many conceptual stumbling blocks. I feel very fortunate to have had their support and advice.

I am also grateful to the many men and women who offered their technical support and expertise. Sylvie Robataille and Carol Seguin of the National Archives of Canada helped me to locate long lost films and radio broadcasts, and served as diplomatic ambassadors in my negotiations with the Audio/Visual Archives. Arthur Gryfe gave me permission to review the archival records of the Health League of Canada. Bill Pack of the Metropolitan Life Insurance Company, and Bernard Lutz of the National Film Board of Canada, welcomed me into their archival vaults and were extremely generous with their time and information. I am also indebted to Dave Smith of Queen's Television, Rand deKleine-Stimpson of Camera Kingston, and Michelle Cortes of the Queen's Information Technology Services, who collectively transformed my cinematic images from moving pictures into printable graphics. All of the images which appear in my thesis are a product of their wizardly. Finally, a very special thanks is reserved for Normal St. John, Judy VanHooser, Cindy Fehr, Debi Stirton, and Yvonne Place, who are the endless patient, endless helpful, and endless good humoured support staff in the Department of History at Queen's University.

Throughout this long and challenging process, I relied heavily on the support and generosity of a large network of extraordinary friends. Together they made certain I was

fed, walked, focused and distracted. Most importantly, they kept me connected to the world outside my head. I am particularly indebted to Paul Jackson and Joy Frith who in addition to being brilliant scholars and fabulous cooks, lived with and through my blackest moods and kept me smiling nonetheless, (I'm less certain how well they fared). Other friends and co-survivors at Queen's saw me through the trials of course work, comprehensives, research, writing and teaching. I am especially grateful for the academic insights and friendship of Amy Bell, Nancy Butler, Kevin Brushett, Ross Cameron, Lara Campbell, Elise Chenier, Melanie Cook, Lorraine Coops, Mike Dawson, Gord Dueck, Ryan Edwardson, Alison Forrest, Pat Gentile, Catherine Gidney, Martina Hardwick, Peter Henshaw, Russ Johnston, Jim Kenny, Krista Kesselring, Susanne Klausen, Alan MacEachern, Jenne MacLean, Ian MacMillan, Dan Malleck, Jenn Marotta, Sandy Ramos, and Danny Samson.

Additional thanks is due to Sarah Withrow who always managed to find the truth as well as the heart of every matter; Susan Belyea who welcomed me into her home and even trusted me with her power tools; JoAnne McCutcheon who kept me awake with tales of horror and adventure during the seemingly endless days of research at the National Archives; and Patricia Power who livened up life in Ottawa.

Beyond the world of academics are my friends Sarah Fraser, Ed Vanhooydonk, Elizabeth Wilton, Ken Myhr, Eric Lee, Andrew Stockwood, Shirley Netten, Kristina Stockwood, and John Bowker. The drinks and dinners we have shared over the years have been an enduring source of emotional sustenance. I can't imagine how I would have coped without them.

Finally, I owe an enormous debt, both emotional and financial, to my family. They have been amazingly supportive throughout this long and sometimes difficult process. They have cheered my successes, commiserated with my frustrations and urged me to persevere whenever my enthusiasm began to flag. And even though I am quite certain they sometimes doubted my sanity, they never seemed to doubt my abilities. I am forever grateful.

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Abbreviations

CNCCVD	Canadian National Council for Combating Venereal Disease, (1919-1922).
CSHC	Canadian Social Hygiene Council, (1922 - 1936).
DCH	Dominion Council of Health, (1919 – present).
DH	Department of Health, (1919-1928).
DNHW	Department of National Health and Welfare, (1945 – present).
DPNH	Department of Pensions and National Health, (1928-1945).
HLC	Health League of Canada, (1936 – present).
ISD	Information Service Division (division of the DNHW).
MLI	Metropolitan Life Insurance Company.
NFB	National Film Board of Canada, (1939 – present).

Introduction

On Wednesday, June 14th 1933 at 6:35 p.m., approximately 200 women stood outside the Capitol Theatre in Niagara Falls Ontario waiting to buy tickets for *Damaged Lives*. The playbill suggested the film was a romantic drama, but it was the bold promise to deliver "vitally instructive" information on "the process of reproduction" and other "normal and abnormal bodily states" that probably drew the crowds.[1] Several years later on October 1st, 1938, just a few minutes before 11 a.m., housewives in Grande Prairie Alberta turned on their radios expecting to hear the familiar sounds of the *Dan and Sylvia* show. Instead, they were treated to a five minute health message; the first in a new series of pre-programmed public service announcements.[2] Almost ten years after that, on March 5th, 1947, 35 workers at the Elmwood Plant of the Alsip Brick, Tile and Lumber Company in Winnipeg Manitoba ate their lunch while watching the industrial health film, *Accidents Don't Happen*.[3] Finally, in October 1950, at a popular cafe somewhere in Northern Alberta, patrons paused to hear the unfamiliar tune of a new 45 on the jukebox.

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[1] The film ran in Niagara Falls for four days between June 12-15, 1933. Women saw the film on June 12th and 14th. Men saw the film on June 13th and 15th. The film was sponsored by the Canadian Social Hygiene Council, who claimed that a total of 1389 women and 1051 men saw the film during its four day performance in Niagara Falls. See Health League of Canada, Attendance Report re. *Damaged Lives*. (c.1933) [National Archives of Canada (NAC), Health League of Canada Collection (HLC). MG 28-I-332, Vol. 137, file 137-1, "Social Hygiene: Films, *Damaged Lives* -- Distributors Correspondence, 1933-34]. A description of the film and a copy of its playbill can be found in the *Niagara Falls Evening Review*, June 12, 1933: 7.

[2] C.L. Berry, (Manager, CFGP radio station, Grande Prairie, Alberta) to F.W. Rowse, (Director, Information Services Division (ISD), Department of Pensions and National Health, (DPNH)), Sept. 25, 1938. [NAC, RG 29, Vol. 121, file 190-1-3].

[3] National Film Board of Canada (NFB), Vol. #1, file 02-040.

The song was entitled, "That Ignorant Cowboy," and the lyrics described the doleful story of a man with syphilis.[4]

Events such as these were repeated in countless variations across the country throughout the twentieth century. Each one represents a brief encounter between Canadian citizens and the various doctors and educators, statesmen and entertainers, who collectively extolled the virtues of public health. It offered citizens a moment in which to contemplate the utility of health, and their obligation to protect it. Whether these specific encounters left a lasting impression on the individuals who witnessed them is impossible to know, but few Canadians would have been able to avoid some contact with this public health promotional material.

Over the course of the twentieth century, health advice has been advertised in books, booklets, pamphlets, posters, newspapers, magazines, exhibitions, lectures, slide shows, radio broadcasts, public service announcements, feature films, instructional documentaries and television commercials. The infinite variety of educational formats is matched only by the diversity of the material's producers, sponsors and distributors. Promoters of public health included government health departments, voluntary agencies and private corporations. While these organizations arranged for the educational material to be produced and distributed, the information itself was premised on the expertise of

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[4] Harold Orr, (Director, Division of Social Hygiene, Department of Health, Alberta) to Dr. B.D.B. Layton. (Assistant to the Director of Health Services, Department of National Health and Welfare, (DNHW)), March 8, 1951. Orr explained that the record had been played only 20 times between October and March, and therefore was "not going to prove of much value." Additional correspondence in this file notes that the flip side of "That Ignorant Cowboy" contained a "Negro Chorus" singing, "I've Got Good News." The song gave thanks to Jesus for finding a cure for syphilis. Neither song appears to have been very popular with Canadian audiences. [NAC, RG 29, Vol. 121, file 190-3-7].

doctors and scientists before being adapted for public consumption by commercial artists, writers, actors, directors, and a large coterie of technical support staff. Together this somewhat unlikely combination of experts tried to persuade Canadians of the value of health.

In many respects their campaign was successful. By the end of the twentieth century, the preservation of health would be recognized as an essential pillar of the nation's social contract. Health issues would appear with frequent regularity in newspaper columns and on television newscasts. The health policies of political parties would dominate electoral debates, and efforts to restructure the delivery of health services would be met with vitriolic opposition from Canadians who, by the end of the twentieth century, regarded the Canada Health Act as a "sacred trust." Interest in the preservation of health is also apparent in the public's general willingness to support laws that prohibit smoking in public venues or require cyclists to wear helmets, motorists to wear seat belts and boaters to wear life jackets. This regulatory legislation has been further supplemented by massive advertising campaigns which encourage smokers to 'butt out', pressures pregnant women to abstain from alcohol, warn young people against recreational drug use, discourages unprotected sex, and proselytizes for physical fitness.

Each of these campaigns is premised on the belief that health is a valuable social asset which ought to be protected and promoted. Health, however, is not purely a public utility, it is also a private one which has to do with the physical integrity of individual bodies. Any effort on the part of the government, or other health agencies, to dictate how individuals should manage their health necessarily challenges the jurisdictional boundaries

between the public and the private, and raises questions about the nature of individual rights versus social obligations. Do individuals have an obligation to be healthy? Do they have a right to engage in activities which might threaten their health? Clearly, the health risks undertaken by one individual must be limited by the harm they might bring to others, but what about those activities which affect the individual alone? For some health advocates the balance of rights and obligations is relatively simple. As one physician concluded after surveying the statistical increase in cellphone related accidents, "Drivers who fail to exercise good judgment must be regulated to do so."[5] But the question remains, how does one define "good judgment" and under what circumstances should it be regulated?

In an attempt to answer some of these questions, this study will explore the early efforts of Canadian public health educators to teach health to citizens. It will examine the social, political and economic objectives which inspired politicians, business leaders, doctors and social reformers to take up the cause of health. It will also consider the various methods through which information about health was disseminated to a popular audience. Finally, this project will endeavour to assess the information itself. Health information was primarily intended to inspire citizens with the desire to be healthy, and to provide them with the advice they needed to avoid disease and debility. In essence, the material was designed to teach Canadians the principles of "good judgment" as understood by public health promoters. Thus, public health information becomes the occasion for an ongoing debate about the rights and responsibilities of citizenship, and the

[5] Quoted in the *Globe and Mail*, May 29th, 2001.

role of health and disease in mediating the relationships of doctors and patients, patients and citizens, citizens and the state.

To some extent the Canadian government has always been involved with the management of public health. In general, however, its services were supplemental; governments picked up where private care-givers left off. In the nineteenth century for instance, private physicians looked after paying patients, while state run hospitals, asylums and convalescent homes looked after those who had nowhere else to go. In times of acute crisis, when sudden epidemics of cholera, smallpox or influenza threatened to overwhelm the community, local and provincial governments would mobilize available health resources to isolate the contagious, care for the sick, and dispose of the dead. These efforts to contain the disease were largely a defensive response to specific medical challenges; once the epidemic subsided and the crisis abated, the programmes were quietly dismantled. By the end of the century, however, governments began to take a more pro-active approach to prevention. Even before the introduction of germ theory in the late 1880s, disease was linked with environmental factors including dirt, flies, decomposition and poor personal hygiene. Faced with mounting pressure from middle class reform lobbyists, municipal politicians initiated new public health policies which concentrated on cleaning-up the urban environment by building sewage systems, constructing water treatment plants, and subsidizing garbage disposal. Legislation was enacted to regulate the standards of work, food and housing. Eventually, specially trained nurses were hired to actively seek out the sick and teach prevention to the well.

The public's willingness to embrace these health initiatives was bolstered by a renewed confidence in the health care professions as a whole. Whereas physicians had once only offered palliative care for the sick and dying, the discoveries of Koch, Pasteur, Lister and others offered patients effective new treatments in the prevention or cure of diseases such as rabies, diphtheria, anthrax, cholera, typhoid, bovine tuberculosis and smallpox. This string of spectacular medical successes augmented the professional authority of medical scientists, and encouraged patients to put their faith in the healing powers of their doctors. By the twentieth century, science had become the symbol of modern progress and its practitioners were venerated for their professional skills as well as their powers of reason, compassion, and objectivity.

Although faith in science was clearly on the ascension, feelings toward progress were somewhat more ambivalent. Science and technology held out the promise of a disease-free future and a world made easier, and more pleasurable, by an ever expanding assortment of exciting new consumer products. Yet, certain anxieties persisted. Along with an enthusiasm for whatever was "new" came a nostalgia for the past, and a concern that traditional values of faith and family were being forgotten amid the excitement of automobiles, movie houses, and dance halls. These concerns were aggravated by the pernicious problems of poverty, crime and disease, and the emergent problems associated with industrialization, urbanization and immigration.

Cultural historians have described this anxiety as an inevitable consequence of the modernist construct. Modernism, according to Marshall Berman, is "a process of incessant inquiry, discovery and innovation, and a shared determination to transform

theory into practice, to use all we know to change the world."[6] Implicit within this quest for improvement is an essential impermanence in which both products and values are subjected to constant scrutiny and re-evaluation. That which is valued one day, may be changed, improved or discarded the next. Marx and Engels suggested this lack of permanence was an inevitable by-product of modern capitalism. They argue that the bourgeoisie's perpetual need to generate new markets for their products, and new products for their consumers, creates a state of constant revolution. The result of such frenetic activity is a society in which, "All fixed, fast-frozen relations, with their venerable train of prejudices and opinions, are swept away, all new-formed ones become antiquated before they can ossify. All that is solid melts into air, all that is holy is profaned, and man at last is forced to face with sober senses his real conditions of life and his relations with his fellow man."[7]

To Berman, who took his cue from Marx and Engels, the modern condition is one of constant change and confusion, accompanied by a longing for more permanent structures of order and authority. It is a search for order in a profoundly disordered world. In Canada, the modernist *dis*-ease is readily apparent in the early twentieth century debates regarding secularization, immigration, popular culture, morality, sexuality, feminism and masculinity. Historians have found that efforts to contain the sprawling diversity of peoples and cultures usually entailed a combination of regulation and

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[6] Marshall Berman, "Why Modernism Still Matters," *Modernity and Identity*, eds. Scott Lash and Jonathan Friedman, (Oxford and Cambridge: Blackwell, 1992): 35. Berman's ideas are more fully developed in his book, *All That is Solid Melts into Air: The Experience of Modernity*, (New York: Simon and Schuster, 1983).

education, both of which became the occasion for discussions regarding national identity, the role of the state, and the nature of citizenship.[8]

The Canadian public health movement fits comfortably within this framework. Life and death might be certain, but good health definitely is not. Even with the many breakthroughs in medical science, Canadians in the early twentieth century still faced an uncertain future of debilitating ailments. Moreover, far from alleviating the burdens of ill-health, much of modern culture and technology seemed to be facilitating new forms of physical degradation. Assembly lines left workers worn out with stress and fatigue. City living offered children fewer opportunities for fresh air, safe playgrounds and wholesome food. The disintegration of families and communities through immigration and relocation, meant young women could no longer rely on the domestic wisdom of their mothers. Even more troubling was the tendency of modern pastimes to excite youthful passions, with the

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[7] Quoted in Berman, "Why Modernism Still Matters." 36. Originally found in Karl Marx and Frederick Engels, *The Communist Manifesto*, (1848).

[8] Although the following histories do not all explicitly discuss the question of modernism, the conflicts associated with modernism are apparent within each. On secularization see Nancy Christie and Michael Gauvreau. *A Full-Orbed Christianity: The Protestant Churches and Social Welfare in Canada, 1900-1940.* (Montreal & Kingston: McGill-Queen's University Press, 1996); David B. Marshall. *Secularizing the Faith: Canadian Protestant Clergy and the Crisis of Belief, 1850-1940.* (Toronto: University of Toronto Press, 1992); Richard Allen, *The Social Passion: Religion and Social Reform in Canada, 1914-1928*, (Toronto: University of Toronto Press, 1971); Ramsay Cook, *The Regenerators: Social Criticism in Late Victorian English Canada*, (Toronto: University of Toronto Press, 1985); on the related issues of immigration, morality and sexuality see, Mariana Valverde. *The Age of Light, Soap and Water: Moral Reform in English Canada, 1885-1925*, (Toronto: McClelland and Stewart, 1991); Carolyn Strange. *Toronto's Girl Problem: The Pleasures and Perils of the City, 1880-1930*, (Toronto: University of Toronto Press, 1995); Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945*. (Toronto: McClelland and Stewart, 1990); On popular culture see Keith Walden, *Becoming Modern in Toronto: The Industrial Exhibition and the Shaping of Late Victorian Culture*, (Toronto: University of Toronto Press, 1997); Colin D. Howell, *Northern Sandlots: A Social History of Maritime Baseball*. (Toronto: University of Toronto Press, 1995); Michael Dawson, "'That Nice Red Coat Goes to My Head like Champagne': Gender, Antimodernism and the Mountie Image, 1880-1960," *Journal of Canadian Studies*, Vol. 32, no. 3 (Fall 1997).

result that both unwanted pregnancies and unwanted sexually transmitted diseases appeared to be on the rise.

Regulatory legislation could address some of these problems, but the real commitment for change would have to come from within the individual. Through education, public health advocates endeavoured to give individuals the information they would need to control the conditions of their own health. In essence, public health enabled individuals to assert order over their own physiological environment, thereby challenging the chaos around them. As medical historian, Stanley Joel Reiser has observed, "if one could not influence the negative effects of the social forces of industrialization, immigration, and urbanization, control over one's life by learning the principles of physiology and hygiene still was possible."[9]

The search for self-control was the legacy of an evangelical tradition which promised salvation to those who practiced self-restraint. By the end of the nineteenth century, an entire industry of preachers and publishers had emerged to lead the public to a state of grace. In the twentieth century, however, grace was understood in somewhat more secular terms. Instead of spiritual redemption, the search was for self-actualization. T.J. Jackson Lears argues that the rationalization of work and leisure, which typified turn-of-the-century capitalism, coupled with a decline in religious fervor had resulted in a sense of pervasive banality. Modern culture, with its emphasis on growth and spontaneity, only added to these feelings of inner "weightlessness" and generated a longing for "bodily

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[9] Stanley Joel Reiser, "Responsibility for Personal Health: A Historical Perspective." *Journal of Medicine and Philosophy*, Vol. 10, no. 1, (Feb. 1985): 13.

vigor, emotional intensity and a revitalized sense of selfhood." Lears suggests that relief was sought in the therapeutic solutions promised by commercial advertisers and public health promoters. In essence, health and consumption replaced religion as the new panacea for the physical, spiritual and material inadequacies felt by individuals and nations.[10]

Part of what made science attractive as an alternative to religion, was the apparent immutability of its methods. Unlike religion whose doctrines were vulnerable to sectarian scrutiny, science claimed to be the product of fixed empirical truths. Where religion offered faith, science offered facts, premised on the logic of pure reason. Science was objective. It was not subject to the flights of modernist fancy. It was, instead, a fixed and knowable quantity. By extension, the practitioners of science were celebrated as a voice of reason amid the cacophony of corporate pitchmen and empty advertising promises. Martin Pernick has observed that because scientific knowledge rested on an assertion of objectivity, it was assumed that "scientific experts would be impartial and fair, and their social decisions would carry moral weight." As a result, science in the early twentieth century was increasingly called upon to provide moral, as well as technical answers, to society's social problems.[11]

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[10] T.J. Jackson Lears, "From Salvation to Self-Realization: Advertising and the Therapeutic Roots of the Consumer Culture, 1880-1930," *The Culture of Consumption: Critical Essays in American History, 1880-1980*, R.W. Fox and T.J. Jackson Lears, eds., (Pantheon Press, 1983): 3-38; Many of these themes were originally discussed in Lear's book *No Place of Grace: Antimodernism and the Transformation of American Culture, 1880-1920*, (New York: Pantheon Books, 1981).

[11] Martin Pernick, *The Black Stork: Eugenics and the Death of 'Defective' Babies in American Medicine and Motion Pictures Since 1915*, (New York: Oxford University Press, 1996): 25-6.

Pernick's study of eugenics and euthanasia in the United States indicates that physicians in the twentieth century believed their professional objectivity gave them the authority, if not the obligation, to pass moral judgment on the life and lifestyles of their patients. Angus MacLaren arrived at similar conclusions with his investigation into Canada's eugenics movement, as did Allan Brandt and Jay Cassell in their studies of venereal disease.[12] In fact, the discourse of science held such social currency that it sometimes seems as if any quasi-professional group who endorsed the principles of the scientific method could lay claim to the title of scientist.[13] While the general public found themselves confronted by a barrage of well meaning advice from doctors and statesmen, social scientists and domestic engineers, it is important to recognize, as Lears astutely observed, that "this was not a conspiracy but an unconscious collaboration."[14] Science, with its diversity of preachers and practitioners, was not so much imposing order from above as reacting to society's own desire for progressive solutions to modern dilemmas.

Of course, to suggest that the public was complicit in the promotion of scientific authority does not mean that people always liked or even welcomed the directives they were given. History certainly provides many examples of medical experts, who privileged

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[12] Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945*, (Toronto: McClelland and Stewart, 1990); Allan Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880*, (New York: Oxford University Press, 1885); Jay Cassell, *The Secret Plague: Venereal Disease in Canada, 1838-1939*, (Toronto: University of Toronto Press, 1987).

[13] See for example, Marianna Valverde who describes the 'science' of social reform in *The Age of Light, Soap and Water*; JoAnne Brown describes the scientific aspirations of the psychiatric profession in *The Definition of a Profession: The Authority of Metaphor in the History of Intelligence Testing, 1890-1930*. (Princeton, N.J.: Princeton University Press, 1992); Kathy Peiss describes the 'science' of cosmetics in *Hope in a Jar: The Making of America's Beauty Culture*, (New York: Metropolitan Books, 1998); Marlene Shore describes the emergence of social sciences in *The Science of Social Redemption: McGill, the Chicago School and the Origins of Social Research in Canada*, (Toronto: University of Toronto Press, 1987).

social, and sometimes personal, objectives over the rights and wishes of their patients. The mandatory sterilization of feebleminded children, the enforced relocation of tubercular natives, and the use of mental patients for unauthorized experiments in brainwashing comes readily to mind.[15] Less spectacular perhaps, but no doubt more common, were the confrontations between patients whose experience of race, class, and gender put them at odds with their typically white male middle class physicians. Still, the privileging of medical and scientific authority does not occur within a vacuum. It is, instead, a reflection of pre-existing hegemonic forces that organizes power and privilege according to such categories of gender, class, race, sexual orientation, age, physical ability and education. Science and its practitioners may help to legitimize this division of power, but the authority of their work is determined by the governments who finance their research, the educational institutions who teach their ideas and by the general public who continue to seek out their opinions.

Public health education participated in this process in several ways. In its objectives, health education was a straight forward attempt on behalf of the government

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[14] Lears, 17.

[15] On the sterilization of the feebleminded see, McLaren; on the relocation of natives to southern sanitoriums see Pat Sandiford Grygier, *A Long Way from Home: The Tuberculosis Epidemic Among the Inuit*, (Montreal and Kingston: McGill-Queen's University Press, 1994); and Mary-Ellen Kelm. *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950*, (Vancouver: UBC Press, 1998); On the brainwashing experiments conducted on mental patients see Anne Collins. *In the Sleep Room: The Story of the CIA Brainwashing Experiments in Canada*, (Toronto: Key Porter Books. 1988); and Harvey Weinstein, *A Father, A Son and the CIA*, (Toronto: James Lorimer & Co., 1988); Other examples of questionable medical judgement should include the incarceration of 'Typhoid Mary'. the Tuskegee syphilis trials, and the long list of unauthorized human experimentation: Judith Leavitt. *Typhoid Mary: Captive to the Public's Health*, (Boston: Beacon Press, 1996); James H. Jones. *Bad Blood*, (New York: Free Press, 1981); Allan M. Brandt, "Racism and Research: The Case of the Tuskegee Syphilis Studt," *Hastings Centre Report*, 8, (Dec. 1978): Susan E. Lederer, *Subjected to Science: Human*

and other health advocates to assert the authority of science, and to shape the health of Canadian citizens. It was, suggested one hopeful health official, the means whereby "people form desirable patterns of thought and behaviour in line with scientifically valid ways."[16] Yet, even as it endeavoured to lead citizens towards the security of a healthier, more moderate life, public health information continued to reflect the ambiguities of the age. It advocated knowledge, but packaged it as entertainment. It warned against lascivious living, but sensationalized its dangers. It endorsed the ennobling qualities of work and family, while highlighting the physical and emotional pitfalls of both.

In my investigation of Canada's public health literature, (by literature I refer to all forms of educational material), I have chosen to concentrate on the objectives, format and metaphors which collectively defined the material. Rather than reviewing what the information says about specific diseases, I have elected to study the material as a whole. My interest is with the interplay of socio-political objectives and cultural imperatives, and the ways in which both sets of messages managed to percolate up through the material.

Research for the project focused primarily, but not exclusively on the archival material found in the Department of National Health and Welfare. This is an enormous collection which contains well over 2000 metres of poorly indexed documents. My research concentrated on material relating specifically to health education, publicity and

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Experimentation in America before the Second World War. (Baltimore: Johns Hopkins University Press. 1995).

[16] Minutes of the Fourth Federal-Provincial Health Education Conference, Ottawa, October 13-14, 1952. [NAC, RG 29, Vol. 111, file 111-a-18].

promotion. In addition to the government's health records, I also reviewed select records from the Health League of Canada, Dominion Council of Health, Metropolitan Life Insurance Company, and the National Film Board of Canada.

By far the most entertaining aspect of my research was spent in the audio/visual room of the National Archives of Canada. The National Archives now owns most of the films and radio broadcasts of the Department of National Health and Welfare and the Health League of Canada. Unfortunately, at the time that I was conducting my research the National Archives possessed not one, but four different indexing systems for their audio/visual collection, and none of these databases offered a complete list or full description of the collection. In total, I managed to find and review 153 films, 42 radio broadcasts, 212 radio scripts, and approximately 700 pamphlets, posters, lectures and speeches. Information from the National Film Board gave me detailed descriptions of an additional 53 health and welfare films. Although my search for public health material was exhaustive, these figures should be regarded as but a small fraction of the total amount of information produced and distributed in Canada between 1920 and 1960. The internal correspondence of the government and Health League of Canada frequently make references to films, radio dramas and pamphlets which were once widely distributed throughout the country, but are now, apparently, lost in perpetuity.

Selection of the films, radio and printed matter was primarily determined by distribution rather than by production. Canadian public health agencies, including the federal and provincial governments relied heavily on educational material that was produced in the United States and Britain. Only 88 of the 153 films reviewed (roughly 58

%) were produced in Canada. Many of the most popular and widely distributed films (which have since disappeared) were in fact American. The prevalence of American educational films reflects the inadequacy of the Canadian film industry prior to the establishment of the National Film Board of Canada in 1939. In fact, even after the National Film Board began making instructional films for the Canadian government, the more prolific American films continued to flood Canada's educational market. To exclude all non-Canadian films from my study would distort the experience of Canada's public health education campaigns. On the other hand, the widespread use of American material certainly makes problematic my assertion that public health information was, in part, a product of Canadian nation building.

My solution to this conundrum is perhaps best summed up by a comment attributed to the Canadian comedian, Martin Short. When asked to describe the differences between Canadians and Americans, Short is said to have replied, "Americans watch television, while Canadians watch American television."[17] In other words, the American domination of the Canadian cultural market does not necessarily preclude the existence of an autonomous Canadian identity. Canadians are fully capable of distinguishing between Canadian and American cultural products, in part, because the American media is so unabashedly American. Moreover, since Canadians have not been entirely seduced by American culture, they have become astute observers of it. Thus, it

[17]Martin Short is believed to have made the comment on the *David Letterman Show*, however, the only concrete reference comes from the July 26th 1993 issue of *McLean's* magazine, in which Canadian comedian, Mike Meyers, quotes Short during an interviewed about Lorne Michaels, (the Canadian producer of the American comedy show, *Saturday Night Live*).

seems safe to assume that Canadians who were presented with American public health material were able to take whatever information they needed and leave the American nationalism behind. That said, Canadian public health advocates were also keen to develop their own 'made-in-Canada' information, and the establishment of the National Film Board, whose objective was to teach Canadians about Canada, certainly facilitated this process.

The thesis itself is organized thematically with each chapter reviewing a different aspect of the public health picture. The thesis is unofficially divided into two parts. Chapters 1 and 2 explore the material substrata upon which public health education was built. Chapters 3, 4 and 5 analyse the content of the public health message.

In the first chapter I examine the social, economic and political context which gave rise to public health education in Canada. I offer a brief history of the Federal Department of Health, the Health League of Canada and the Canadian branch of the Metropolitan Life Insurance Company. These three organizations were selected as the institutional representatives of the public, private and philanthropic interests that underscored the public health movement. The chapter suggests that public health promotion was not the product of simple altruism. Although individual health advocates may have been motivated by a concern for public welfare, institutional interests were generated out of a concern for the preservation of hegemonic objectives. These objectives included the promotion of economic productivity, the protection of the family, and respect for national and government institutions.

In Chapter 2, I examine how public health information was produced and distributed. Focusing specifically on the work of the Federal Department of Health, this chapter gives a indication of the scope and complexity of public health information. The chapter describes the process through which public health advice was translated into print, radio and film. The process of production and distribution varied according to the format of the material, thus demonstrating that whatever the objectives of the institutions who produced the material, the information itself was circumscribed by the limitations of the medium.

The next three chapters examine the content of the public health material. Each chapter explores a different element of what is known as the Hippocratic triangle. The first of these three chapters concentrates on the changing portrait of disease. Despite changes in scientific theory, disease has typically been imagined as some form of mythic and malevolent being who preys upon the weak and corrupt. Even after germ theory gained widespread acceptance among the general population, artistic renderings still used visual allegories to convey a sense of the fear and loathing associated with disease. In the twentieth century, however, the images were drawn from more contemporary cultural tropes. Disease was likened to immigrants, soldiers, socialists and saboteurs.

In Chapter 4, I focus on the representation of doctors and scientists. Often hailed as the heroes of health, doctors and scientists are regarded as paternalistic experts who were willing to forego all personal pleasures in their pursuit of the common good. Although experts such as Louis Pasteur, Robert Koch and Joseph Lister are remembered for their unique contributions to science, most of the doctors and scientists portrayed in

the public health literature remained anonymous. They appear as tireless practitioners whose only passion was for their craft. Much like the germs described in the preceding chapter, scientific professionals appear to be highly organized, uniform and single-minded in the pursuit of their desired end. Together doctors and disease represent competing elements of the modern temper. Both appear as highly structured and efficient communities, but the similarity of means resulted in entirely divergent ends. Whereas disease brought chaos, science re-asserted order.

In the final chapter, I examine the image of patients, which I define as anyone who is actively unwell, or whose activities are conducive to disease. Patients are the real wild card in the health/disease equation. Through their choices of lifestyle and behaviour, patients either prevented disease or allowed it to fester. Public health material invited audiences to identify with the patients portrayed within the literature, and to desire the same qualities of beauty, success and domestic security which eluded the sick and rewarded the healthy. Moreover, the material encouraged audiences to regard health as a civic virtue which fostered the advancement of national social and economic goals. To preserve their health, and therefore the health of the nation, individuals were advised to adopt a policy of self-reflective moderation. They were not expected to make the sort of selfless sacrifices of physicians, nor were they to indulge in the excesses typical of the diseased patients. Rather, individuals were to find a middle ground somewhere in between.

The combination of disease, doctors and patients collectively define the relationship between sickness, science and society. An understanding of one is contingent

on an understanding of the other two. Whatever the stated objectives of public health promoters, they could not escape this discursive framework. Consequently, their own ambitions vis-à-vis the preservation of social goals, the promotion of professional objectives and the advocacy of health and well being, could not help but infiltrate their advice literature. When they constructed their advice literature the weight and history of all of these objectives and presumptions came into play. The result was a complicated, but colourful picture of health.

Chapter 1: The Producers - Public and Private Health Advocates

In 1919, the federal government of Canada established the nation's first federal Department of Health. From a constitutional perspective, the federal government's interest in health was rather odd. The British North America Act of 1867 placed the administration of public health within the jurisdiction of the country's provincial governments. From an economic standpoint the federal government's interest in health was also curious. Having just survived five years of international warfare, the coffers of Sir Robert Borden's Union government were far from flush. Clearly, Borden's interest in public health was informed by something other than political or economic expediency. In fact, the federal government's interest in health was primarily social. Through the promotion of public health, the federal government hoped to resolve a number of pressing social problems, not the least of which concerned the poor physical condition of Canadian citizens.

This chapter will survey the various social issues which inspired the creation of the Dominion Department of Health. It will also examine the health interests of two non-government organizations, namely the Metropolitan Life Insurance Company and the Health League of Canada, both of whom were active allies in the government's health education campaigns. Finally, this chapter will also consider the impact of various social issues on public health initiatives and the way in which national objectives concerning health and citizenship permeated efforts to improve the physical health of Canadian citizens.

Social Context

When the Canadian government first introduced the idea of establishing a separate Department of Health it was not so much leading the way in social legislation as responding to a pre-existing social crisis. Like other countries, Canada entered the twentieth century with a mixture of confidence and trepidation. Notwithstanding Wilfrid Laurier's assertion that the twentieth century belonged to Canada, many Canadians were concerned about the social costs of industrial progress. For most middle class Canadians, industrialization meant a higher standard of living, greater disposable income, an expansion in leisure activities and an ever increasing number of affordable consumer products. Sadly, not all Canadians shared equally in the fruits of progress. For members of the working classes, participation in the new economy was tempered by the persistence of low wages, long hours, unsafe working conditions, the lack of job security and the deterioration of urban housing. This volatile combination of poverty and urban overcrowding was attended by a statistical increase in crime, violence, juvenile delinquency, prostitution and illegitimacy. The urban poor were also plagued by infectious diseases such as tuberculosis, cholera, typhoid and dysentery. In an era when palliative care was expensive and actual medical cures were virtually non-existent, even the most minor infections could have serious consequences. Chronic malnutrition, contaminated food and water supplies, and unhealthy home and work environments further undermined

the physical vitality of working class Canadians, which in turn helped to sustain an infant mortality rate of about 12 % and a maternal mortality rate of about 5 %.[1]

Solutions to these problems varied. For instance, workers understood these problems to be primarily economic. Their demands for a more equitable division of work, wages and power were forcefully expressed through the growth of international trade unions, strikes and protests, and the emergence of left-wing political parties such as the Independent Labour Party (1906), the Socialist Party of Canada (1904), and the Social Democratic Party (1910). Between 1897 and 1914, the number of craft unions grew from 400 to 1775, and there were approximately 800 strikes around the country. In an attempt to forestall strike and union activity, many of the larger employers adopted a policy of corporate paternalism. The new policies improved the environmental conditions of work, but did little to improve the worker's actual wages.[2]

For most middle class Canadians the confrontational tactics advocated by labour leaders were both radical and alarming. They acknowledged that poverty was a problem,

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[1] Infant and maternal mortality rates vary considerably from province to province, rural to urban communities, and even between urban neighbourhoods. Terry Copp reports that between 1897 and 1911, approximately one out of every three infants born in Montreal died before their first birthday, whereas in Toronto, the rate was closer to one in five. See Terry Copp, *The Anatomy of Poverty: The Condition of the Working Class in Montreal, 1897-1929*, (Toronto: McClelland and Stewart, 1974):93, 167; Michael Piva shows that that the infant mortality rate in Toronto fell from 16% in 1901 to 9% in 1921, see Michael Piva, *The Condition of the Working Class in Toronto, 1900-1921*, (Ottawa: University of Ottawa Press, 1979): 114; The figures cited in the text are derived from Angus McLaren and Arlene Tigar McLaren, *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1880-1980*, (Toronto: McClelland and Stewart, 1986): 44-45; Bryan D. Palmer, *Working-Class Experience: The Rise and Reconstitution of Canadian Labour, 1800-1980*, (Toronto: Butterworth & Co., 1983): 136-184.

[2] Palmer, 136-184; J.L. Finlay and D.N. Sprague, *The Structure of Canadian History*, 4th edition, (Toronto: Prentice Hall Canada, 1993): 274-276; Janice Newton, *The Feminist Challenge to the Canadian Left, 1900-1918*, (Montreal & Kingston: McGill-Queen's University Press, 1995); Joan Sangster, *Dreams of Equality: Women on the Canadian Left, 1920-1950*, (Toronto: McClelland and

but they tended to be more concerned with the social costs of poverty rather than with poverty itself. Consequently, their solutions generally focused on the regulation of crime, disease and immorality. Toward this end, middle class social reformers campaigned for a variety of legislative and educative measures to regulate social behaviour. Reformers petitioned for legislation to limit strikes, restrict child labour and protect women workers. They pressured municipalities to rationalize urban development and establish health and safety standards for food, water and housing. They lobbied governments for tougher laws against prostitution, domestic violence, sexual assault, and juvenile crime. Reformers even tried to legislate morality by prohibiting the sale of alcohol and tobacco, regulating dance halls, movie theatres, and restaurants, and censoring all books and films which contained salacious, violent or politically controversial material.[3]

In addition to formal legislation, social reformers relied on the less formal tools of persuasion to promote their regulatory agenda. Using books, booklets, newspapers, magazines, lectures, workshops, sermons and camp meetings, reformers offered practical advice and moral inspiration on everything from home economics to child care, physical fitness to sexual purity. With this material, reformers hoped to lead Canadians, especially less privileged Canadians, through the maze of opportunities and temptations which bedazzled modern society. In practice, the material offered a rather narrow prescription

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Stewart, 1989); Paul Craven, *"An Impartial Umpire": Industrial Relations and the Canadian State, 1900-1911*, (Toronto: University of Toronto Press, 1980).

[3] Richard Allen, *The Social Passion: Religion and Social Reform in Canada, 1914-28*, (Toronto: University of Toronto Press, 1971); Carolyn Strange, *Toronto's Girl Problem: The Perils and Pleasures of the City, 1880-1930*, (Toronto: University of Toronto Press, 1995): esp. 116-143.

of behavioural norms which reflected the social and cultural values of the primarily white, Anglo-Protestant middle class reformers who produced it.[4]

In both legislative and educative reforms, health played a central role. Reformers recognized the economic burden of disease and debility. They also worried about the long term effects of ill-health and malnourishment on generation after generation of working class Canadians. For many reformers, eugenic concerns over the physical deterioration of Canadian workers was compounded by xenophobic anxiety over the growing population of ethnically diverse immigrants. The corresponding decline in middle-class fertility only added to their alarm. With the advent of war in 1914, many of these issues seemed to become more acute. Medical officers claimed that over 40% of wartime recruits were suffering from health problems which rendered volunteers unfit for active service. Many of those in active service were afflicted by physical and psychological disorders which some experts attributed to a lack of personal stamina. The mobilization of troops also accelerated the pandemic spread of infectious diseases like Spanish Influenza which killed more Canadians at home than the war did soldiers abroad. Finally, the relaxation of normal social controls over the sexuality of young people gave Canada the dubious distinction of having the highest rate of venereal disease among all of the allied forces.[5] By

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[4] Allen; Mariana Valverde, *"The Age of Light, Soap and Water": Moral Reform in English Canada*, (Toronto: McClelland and Stewart, 1991): 44-76; Nancy Christie and Michael Gauvreau, *A Full-Orbed Christianity: The Protestant Churches and Social Welfare in Canada, 1900-1940*, (Montreal & Kingston: McGill-Queen's University Press, 1996); Michael Bliss, "Pure Books on Avoided Subjects: Pre-Freudian Sexual Ideas in Canada," *Historical Papers*, (Canadians Historical Association, 1970): 89-108.

[5] For fertility rates and eugenics see McLaren, *The Bedroom and the State:* 18, 71-91; Valverde, 104-128; Donald Avery, *"Dangerous Foreigners": European Immigrant Workers and Labour Radicalism in Canada, 1896-1932*, (Toronto: McClelland and Stewart, 1979): 65-89; Janice Dickin McGinnis, "The Impact of Epidemic Influenza: Canada, 1918-1919" in S.E.D. Shortt (ed.), *Medicine in Canadian Society: Historical Perspectives*, (Montreal & Kingston: McGill-Queen's University Press, 1981): 458.

the time the war ended, it was clear that the future prosperity of the nation would depend, at least in part, on the health of its citizens.

Institutions

Campaigns for the promotion of public health were initiated by several different types of institutions including private corporations, non-government voluntary groups and the various levels of the Canadian government. Private corporations, such as the Metropolitan Life Insurance Company [MLI], used health as an advertising gimmick with which to sell their product. Voluntary groups, like the Health League of Canada [HLC], were interested in disease prevention for more altruistic reasons. Finally, government health departments recognized that health could be promoted as a valuable public service as well as a self-serving promotional device. Despite their different institutional objectives, each of these groups played an important role in shaping the delivery of health services and the advancement of public health ideals.

Metropolitan Life Insurance Company

By the late nineteenth and early twentieth centuries, corporate advertisers had discovered that good health, or at least the promise of good health, could be good

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467; Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945*, (Toronto: McClelland and Stewart, 1990): 43, 63, 93, 110; Desmond Morton, *When Your Number's Up: The Canadian Soldier*

business. The public's interest in health and hygiene generated a demand for personal health products which manufacturers were only too happy to supply. Manufacturers also recognized that the public's desire for health could be manipulated to sell products whose actual health-giving properties were not readily apparent. Thus, advertisers used the promise of health to sell everything from clothing to tonics, bicycles to soap. Some products, like Lydia Pinkham's "Pink Pills for Pale Ladies" offered direct relief for a host of vague physical symptoms. Other commodities, such as Pear's soap, Lysol disinfectant, Bovril beef flavouring, Wrigley's chewing gum and Kellogg's cereal, were marketed as health saving products.[6] Of all the different industries to use the promise of health to peddle a product, the life insurance companies were undoubtedly the most enterprising.

Unlike many businesses, life insurance companies have a vested interested in preserving the health of their clients. The longer their clients stay healthy and alive, the longer their clients will invest in the company's insurance policies. In 1871, the New York based Metropolitan Life Insurance Company [MLI] introduced a modest health education programme when it began to publish a series of "Health Hints" in the periodicals and reports that it distributed to policy-holders. In 1897, the series was compiled into a small manual entitled, *Health Hints for the Home*. Company historians claim this booklet

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in the First World War, (Toronto: Random House of Canada, 1993): 60, 71-72; Jay Cassell, *The Secret Plague: Venereal Disease in Canada, 1838-1939*, (Toronto: University of Toronto Press, 1987): 122-144.

[6] On the use of health in advertising see, T.J. Jackson Lears, *Fables of Abundance: A Cultural History of Advertising in America*, (New York: Basic Books, 1994): 140-147, 162-195; Paul Rutherford, *Endless Propaganda: The Advertising of Public Goods*, (Toronto: University of Toronto Press, 1999): 96-115; Vincent Vinikas, *Soft Soap, Hard Sell: American Hygiene in an Age of Advertisement*, (Ames: Iowa State University Press, 1992); Nancy Tomes, *The Gospel of Germs: Men, Women, and the Microbe in American Life*, (Cambridge, Mass.: Harvard Univesity Press, 1998): esp. 157-182.

was "the first health publication of its kind ever to be issued anywhere."[7] The popularity of this first booklet inspired the creation of a series of similar advice manuals which were collectively published under the title, *A Friend in Need is a Friend Indeed* (1898).[8]

By 1909, the Company's directors were convinced by the efficacy of public health education and decided to expand their operations. They established a special Division of Health and Welfare to survey national morbidity rates, investigate methods of disease prevention, distribute educational materials and encourage governments to enact protective health legislation.[9] On the advice of Lillian Wald, a New York settlement house worker and vocal advocate of social reform, Metropolitan Life also began to employ professionally trained public health nurses to visit sick policy-holders, distribute literature, and offer simple medical advice regarding modern methods of "sanitation and wholesome living." According to William P. Shepard, (former medical director of Metropolitan Life), when Metropolitan Life introduced its nursing service there were no cities in North America that provided free visits and home care. Fifty years later, there were few cities without a public health nursing programme.[10] In 1959, Metropolitan Life's Division of Health and Welfare celebrated its fiftieth anniversary. Company executives boasted that over the past fifty years approximately 1,711,529,994 health and safety pamphlets had been distributed, 12,625,000,000 "Health Hints" advertisements had

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[7] "The Papers of Dr. Thomas Simpson, Metropolitan's First Medical Examiner in Canada" prepared by Hon. Brooke Claxton. Reprinted from the *Canadian Services Medical Journal*, XIII. 1957. [MLI archives, 6-HW-1].

[8] *A Brief History of Metropolitan Life's Health and Safety Activities, 1871-1971*, MLI Health and Welfare Division, c. 1972. [MLI archives, 10-HW-Col.]

[9] Carl Carmer, *A Tower of Strength: Metropolitan Life Insurance Company*, (New York: Metropolitan Life Insurance Co., 1959): 9. [MLI archives, 6-HW-5, #49].

been published in newspapers and magazines, 280,204,504 people had watched the Metropolitan's health and safety films in theatres and on television, and 107,594,527 home visits had been conducted by company nurses.[11]

In return for its $170 million investment, medical researchers at Metropolitan Life noted a significant improvement in the health and longevity of its policyholders. In 1959, the Company congratulated itself on a 98 percent reduction in deaths due to "measles, scarlet fever, whooping cough and diphtheria," a 79 percent reduction in deaths due to appendicitis, and a 38 percent reduction in deaths due to syphilis.[12] The Company also claimed to be fundamental in reducing the health disorders associated with certain industries, such as silicosis among miners and TNT poisoning among munitions workers.[13] As the death rate from these common preventable diseases declined, the lifespan of policyholders increased. In 1912, Company statisticians claimed that the average policyholder lived a mere 46.6 years; however, by 1933 their life expectancy had increased to 59.2 years. Ten years later, the average life expectancy of policyholders was reported to be 64 years.[14]

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[10] William P. Sheppard, "Insurance as a Social Program" transcribed speech reprinted in booklet. *Fifty Metropolitan Years in Public Health, 1909-1959* (c. 1959): 9. [MLI archives, 6-HW-3].

[11] Carmer, 27; also Sheppard, 8.

[12] Thomas M. Rivers, (Vice-President of Medical Affairs, The National Foundation), "Medical Research - 1909 to 2009" transcribed speech reprinted in *Fifty Metropolitan Years in Public Health*, 1909-1959, 11; see also Carmer, 14-18.

[13] Sheppard, 8.

[14] Though rarely acknowledged by MLI histories, these life expectancy ages represent the average age of death from infancy to old age. If MLI statisticians had only recorded the average age of death for persons over age 20, the life expectancy rate would most likely have been closer to 65. Thus, the increase in life expectancy was primarily due to the decrease in infant and maternal mortality rates. *Twenty-Five Years of Life Conservation*, (New York: Metropolitan Life Insurance Co., c. 1934). [MLI archives, 3-HW-3]; also booklet, *What We Did in '43: A Report to Metropolitan's Personel on the Accomplishments of Last Year*, (New York: Metropolitan Life Insurance Co., 1943), [MLI archives, 6-Pubs-28].

Metropolitan Life's dedication to health preservation projected an image of corporate paternalism which proved to be highly marketable with potential clients. Metropolitan field agents were encouraged to present themselves as "health messengers" whose primary interest was in selling health rather than selling insurance.[15] Training manuals for new Insurance Agents included step-by-step instructions on how to incorporate the company's health booklets into the agent's sales pitch. [16] Field agents were also encouraged to use the health booklets to demonstrate both the fragility of life and the protective compassion of the Metropolitan Insurance Company. When talking with potential clients, agents were told to:

> Urge the *certainty* of *death*. Don't say "*If* you die." Say "*When* you die." ... Urge the *un*certainty of life... Work in your own way to force home the truth that the danger of dying is an ever-present danger. A man is healthy and active to-day, and to-morrow there is pneumonia or accidental violence or something wrong with the oysters, salad or ice-cream and in a few hours all is over.[17]

With their health booklets in hand, door-to-door insurance agents were to present the Metropolitan Life Insurance Company as a source of security in an insecure world. As George Wheatley, (a distinguished pediatrician, public health advocate and Metropolitan Life executive), declared in 1959:

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[15] In its 1909 list of objectives, Met. Life's Division of Health and Welfare stated its believe that "Metropolitan Agents visiting the homes of policyholders weekly could become a valuable body of health messengers." See Carmer, 9.

[16] *The Metropolitan Prospecting and Selling Plan: Part One, Be Prepared for the Rainy Day*, (Canada: Metropolitan Life Insurance Co., 1940), [MLI archives, 1940-Pub-03]. New insurance agents were given a script which they were supposed to memorize. The script included specific references to the Health booklets and how they were to be incorporated into the agent's sales pitch. See *Getting Acquainted*, (Canada: Metropolitan Life Insurance Co., 1933), [MLI archives, 1933-Pub-04].

[17] *Talks to New Agents*, (New York: Metropolitan Life Insurance Co., 1924): 12, [MLI archives, 1924-F-02].

> Health is almost a frenzied pursuit. All kinds of products are sold in the name of health. The public is bewitched, bothered, and even bewildered by claims and counter claims based on half-truths....Today, in this fog of motions, notions, and beliefs about what to do and what not to do for good health, our health information program is a tower of strength -- a beacon, if you will, shedding light on health. We intend that it be a light that never fails.[18]

Metropolitan Life's medical director, William P. Shepard, concurred. "When [agents] hand a policyholder a booklet on overweight or nutrition, on mental health or Salk vaccine," stated Shepard, "their motive is unquestioned. This booklet carries the recommendation of the Company which insures that individual's life, or health or both. What the Company says must be right."[19]

Metropolitan Life's efforts to sell themselves by selling health was clearly successful. By 1932, Metropolitan Life boasted that it was "the largest life insurance company in the world," with greater assets than any other financial institution. In Canada, the company controlled one-sixth of all insurance policies.[20] Twenty-five years later it was still among the most prosperous financial corporations in North America.[21] Moreover, Metropolitan Life clients seemed genuinely appreciative of the health services provided by the company. Company officials claimed to receive thousands of letters from thankful policyholders who attributed the health pamphlets with improving their health and extending their lives.[22] Denyse Baillargeon's study of Metropolitan Life's visiting nursing

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[18] George M. Wheatley, "Health Needs - Today and Tomorrow" transcribed speech reprinted in *Fifty Metropolitan Years in Public Health*, 1909-1959, 10.
[19] Sheppard, 8.
[20] *Serving Canada since 1872*, (Toronto: MLI, 1932): 4-5. [MLI archives, 1932-Pub-06]
[21] Frederick H. Ecker, "Metropolitan's Interest in People" transcribed speech reprinted in *Fifty Metropolitan Years in Public Health*, 1909-1959, 5.
[22] Carmer, 10, 18-19, 22-23.

programme found that most policyholders actively sought out the services provided by the nurses, for unlike the municipal public health nurses who were often regarded as agents of an intrusive government, Metropolitan Life nurses were welcomed as one of the many benefits of being a Metropolitan Life policyholder.[23]

Part of the reason Metropolitan Life's health and welfare programme appeared so altruistic was that the booklets, advertisements, pamphlets and films focused exclusively on health issues and rarely mentioned insurance. Between 1940 and 1960, Metropolitan Life purchased advertising space from approximately 20 different Canadian magazines and newspapers.[24] Published in both French and English, these publications reached a circulation of roughly 3 million people.[25] Out of 197 different half page advertisements, not a single one directly discussed the benefits of buying life insurance. Instead, the advertisements offered general information on specific health issues and then invited interested readers to contact Metropolitan Life for more information.[26] Health booklets, pamphlets and films worked on the same principle; rather than selling insurance, they sold health information sans gratis.

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[23] Denyse Baillargeon, "Care of Mothers and Infants in Montreal Between the Wars: The Visiting Nurses of Metropolitan Life, Les Gouttes de Lait, and Assistance Maternelle" *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, eds. Diane Dodd and Deborah Gorham. (Ottawa: University of Ottawa Press, 1994): 164-181.

[24] Metropolitan Life kept copies of each of their monthly advertisements along with a list of all the magazines and newspapers who published their advertisements. Although there were some changes in the magazines which carried MLI advertising, the total number remained fairly constant. "Welfare Advertisements: Appearing in Canadian Publications, 1940-45, 1951-55, 1956-60" [MLI archives , 4-Pub-19XL, 6-Pub-13XL]

[25] Unfortunately, the precise circulation was not regularly recorded; however, in October 1952, Metropolitan listed 16 publications that carried MLI advertisements. These publications recorded a combined circution of 2,981,511. Ibid.

[26] Ibid.

While other private corporations certainly capitalized on Canadians' interest in health and faith in science, Metropolitan Life's Division of Health and Welfare offered the first and most comprehensive programme of preventive education and practical services. When the federal government eventually launched its own public health educational programme, it derived considerable inspiration from the Metropolitan Life model. In fact, Metropolitan Life and the federal government routinely collaborated on national projects, relied on each other's statistical databases and sometimes exchanged personnel.[27]

Health League of Canada

In addition to private corporations who promoted health to sell their product, voluntary groups also generated a considerable amount of health education literature. In the early decades of the twentieth century, many social reformers initiated health programmes through their own philanthropic organizations. Women's groups such as the Women's Christian Temperance Union, the Imperial Order of Daughters of the Empire, Women's Institutes, and the National Council of Women, included health education, especially as it pertained to women and children, among their various activities. Other voluntary organizations, like the Canadian Tuberculosis Association, the Canadian Red Cross Society and St. John's Ambulance, sprang up in response to specific diseases or

[27] The most notable person to work in both organizations was Hon. Brooke Claxton. Claxton was the Federal Minister of Health and Welfare from 1944-1946. After leaving politics, Claxton joined the Metropolitan Life Insurance Company, where he served as Vice President and General Manager from 1944-1960.

medical problems. In 1919, these single issue health interest groups were joined by the Canadian National Council for Combating Venereal Disease (CNCCVD).

The primary objective of the CNCCVD was "to combat Venereal Diseases by whatever means seem desirable." In practice this objective was translated to mean "the dissemination of sound knowledge of the psychological and moral laws of life," the provision of "accurate and enlightened information" regarding the disease and its treatment, and the promotion of "legislation, social and administrative reforms."[28] The founding of the CNCCVD coincided with the establishment of the Dominion Department of Health, and for several decades the two organizations maintained an exceptionally close working relationship. Historian Jay Cassel argues that international distress over the prevalence of venereal disease during World War One and its attendant social problems made VD prevention one of the principal concerns of the federal government.[29] The CNCCVD, like its counterparts in Britain, Europe and the United States, was expected to supplement the government's own educational initiatives and to generate public support for the government's reform initiatives. Although it presented itself as a non-partisan, non-government health advocacy group, the CNCCVD was one of the government's most energetic cheerleaders. This enthusiasm did not go unrewarded. In the early years, Dominion health grants accounted for roughly 75% of the CNCCVD's operating budget.

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[28] "Constitution of the Canadian National Council for Combating Venereal Disease." *Canadian Public Health Journal*, Vol. 10, (1919): 375-8.
[29] Cassel, 145-175.

Other sizable grants came from the Ontario government, the City of Toronto, and the Metropolitan Life Insurance Company.[30]

In addition to the government's economic support, the CNCCVD was endorsed by many of the country's leading government bureaucrats, religious leaders, health specialists and social reformers. Indeed, the organization's Board of Directors was top heavy with prestigious but largely honourary executive officers. Among the officers named at the founding of the CNCCVD were Viscount Willingdon (Governor General of Canada), Hon. Mr. Justice Riddell (Chief Justice of the Ontario Supreme Court), the provincial Deputy Ministers of Health and/or directors of provincial VD programmes, Sir Arthur Curry (Commander of the Canadian Armed forces), Mrs. A.M. Huestis (suffragist and women's rights activist), and Judge Emily Murphy (lower court Magistrate and vocal advocate of women's rights). Initially the board also included representatives from Catholic, Protestant and Jewish religious communities. The founder and General Secretary of the CNCCVD was Dr. Gordon Bates, whose messianic dedication to the health education cause kept the organization going long after its raison d'être had disappeared.[31]

Even with such distinguished patronage, the CNCCVD found it difficult to maintain public interest in the somewhat disreputable problems of syphilis and

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[30] Ibid, Appendix E, 268-9.

[31] R.R. Robinson's short essay in the *Ontario Medical Review* characterized Bates as a self-important health advocate who, by the 1950s, was regarded by many medical experts as both amusing and exasperating. R.R. Robinson, "Bates of the Health League: An Insider's Perspective," *Ontario Medical Review*, Vol. 49, (1982): 305, 308.

gonorrhoea.[32] In 1922, the CNCCVD re-invented itself as the Canadian Social Hygiene Council (CSHC). Similar to both the British and American Social Hygiene Councils, the CSHC continued to focus on the problem of VD, but recognized the numerous social, economic, medical and moral factors which contributed to the spread of the disease. Thus the CSHC began to produce educational material that addressed VD prevention and treatment, as well as literature on sex education, pre- and post-natal care, and various contagious diseases. In 1936, the organization underwent another facelift. Operations were expanded to cover a much broader assortment of health problems, including child and maternal health, tuberculosis, mental health, diphtheria, accident prevention, sex education, and eventually cancer, alcoholism, drug addiction, smoking, heart disease, and atomic warfare. Venereal disease still remained a favourite issue, but it no longer served as the organization's primary focus. To reflect its new and more diverse interest in disease prevention, and to distance itself from the type of social purity evangelism that typified the American Social Hygiene Council, the CSHC changed its name to the Health League of Canada (HLC).[33]

Like the Metropolitan Life Insurance Company, the CNCCVD/CSHC/HLC drew upon a wide variety of popular information media to convey ideas about health and disease. It produced pamphlets, booklets, and posters. It broadcast health information over the radio in the form of dramas, panel discussions and spot announcements. It also

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[32] Minutes from the CSHC Annual Meeting in 1925 suggest that the CNCCVD was also worried about sustaining the government's interest. As one CNCCVD board members observed, it is "extremely difficult to maintain Dominion Government interest in a single disease problem." By expanding its activities, the CNCCVD/CSHC hoped to satisfy the government's broadening interest in health preservation. [NAC, MG 28-I-332, Vol. 10, file 10-23].

[33] *Health League of Canada*, (pamphlet, 1936). [NAC, HLC, MG 28-I-332, Vol. 1, File 1-1]; Cassel, 243.

arranged for special screenings of social hygiene and health education films. The organization advertised its message in newspapers and magazines, as well as in classrooms, workplaces and streetcars.[34] Cross-country lecture tours were conducted by notable doctors, politicians, and social reformers (including English suffragists Emmeline Pankhurst and Flora Drummond).[35] The HLC and its predecessors organized immunization drives and National Health Weeks to raise awareness about various diseases and to garner public support. It created impressive health exhibits which were displayed at agricultural fairs and medical conferences. It even arranged Social Hygiene days in which local Protestant, Catholic and Jewish churches were encouraged to deliver uplifting sermons on the spiritual virtues of health preservation.[36]

By constantly bombarding the public with health information, Bates and his associates hoped to inspire Canadians with the means and desire to be healthy. "The matter of health conservation is fundamentally the most important problem which can face any people" stated Gordon Bates in 1927. "Our task is to increase the feeling of responsibility which should be felt by each citizen to the end that by the strivings of each we may build up a healthier and finer race."[37] With the information provided by the CSHC, Bates promised that "the tremendous toll now taken in this country by

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[34] HLC minutes, June 26, 1944 [NAC, MG 28-I-332, Vo.l, file 1-14]

[35] Emmeline Pankhurst, accompanied by Dr. Gordon Bates and Dr. J.J. Heagerty (Dir. of the Venereal Disease Division and later Dir. of Health in the DPNH, 1930-1945), spoke about the dangers of venereal disease to large crowds of Canadians in 1922 to 1923. Jay Cassell notes that "it was estimated that 60,000 people between Ottawa and the Rockies had come to hear her." See Cassell, 214-215; note also CSHC, Minutes of Executive Ctte. Minutes, June 8, 1922 [NAC, MG 28-I-332, Vol. 1, file 1-10]; Flora Drummond came to Canada in 1927 to coordinate the efforts of business leaders in "dealing with industrial unrest, attacking Bolshevism and Communism in industry and encouraging a proper type of emmigration." Bates to E.W. Beatty (CPR Co.), Oct. 8, 1927. [NAC, HLC Col., MG 28-I-332, Vol. 7, file 7-1].

preventable illness and premature death may be decreased and with it as an inevitable result, much of the social disorder caused by broken homes, poverty and ignorance."[38] Bates further recognized that health information alone would not overcome the many obstacles to achieving good health. Bates believed that true reform would come through an expansion of the government's social welfare responsibilities. Thus, in addition to providing basic health advice, the CSHC and the HLC encouraged Canadians to lobby government to adopt a more interventionist approach to public health policies. In 1928, the CSHC Annual report promised "We shall continue as ever our task of education to the end that we may create a body of public opinion and public support behind our official departments of health, behind the medical profession and behind all allied agencies that have as their ultimate aim the building up of a finer, healthier longer lived race."[39] "It is the business of the Government to look after the people" declared Dr. Howden in 1936. "We must interest the people to the extent that they will demand of the government that certain conditions be brought about.... The way to the Government is through the People and the way to the People is through the Health League of Canada."[40]

It was only after the federal government began to embrace the principles of social welfare that the HLC began to temper its advocacy for legislative change. Prior to the second world war, the HLC saw itself as an emissary of governmental reforms. After the war, the government's decision to redefine the social contract made the work of the HLC seem redundant. Government officials within the health department increasingly regarded

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[36] HLC minutes, Feb. 18, 1944. [NAC, MG 28-I-332, Vol. 1, file 1-14]
[37] CSHC 9th Annual Report, June 1928. [NAC, MG 28-I-332, Vol. 9, file 9-13].
[38] CSHC minutes of the Annual Meeting, 1930. [NAC, MG 28-I-332, Vol. 10, file 10-31].

the activities of the HLC as tedious and embarrassing. In response, Bates re-positioned the HLC as a democratic check against the government's autocratic reforms. "If we are to achieve fundamental social reforms," declared Bates in 1946, "it must be by virtue of voluntary action on a large scale.... It appears to be extremely significant in a democracy"[41]

Federal Government

The educative work of organizations like the Metropolitan Life Insurance Company and the Health League of Canada served as an important backdrop to the work that would eventually be undertaken by the federal government. With the active support of representatives in the corporate sector, as well as from some of the country's leading physicians, reformers and philanthropists, the federal government could feel reasonably confident that their venture into the field of health and welfare would be greeted with some measure of approval.

The federal foray into public health was not entirely without precedent. Prior to the formation of the Dominion Department of Health, public health was administered by municipal governments which were regulated according to provincial guidelines. Under the terms of the British North America Act of 1867, federal responsibility was restricted to the care of Natives, federal employees (including federal civil servants, postal workers

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[39] CSHC minutes of the Annual Meeting, 1928. [NAC, MG 28-I-332, Vol. 10, file 10-26].
[40] HLC minutes of the Board of Directors, June 15, 1936. [NAC, MG 28-I-332, Vol. 5, file 5-15]

and members of the Canadian armed forces), and individuals whose transience essentially rendered them provinceless (such as mariners and immigrants).[42] Aside from these limited federal services, the provision of basic health and hospital services was almost entirely left to municipal governments and private charities. Toward the end of the nineteenth century, municipalities found it increasingly difficult to meet the health needs of a rapidly expanding industrial urban society. In 1884, the Ontario government passed the first ever provincial Public Health Act, thus signaling its intention to take a more active role in the administration of public health services.[43] Supporters of the Act were quick to credit the newly formed Provincial Board of Health with successfully protecting Ontario residents from the 1885 smallpox epidemic. In contrast to the 7000 people who died in Quebec, only 18 deaths were recorded in Ontario. Whether Ontario's success at withstanding the epidemic was the result of good planning or merely good luck is debatable, however, it was definitely good for the policy-makers, and helped to convince Quebec and the other provinces to adopt similar health measures.[44] According to historian Janice Dickin McGinnis, the centralization of public health responsibilities helped coordinate the delivery of health services within and between municipalities, but there was little effort at long-term

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[41] Bates to John E. Robbins (Gen. Sec'y of the Canadian Council of Education for Citizenship, Ottawa). Jan. 11, 1946 [NAC, MG 28-I-332, Vol. 8, file 8-6].

[42] Canada. *The British North America Act*, 1867, article 91, sections 7, 8, 11 24, 25.

[43] "The Public Health Act," Assented to March 25th, 1884, *Statues of Ontario*, Ch. 38.

[44] Peter H. Bryce, "The Story of Public Health in Canada," *A Half Century of Public Health*, ed. Mazyck Porcher Ravenel, (New York: Arno Press, 1970): 61-63; Michael Bliss, *Plague: A Story of Smallpox in Montreal*, (Toronto: Harper Collins, 1991); William B. Spaulding, The Ontario Vaccine Farm, 1885-1916," *Canadian Bulletin of Medical History*, Vol. 6, (1989): 45-56; Barbara Craig, "Smallpox in Ontario: Public and Professional Perceptions of Disease, 1884-1885," *Health, Disease, and Medicine: Essays in Canadian History*, ed. Charles G. Roland, (Toronto: Hannah Institute for the History of Medicine, 1984): 215-249; Jacalyn Duffin, *Langstaff: A Nineteenth-Century Medical Life*. (Toronto: University of Toronto Press, 1993):229-233.

health planning. Nor was there any attempt to protect health programmes against the shifting forces of political expediency or economic circumstance.[45]

If the provincial boards of health lacked structure and coordination, the federal government was hardly a model of efficiency. By 1900, the federal government managed to spread its few health responsibilities over a total of fifteen different government departments.[46] Even by government standards such a diversity of departments was regarded as inefficient and in need of reform. The drive for the consolidation of health services was further strengthened by health lobbyists (both corporate and voluntary) who hoped the government would regulate and improve provincial standards, and by social activists who demanded relief from the burdens of economic deprivation. The final catalyst for change came as a result of the First World War. The war revealed the naiveté of viewing disease from a purely local perspective. Diseases such as syphilis, gonorrhoea, and influenza simply did not respect provincial boundaries, and it was clear that efforts to prevent the spread of disease were doomed to failure so long as the country lacked a coordinated national approach. Finally, after several years of deliberation, the Canadian Parliament assented to "An Act Respecting the Department of Health" on the 6th of June, 1919.

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[45] Janice P. Dickin McGinnis, "From Health to Welfare: Federal Government Policies Regarding Standards of Public Health for Canadians, 1919-1945." Ph.D. Dissertation, Dept. of History, University of Alberta, 1980: 19.

[46] Until the creation of the Dominion Department of Health in 1919, federal health initiatives were administered by whichever department or ministry was in charge of the patient. Consequently, health policies could be found within the Ministry of the Interior (which was responsible for Native peoples) and the Departments of Immigration, Defence, Public Works, Trade and Commerce, Overseas Militia Forces, Navy Service, and the Soldiers' Civil Re-establishment League. Health also came under the jurisdiction of the Ministries of Finance, Justice and Customs. See McGinnis, 20-21.

Under the new Act the duties and powers of the Dominion Department of Health would "extend to and include all matters and questions relating to the promotion or preservation of the health of the people of Canada."[47] The Act assumed jurisdiction over the medical care of immigrants, seamen, and civil servants (the health of Native peoples would not be transferred until 1945).[48] In addition to consolidating the federal government's health responsibilities under one roof, the Department of Health pledged itself to "the establishment and maintenance of a national laboratory for public health and research work,"[49] and to the "improving of public health, the conservation of child life and the promotion of child welfare."[50] The Act also specifically promised to promote public health through "the collection, publication and distribution of information relating to the public health, improved sanitation and the social and industrial conditions affecting the health and lives of the people."[51]

To administer to these different objectives, the Department of Health created ten divisions within the Department to deal with specific problems: the Division of Quarantine Service, Immigration and Medical Service, Food and Drug Laboratories, Opium and Narcotic Drugs, Propriety and Patent Medicine, Marine Hospitals Service, Venereal Disease Control, Publicity and Statistics, Child Welfare, and Housing.[52] Although each of these divisions had its own director and staff, there was considerable overlap in the

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[47] Canada, "An Act Respecting the Department of Health". (assented to 6th June, 1919), 9-10 George V. *Statutes of Canada*, Chapter 24, preamble.
[48] Ibid, section 4c, d, & e.
[49] Ibid, section 4b.
[50] Ibid, section 4a.
[51] Ibid, section 4h.
[52] Canada, "Report of the Department of Health" *Sessional Papers*, No. 12, 1921 (for the year ending March 31, 1920): 5.

execution of responsibilities. For instance, venereal disease had its own division, but because of the diversity of its victims the problem was also discussed within the divisions of Immigration, Marine Hospitals, Housing, and Child Welfare. Similarly, issues relating to the welfare of children came under the auspices of the divisions of Child Welfare, as well as Housing, Immigration, Food and Drugs and Publicity.

In addition to overlapping with each other, many of the divisional recommendations crossed the constitutional border into provincial jurisdiction. Thus, venereal disease was acknowledged as a federal problem when it related to immigrants, mariners, and veterans, but was a provincial matter when it concerned the actual treatment of patients. Likewise, the federal Division of Child Welfare could demand an expansion of the prenatal education campaign, but it was the municipalities who had to foot the bill. Clearly, the success of federal health initiatives largely depended on the willingness of the provinces to cooperate. To help secure this cooperation, the government formed the Dominion Council of Health (DCH) in the autumn of 1919. The DCH was comprised of leading civil servants from each of the federal and provincial health departments, as well as representatives of labour, women, science and agriculture. The Council met twice yearly to exchange information and discuss policy initiatives. Although the DCH offered an important forum for the communication of ideas, it lacked the authority to enforce any of its recommendations, leading one historian to dismiss the Council as "little more than a debating club."[53]

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[53] McGinnis, 167.

The DCH's legislative impotence was compounded by the federal Department's lack of vision, funding and leadership. For the first two decades of its existence, the Department showed little innovation. Basically, it patrolled the borders of health; limiting the traffic in illegal drugs, prohibiting the entry of diseased immigrants, and restricting the mobility of Canadians suffering from contagious diseases. While these activities contributed to the health and safety of Canadians, they did little to alter the day to day conditions which allowed disease to fester. Nor did these initiatives provide relief for those individuals who were unable to afford medical treatment. The one area in which the federal government might have shown real leadership was in the development of health insurance. The virtue of such a scheme was periodically debated by the DCH, but negotiations did not begin in earnest until 1943 and even then the plan was shelved until the late 1950s.[54] As historians Robert S. Bothwell and John R. English have asserted, the Health Department "failed to win, show or place in the health insurance sweepstakes" and by 1939 the Department of Health "was regarded in Ottawa as a mediocre department filled with second-raters."[55] McGinnis reached somewhat similar conclusions. She noted that health issues rarely made it onto the House of Commons or Senate agenda, and when they did, they were often relegated to the least opportune time-slot, such as 8 to 11 p.m.

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[54] For discussions of the history of Canadian Health insurance see for instance, David C. Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966*, (Montreal & Kingston: McGill-Queen's University Press, 1986); and Malcolm G. Taylor, *Insuring National Health Care: The Canadian Experience*, (Chapel Hill, N.C.: University of North Carolina Press, 1990); Doug Owram, *The Government Generation: Canadian Intellectuals and the State, 1900-1945*, (Toronto: University of Toronto Press, 1986): 280, 298-90.

[55] Robert S. Bothwell and John R. English, "Pragmatic Physicians: Canadian Medicine and Health Care Insurance, 1910-1945," *Medicine in Canadian Society: Historical Perspectives*, ed. S.E.D. Shortt. (Montreal: McGill-Queen's University Press, 1981): 486.

on Friday evenings.[56] In 1928, when the government announced its intention to merge the Department of Health with the Department of Soldiers' Civil Re-establishment to form the Department of Pensions and National Health [DPNH], the move was criticized as an insult to veterans.[57]

Sadly, the newly created DPNH proved to be as ineffectual as the previous Department of Health. This was made readily apparent during the crisis of the Great Depression and the World War that followed it. The Depression drew immediate attention to the connection between health and poverty. As unemployment rose and incomes dropped, families found it increasingly difficult to maintain a healthy standard of living. Suffering from malnourishment and inadequate housing, an increasing number of people succumbed to otherwise preventable diseases. Moreover, the lack of disposable income meant that families could not afford to seek medical advice. Consequently many medical problems evolved into chronic afflictions. Hospitals offered free clinics and treatment programmes to indigent patients at provincial and municipal expense, but many poor patients were reluctant to take advantage of this modicum of welfare relief if it meant being stigmatized as indigent. For physicians in private practice the Depression introduced an ethical dilemma. While some doctors felt morally obliged to offer medical treatment to all who requested it, others were reluctant to provide medical services for which they would receive no remuneration.[58]

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[56] McGinnis, 147; note also, *House of Commons Debates*, 1929, p. 2622; *Senate Debates* 1928, p. 564.
[57] McGinnis, 148-9.
[58] On health care problems during the 1930s see, McGinnis, 200-201; Veronica Strong-Boag, *The New Day Recalled: Lives of Girls and Women in English Canada, 1919-1939*, (Markham: Penguin Books, 1988: 145-177; Margaret Jane Hillyard Little, *'No Car, No Radio, No Liquor Permit': The Moral Reguation of Single Mothers in Ontario, 1920-1997*, (Toronto: Oxford University Press, 1998): 76-106

For its part, the DPNH offered neither leadership nor relief. Aside from distributing advice literature on nutrition and childcare, the DPNH seemed relatively content simply to batten down the hatches and weather out the storm of economic disaster. Rather than attempting to reform its delivery of health relief, the DPNH actually cut back on the few services it had previously provided. Between 1930-1934, the Department reduced its funding to voluntary health agencies by about 44%, thereby adding to the strain of agencies such as the Red Cross and Victorian Order of Nurses who were among the few organizations offering medical relief to the poor.[59] The DPNH also canceled its grants to the Division of Venereal Disease control and disbanded its Division of Child and Maternal Welfare.[60] As J.J. Heagerty, Deputy Minister of Health, stated in his 1932 annual report to the DCH, "There is not a great deal to report in the way of activity in the department; we have been more or less marking time during the past year, and I think perhaps that has been common to all departments of health throughout the country."[61] The two areas that saw some increase in activity were the exclusion and deportation of immigrants who were revealed to suffer from health problems, and the medical surveillance of federal civil servants who were believed to be wasting tax payers' money by claiming too many unwarranted sick days.[62] The DPNH even failed to provide

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[59] "Annual Report of the Department of Pensions and National Health," for the years ending March 31, 1931-1934, *Sessional Papers*, 1932, 1933, 1934: 154, 134, 113, 119.

[60] In 1933, Dr. Helen MacMurchy was listed as the Chief of the Division of Child Welfare. Neither MacMurchy nor her Division appear on the list of departmental offices in 1934, *Sessional Papers*, 1933 & 1934: 7 & 5 respectively; Dr. F.S. Parney was Chief of the Division of Venereal Disease Control in 1934. In 1935, Parney was appointed Chief Medical Adviser of the Examination of Civil Servants Branch, and the Division of Venereal Disease Control was disbanded, *Sessional Papers*, 1934 & 1935: 5 & 5 respectively.

[61] NAC, DCH Minutes, 24th meeting, 28-31 May 1932.

[62] *Sessional Papers*, 1935: 14.

funding for the provincial health units which had been set up throughout the remote regions of the country to provide subsidized care to Canadians who would not otherwise be able to afford medical treatment.[63]

With the declaration of war in 1939, many of the same health issues which had been made apparent in World War I were again laid bare for public admonishment. Once more, medical examinations of recruits revealed that approximately 44% of the volunteers were unfit for service.[64] Venereal disease was again on the rise. The evidence of malnutrition and preventable congenital abnormalities demonstrated the government's failure to achieve its interwar goals. To meet the wartime crisis, the government re-established its venereal disease division,[65] initiated a nutritional division,[66] started an industrial hygiene division (in order to safeguard the health of workers in vital war industries)[67] and increased its funding to the Canadian Nurses' Association (thus encouraging more women to pursue careers in nursing in either the military or civilian context).[68]

Although the federal government was clearly unprepared to restructure the DPNH in the midst of the wartime crisis, negotiations for postwar reforms were already underway. In 1940, the Royal Commission on Dominion-Provincial Relations recommended that the federal government assume greater authority over the administration of provincial social security programmes, beginning with the management

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[63] McGinnis, 216-220.
[64] Ibid, 264.
[65] *Sessional Papers*, 1945: 4.
[66] Sessional Papers, 1942: 4.
[67] Although the Division of Industrial Hygiene was originally introduced in 1937-38, it did not begin submitting regular reports until 1940. see *Sessional Papers*, 1940: 145-6.

of unemployment compensation. Three years later, in 1943, the federal Liberals outlined its plan for postwar reconstruction in the Marsh Report. Inspired by Britain's Beveridge Report, Roosevelt's New Deal, and King's own magnum opus, *Industry and Humanity* (1918), the Marsh Report encouraged an expansion of the government's social welfare programmes, including the adoption of Family Allowances, Old Age pensions and a National Health Insurance plan. The recommendations were adopted at a slow and staggered rate. Family Allowances came first in 1944, but universal medicare, which was debated on and off for the next twenty years, was not fully adopted until 1966. Despite the slow pace of actual reform, the government's new enthusiasm for social welfare planning was reflected in its decision to restructure the DPNH. In 1945, the DPNH was replaced by the Department of National Health and Welfare (DNHW). In addition to its former responsibilities, the new department would also oversee the administration of all new social welfare policies. However, rather than embarking on expensive new programmes, like the aforementioned health insurance plan, the government simply broadened the scope of its educational campaigns to include the prevention of disease, the avoidance of deviant social behaviour and the adoption of healthier lifestyle choices. Thus, despite its new and improved appearance, the DNHW was not dissimilar from its predecessors. Its objective was to facilitate greater social harmony by encouraging Canadians to adopt a lifestyle which was deemed to be physically healthy and socially propitious.[69]

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[68] McGinnis, 267.

Federal Health Education

Like the material produced and distributed by the Metropolitan Life Insurance Company and the Health League of Canada, the government's public health literature was packaged in a variety of popular formats, including books, booklets, pamphlets, flyers, posters, displays, exhibitions, magazine articles, press releases, radio announcements, radio talks, radio dramas, feature films, instructional films, and eventually television programmes and commercials. Originally, the Department of Health produced educational material designed to ameliorate those problems which had inspired its creation. The Department concentrated on eradicating the venereal diseases, reducing infant and maternal mortality, and preventing the spread of a variety of contagious diseases including tuberculosis, rheumatic fever, smallpox, diphtheria, whooping cough, influenza, polio, and even the common cold. As antibiotics, vaccines and improved hygiene reduced the threat posed by these diseases, the department added other medical problems to its roster of health issues. Among these later problems were cancer, mental illness, and occupational health and safety. The DNHW's postwar interest in social security also inspired the production of information on all aspects of social interaction, including the problems associated with puberty, adolescent rebellion, teenage dating, racism, alcoholism, crime, unemployment, inter-racial relationships, home economy, domestic relations, and community service.

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[69] Naylor, 95-213; Taylor, 33-151; Owram, 280, 298-90.

The style of the information varied according to its objectives. The primary objective was to provide Canadians with medically accurate and up-to-date information on a wide range of health issues. The second objective was to convince Canadians to embrace the information being offered to them. One government report referred to this as form of information as "health propaganda." "True," admits the report's anonymous author, "there might be a sort of stigma attached the word [propaganda]... nevertheless, it is a perfectly good word which simply means the propagation of an idea."[70] With health propaganda, the government hoped to "sell" the idea of health to Canadians. "'Selling health' may not be as easy as selling cigarettes," confessed the author, "but I think you will agree that the use of advertising media in the development of national and international campaigns for certain health services... is certainly propaganda."[71] In combining health information with health propaganda, the government hoped to provide Canadians with the means and motivation to preserve their health. As the report rather boldly stated; "We want to change their knowledge -- we want to change their attitudes -- we want to change their habits."[72]

But what would this change in knowledge, attitude and habit look like? The answer depends in part on who's asking the question. For individual Canadians, health was primarily a physiological problem which the World Health Organization described as "a state of complete mental, physical and social well-being, not merely the absence of

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[70] The report is untitled and the author is anonymous. Comments within the report suggest that it was written by C.W. Gilchrist, (Director of the DNHW's Information Service Division). The report may also have appeared in the March/April issue of the HLC magazine *Health*, 1948. [NAC, RG 29, Vol. 109, file 180-18-1]

[71] Ibid.

[72] Ibid.

disease or infirmity."[73] For government officials, health was both a private and a public issue. It concerned the welfare of the citizen as well as the welfare of the state. In metaphoric terms, health was regarded as a measure of national vitality, economic prosperity and social security. Dr. J.R. Robertson of the Canadian Red Cross, understood this dual nature of health when he told the members of the Dominion Council of Health that "ill-health" was responsible for "the feeble condition of the masses of our people... and [was a] menace to the stability of civilization."[74] For Robertson, disease not only endangered the individual, it undermined the stability of the nation. Almost a decade later in 1931, J.P. Howden, a Liberal member of parliament, used this same logic to justify his motion in favour of a national health insurance policy. In his speech before the House of Commons, Howden declared:

> The wealth of any country and particularly this country was originally purchased, not by gold or silver, but by the labour of her people. Efficient labour can be the product only of a strong and health body. The wealth of Canada must, therefore, depend on the health and strength of her people... if Canada is to make the best of her heritage we must see to it that her people are strong in intellect, strong in purchase, strong in body and limb.[75]

For Robertson, Howden and other members of the Department of Health, the physical integrity of the individual and the social integrity of the nation converged within the body of the citizen. This is particularly evident with respect to workers whose health was regarded as a key determinant of economic productivity. "Whereas the preservation of... health is essential to the happiness and satisfactory economic status of the worker and

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[73] Minutes of the Fourth Federal-Provincial Health Education Conference: Appendix C. Ottawa. Oct. 15, 1952. [NAC, RG 29, Vol. 111, file 181-1-9 pt. 2]

[74] Dr. J.R. Robertson, minutes of the 2nd meeting of the DCH, May 19, 1920. [NAC, DCH. C-9814].

his family," explained one government report in 1939, "the health and happiness of workers are of utmost importance to industrial management in the matters of maintaining high standards of output and efficiency and the lessening of industrial accidents and workmen's compensation costs...."[76]

In other eras, the social utility of health was fashioned somewhat differently. For instance, during World War II, health was considered to be a vital element in the allied victory against Europe's fascist armies. As Dr. James J. McCann, President of the Canadian Public Health Association, proclaimed in a rousing radio broadcast on March 17, 1942:

> Canada is at war -- This is a war -- not of armies -- but of peoples. We are engaged in the most momentous and desperate struggle in world history. Not only are we fighting to protect our democratic institutions and our way of life, but we are fighting for our very existence. Our effort to achieve victory must be an "ALL OUT" effort, and "ALL OUT" means every sinew against every enemy.... What does that mean? It means that all our resources, material and human, must be used to achieve final victory, and nothing in the achievement of that objective is of more importance than the maintenance of physical and mental health of the civil population, from which the military and industrial personnel must be extracted."[77]

From McCann's perspective, the protection of personal health was tantamount to a patriotic duty. An internal report of the DPNH in 1942 reached the same conclusions: "It is well known that the common cold causes more loss of time in industry than any other

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[75] J.P. Howden, speech before the House of Commons, April 27th 1931, presented at the the 22nd meeting of the DCH, June 23-25, 1931. [NAC, DCH, C-9814].

[76] This statement appears as part of a motion from the Technical Advisory Committee on Industrial Hygiene to congratulate C.G. Power (Minister of the DPNH) on instituting a special division of Industrial Hygiene within the DPNH. The motion was presented and approved during the 38th meeting of the DCH, June 15-17, 1939. [NAC, DCH, C-9815]

[77] Dr. James J. McCann, (President Canadian Public Health Association), transcript from "Our Wartime Health" CBC Radio Broadcast, March 17, 1942. [NAC, RG 29, Vol. 120, file 190-1-1 pt1]

single cause.... Without good health, neither the efforts of our fighting forces nor the productive capacity of our industrial workers can be at their peak."[78]

After the war, the social utility of health was once again measured by the prosperity of the nation's citizens. In promoting health and social welfare, the government hoped "to give to Canadian families both security and freedom of opportunity to develop their lives in socially useful ways that will be of benefit to themselves and to their immediate families, as well as the larger society in which they live."[79] Working from the premise that "social justice is good business,"[80] Paul Martin [Sr.], (Minister of the DNHW), argued in 1952 that "social security is a desirable complement of Canadian prosperity." [81] "If we neglect this simple truth," warned Martin, "then we are not only being negligent of the health and well-being of the people on whom all our prosperity depends -- we are also being careless about prosperity itself." [82] In case this warning was not enough to convince Canadians of the efficacy of good health, Martin raised the spectre of communist infiltration. "Communism can happen to any country that neglects social need,"[83] explained Martin. "If Communism finds its opportunity in human misery," he argued, "democracy finds its justification in a prosperous, humane and neighbourly

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[78] "A Statement on the Effects of Cutting Off the Department's Supply of Health Literature", c. 1942. [NAC, RG 29, Vol. 116, file 186-1-2].
[79] Hon. Paul Martin, "Social Welfare in a Changing World." speech delivered May 8th, 1947. [NAC, RG 29,Vol. 1506, file 201-3-5 pt. 1]
[80] Hon. Paul Martin, "Social Action -- Investment in Prosperity" speech to the Ontario Urban and Rural School Trustees Association, June 23, 1952. [NAC, RG 29, Vol. 1506, file 201-3-5 pt. 2]
[81] Ibid.
[82] Ibid.
[83] Hon. Paul Martin, "Canada's Program for Social Progress" speech to the Canadian Congress of Labour, Vancouver, Sept. 18, 1951. [NAC, RG 29, Vol. 1506, file 201-3-5 pt 2]

society."[84] In other words, to prevent communism the state had to ensure that its citizens remained happy and prosperous. Once again, the protection of the individual's health and welfare was championed as the means to preserving the socio-economic ends of the Canadian state.

In equating good health with productivity, patriotism and domestic security, government health officials blurred the distinction between the personal and the political. Good health became a feature of good citizenship. With good health individuals were better able to fulfill their role as workers, parents, soldiers, and patriots. Canadians who failed to preserve their health were cast as problematic citizens. This was especially evident among Canadians whose cultural affiliations already challenged the profile of a 'proper' Canadian. During the interwar era, the diseases of immigrants and aboriginals were regarded by government health officials as particularly pernicious. For many government health officials the threat posed by immigrants and 'Indians' was not just medical and economic, it was also social. It was their status as cultural 'outsiders' which helped to transform them into a medical health risk.

For instance, in 1924, Mrs. C.E. Flatt (DCH representative on Child Welfare issues) told the other members of the DCH that the health problems associated with Saskatchewan's population of "Ruthenians... Poles, Russians, Austrians, French and French Canadians... Indians and a sprinkling of Canadians" were due to the fact that

[84] Hon. Paul Martin, "Social Action -- Investment in Prosperity."

"These people are absolutely ignorant."[85] Dr. Laidlaw (Deputy Minister of Health for Alberta) similarly complained that the immigrants in Alberta were ignorant, miserly and obstinate: "They never send for a doctor until the children are in extremis, and very often not then... while these people are fairly well to do, they are loath to spend money for that purpose."[86] These same sentiments were echoed in 1932 when Dr. Helen MacMurchy (Director of the Division of Child and Maternal Health) complained that poverty, dirt and ignorance were responsible for the high rates of maternal mortality among the "non-English speaking people." MacMurchy also criticized "foreigners" for having "odours [that] are often appalling... no money -- many children" and a preference for "moonshine and tobacco" over "suitable food and clothing for their family."[87]

In addition to the problems of poverty, ignorance and poor hygiene, health officials worried that Canada's immigrant population was often physically and/or mentally "defective." "There is a great deal of mental deficiency in the province of Alberta," declared Laidlaw, "the great bulk of these are in the foreign born district."[88] The statistics compiled by Dr. M.M. Seymour, (Deputy Minister of Health for Saskatchewan), suggested that "the proportion is a little larger in Saskatchewan."[89] Dr. J.W.S. McCullough, (Deputy Minister of Health for Ontario) observed a similar problem in the

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[85] Mrs. Flatt's comments were inspired by her discussions with Dr. Scott, a district medical health officer near Warman, Saskatchewan. Minutes of the 11th meeting of the DCH, Dec. 15-17, 1924. [NAC, DCH, C-9814]
[86] Minutes of the 11th meeting of the DCH, Dec. 15-17, 1924. [NAC, DCH, C-9814]
[87] Minutes of the 24th meeting of the DCH, May 28-31, 1932. [NAC, DCH, C-9814]
[88] Minutes of the 13th meeting of the DCH, Dec. 8-10, 1925. [NAC, DCH, C-9814]
[89] Ibid.

"unorganized territory of Ontario" where "nearly all the people who appeal to us for admission to the sanitoria for tuberculosis have foreign names."[90]

To neutralize the health dangers posed by immigration, DCH officials recommended that the immigrants undergo a thorough medical examination before they leave for Canada as well as at the time of their arrival.[91] Immigrants who managed to slip past the medical examiner but were later discovered "to be suffering from tuberculosis, defective mental condition or a loathsome disease"[92] were to be deported.[93] Some DCH health officers suggested that the best way to reduce the health problems of immigrants was to reduce the number of immigrants, or at least to be more discriminating in the selection of "suitable people." Dr. G.G. Melvin, (Provincial Health Officer for New Brunswick), was particularly adamant on this point: "If there were any restrictions at all placed upon immigration," stated Melvin in 1925, "I would put them with regard to race.

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[90] Ibid.

[91] The medical inspection of immigrants was discussed at several different DCH meetings in the 1920s and 1930s. Their concern stemmed, in part, from the inability of physicians to detect certain ailments during a quick medical inspection. Amyot explained: "The epileptic -- how are you going to stop him? We ask a man if he has had epilepsy and he answers -- no... Now the feeble-minded, unless he has the stigma of imbecility or idiocy, it is pretty hard to stop him." See, Minutes of the 21st meeting of the DCH, Dec. 10-12, 1930. [NAC, DCH, C-9814]. In 1925, the DCH passed a resolution stating: "[I]t is the opinion of this Council that all immigrants should be medically examined as near as possible to their homes by medical officers paid by the Government." Resolution, of the 13th meeting of the DCH, Dec. 8-10, 1925. [NAC, DCH, C-9814].

[92] Minutes of the 8th meeting of the DCH, June 19-21, 1923. [NAC, DCH, C-9814]

[93] In British Columbia it was estimated that 600 "defective immigrants" were deported in a single year. Of course deportation was not a perfect solution because of the ethical problems it raised. Laidlaw wondered whether the state had the right to deport an entire family if only one of the children were discovered to be "defective." Deslodges wondered whether Canada was required to care for immigrants who moved to the United States, but were later deported back to Canada as "unfit" -- could they be deported back to their homeland? Finally, J.A. Amyot worried about the ethics of deporting immigrants whose home country was likely to be unwelcoming. For instance, Amyot noted that "Ninety-five per cent of the Russians that have come to this country are Jews, and you might just as well throw those Jews to hell as send them back to Russia. That is the cry they put up. I do not know that Russia refused to take them back." See, minutes of the 13th meeting of the DCH, Dec. 8-10, 1925; For a more extensive discussion of Canada's

I would make immigration to Canada, for a while, almost entirely restricted to the Nordic race."[94]

For members of the DCH, the health status of immigrants was measured in part by their willingness (and ability) to adapt to Canadian customs. For instance, Laidlaw was particularly frustrated with the "Ukrainians, Poles and Russians" because "they attach a good deal of importance to any ceremony." Laidlaw explained that "Their weddings last three or four days, and their funerals last all day. The relatives and the whole neighbourhood will come into the house and most of the houses are mud houses, with walls four feet thick, and no ventilation." "When you get these conditions," complained Laidlaw, "there is bound to be a spread of disease." Rather than petitioning for the provision of better housing, Laidaw recommended that the immigrants be encouraged to forego their cultural ceremonies. Laidlaw believed that education was helping to change their behaviour, but he found that the local police were even more effective. "The police are working in the district," explained Laidlaw, "and the people have more respect for a man in uniform than they have for anybody else." "Perhaps it is fear of the police, who are really very good at handling them," he mused.[95]

Despite the success of the police at "handling" the immigrants, Laidlaw concluded, "it is a mistake to allow these people to settle in communities. They keep up their old customs and they do not learn." Dr. H.E. Young (Provincial Health Officer of British Columbia), came to similar conclusions regarding the Doukhobor population.

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deportation policies see Barbara Ann Roberts, *Whence They Came: Deportation in Canada, 1900-1935*. (Ottawa: University of Ottawa Press, 1988); Avery, 134-139; McLaren, *Our Own Master Race*, 56, 59, 65.

[94] Minutes of the 13th meeting of the DCH, Dec. 8-10, 1925. [NAC, DCH, C-9814]

Although Young admired the Doukhobors success at transforming their district into "a perfect garden," he complained "that group colonization does not tend to the development of Canada." Young surmised that where group colonization exists, "assimilation... will take two or three generations," but where group colonization "is missing, the second generation will become citizens educated in Canadianism and tend to the development of the country." Health education was to play an important role in this process of Canadianization. By teaching mothers "the value of life, fresh air and cleanliness," it was hoped that children would be healthier and more amenable to Canadian customs. Local physicians and district health nurses were asked to teach health as well as to administer it, and schools were encouraged to incorporate health lessons into their curriculum. Health officials were particularly anxious for the children of immigrants to learn English (learning French does not seem to have been an option), so that they could then teach their parents the rudiments of Canada's health rules. "The only way to communicate with these people" explained Laidlaw, "is through the children."[96]

Like immigrants, the health problems of Canada's native peoples were understood in social as well as medical terms. In the interwar years, members of the DCH expressed genuine alarm over the disproportionately high rates of tuberculosis and trachoma among Canadian natives.[97] Their concern, however, was as much for the white community who

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[95] Minutes of the 11th meeting of the DCH, Dec. 15-17, 1924. [NAC, DCH, C-9814]
[96] Ibid.
[97] Trachoma is a highly infectious eye disorder, which initially affects the membrane lining the eyelids. It causes severe inflamation, redness, burning and watering of the eyes. If left untreated, it can eventually result in blindness. Usually associated with dry arid environments, the disease was believed to be endemic among the North American Natives (especially those living in the prairie provinces). In his report to the DCH in 1933, Dr. J.J. Wall, (Dept. of Indian Affairs, Canada), estimated that approximately 40 to 50 % of the Native population of Western Canada was infected with the disease. The disease can

might become infected, as with the natives who were actually sick. "Indian Reserves are a very distinct menace to the health of the population in the immediate vicinity," cautioned Dr. Jost, (Chief Health Officer for Nova Scotia), in 1923.[98] Eleven years later, Dr. R.G. Ferguson (Director of the Medical Services of the Saskatchewan Anti-Tuberculosis League) offered an identical warning, "These reserves... constitute a constant menace to the health of the white citizens of this province."[99] The warning issued by D.A. Stewart (Medical Superintendent of Manitoba) was, if anything, more dire. In his extensive report on tuberculosis among Manitoba Indians in 1934, Stewart characterized "the Indian" as a "dangerous neighbour" whose "reservations and settlements are reservoirs of diseases leaking out into the ordinary communities."[100] "The question at present," stated Stewart, "is not, what do Indians need and deserve... It is, what must be done for and with the Indians to reduce the present menace of their diseases to the health of the ordinary citizen?"[101]

One commonly proposed solution to the Indian health problem was education. Recommendations for change included alterations in the way native parents fed, raised and handled their children, as well as modifications to their style of dress, work and housing. As with immigrants, most health officials found native parents, especially

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now be treated with antibiotics, however, in the interwar era (prior to the introduction of antibiotics) the disease was still very serious. Members of the DCH were particularly alarmed by the growing number of immigrants who were diagnosed with the disorder. Typically, the spread of the disease was blamed on the activities of Indians. See, J.J. Wall, "Trachoma Among the Indians of Western Canada." presented to the 26th meeting of the DCH, June 13-15, 1933. [NAC, DCH, C-9815].

[98] Minutes of the 9th meeting of the DCH, Dec. 11-13, 1923. [NAC, DCH, C-9814].

[99] Dr. R.G. Ferguson (Dir. of Medical Services of the Saskatchewan Anti-TB League) to Dr. Davidson. Nov. 19, 1934. presented at the 29th meeting of the DCH, Nov. 29-Dec. 1, 1934. [NAC, DCH, C-9815]

mothers, reluctant to give up their domestic customs. "Old women are much less tractable... than are the old men," complained Dr. J.J. Wall (Dept. of Indian Affairs), "They view with suspicion any suggestions coming from a stranger and are inclined to scoff at anything savouring of advice."[102] Like many of his colleagues, Wall believed that the best way to teach health was to teach children. "The school is the natural and most advantageous place from which to spread all propaganda," claimed Wall in 1933.[103] Residential schools in which the children were removed from the direct influence of their families were deemed to be particularly advantageous.[104]

In addition to education, many health officials argued for improvements in the distribution of health services within native communities. Even D.A. Stewart who seemed so adamant in preserving the distinction between "Indians" and "ordinary citizens," admitted that better services might lead to better health. After dismissing Indians for lacking the "industry, stamina, and skill to keep up with the white man," Stewart seemed surprised to learn that:

> A Saskatchewan experiment in the past few years shows that Indians with reasonable advantages of doctor, nurse, and hospital reduce their death rates most astonishingly. This would seem to suggest as the best cure for

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[100] D.A. Stewart, (MD, Medical Superintendent for Manitoba), "Present Views and Facts re. Tuberculosis among Indians in Manitoba" presented at the 29th meeting of the DCH, Nov. 29- Dec. 1, 1934. [NAC, DCH, C-9815]

[101] Ibid.

[102] Wall, "Trachoma Among the Indians of Western Canada."

[103] Ibid.

[104] Mary-Ellen Kelm's recent study of Aboriginal health and healing describes the clashes between Aboriginal traditions and government health policies. Kelm did not review the records of the Dominion Council of Health, but her research demonstrates that its policies were in keeping with other government departments. Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950*, (Vancouver: UBC Press, 1998); On residential schools see for instance, John S. Milloy, *A National Crime: The Canadian Government and the Residential School System, 1879-1986*. (Winnipeg: University of Manitoba Press, 1999); and Basil Johnston. *Indian School Days*, (Toronto: Key Porter. 1998).

> Indian-ills that we try to give them something like the conditions white people need to keep them well and safe.[105]

Unfortunately, such a simple and obvious solution was not always forthcoming. When it came to health care, Treaty Indians fell between the constitutional crack of federal and provincial jurisdictions. The provision of health services was, and is, a provincial responsibility, but Native affairs are handled by the federal government. Since neither level of government was willing to assume full financial and administrative responsibility, natives were caught between what D.A. Stewart described as "the proverbial devil and the deep blue sea."[106]

Because of their unique status as Canadian residents but not Canadian citizens, native people did indeed pose a distinct health problem. The problem, however, went beyond mere administrative difficulties. In characterizing natives as "dangerous neighbours" whose diseases "menaced" "ordinary citizens," health officials were inclined to adopt a siege mentality when it came to the provision of services. The 1953 Regulations for Indian Health offers a fascinating example of this phenomenon. Although the "underlying policy" of the new regulations was "to encourage the Indians to assume the responsibility for their own care in the same way as ordinary citizens of the community or province," the language was decidedly adversarial.[107] The regulations applied to all Treaty Indians[108] and gave local superintendents and medical officers the authority to

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[105] D.A. Stewart, "Present Views and Facts re. Tuberculosis among Indians in Manitoba."
[106] Ibid.
[107] Minutes of the 64th meeting of the DCH, Oct. 5-7, 1953. [NAC, DCH, C-9816]
[108] The regulations applied to "every Indian who ordinarily resides on a reserve; every Indian who follows the Indian mode of life... and every persons other than Indian who resides on a reserve." See Appendix

require "the compulsory examination or treatment of infectious diseases particularly tuberculosis and venereal disease."[109] The regulations stipulated that "where a person who is subject to these regulations neglects or refuses to comply" he shall be committed to "a place of detention" and "shall remain at the place of detention until his release." Persons who "escaped" from "the place of detention" were subject to a fine one hundred dollars and/or three months in prison after they were "apprehended."[110] The language of these regulations suggests that infectious natives were primarily regarded as criminals rather than as patients. The fact that "a place of detention" was defined as a "hospital, sanitarium, clinic, lock-up, gaol, [or] reformatory" does little to dispel the association between native ailments and felonious activities.[111] In keeping with the tone of criminality, the regulations further stipulated that "a superintendent or medical officer may enter, in the daytime, any dwelling or other premises situated on the reserve under his charge, to inquire as to the state of health of any person therein or to examine the hygienic condition of the dwelling or other premises."[112]

The implication that certain groups of people were criminally liable for harbouring infectious microbes was not entirely restricted to native peoples. Other individuals had also found that certain diseases entailed a loss of civil rights. For instance, in British Columbia the early 1920s, certain men and 'flappers' who suffered from venereal disease

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N: Indian Health Regulations, Articles 3(a),(b), (c), 64th meeting of the DCH, Oct. 5-7, 1953. [NAC, DCH, C-9816]

[109] Minutes of the 64th meeting of the DCH, Oct. 5-7, 1953. [NAC, DCH, C-9816]

[110] Appendix N: "Indian Health Regulations," Article 18, 64th meeting of the DCH, Oct. 5-7, 1953. [NAC, DCH, C-9816]

[111] Ibid, Article 2(g).

[112] Ibid, Article 14.

were put in jail.[113] In Alberta and British Columbia, a diagnosis of 'feeble-mindedness' might result in detention in a special home, and/or compulsory sterilization.[114] In all provinces throughout this period, individuals suffering from highly infectious diseases, such as polio, smallpox, tuberculosis, meningitis and typhoid found themselves legally confined to their home, hospital or sanitorium. The difference for native peoples was that infection was regarded, and treated, as a cultural as well as a medical distinction.

Conclusion

For natives and immigrants, health was imagined as both a physiological and an ideological state. It concerned their status as potential citizens, as much as their status as potential patients. For all Canadians, health was promoted as the junction where the self-interest of the individual intersected with the social obligation of the citizen. Thus, in the same way that the Metropolitan Life Insurance Company used health to sell insurance, the federal government used health to sell a particular image of Canada and Canadians. This does not mean that the health information being distributed was inaccurate, ineffective or merely fatuous propaganda. Indeed, government health advocates earnestly believed that the information they produced could positively enhance and lengthen the lives of Canadian citizens. Nevertheless, the material was produced within a particular hegemonic framework that was premised on specific notions of citizenship and the relationship

[113] Young explained to his colleagues on the DCH that in his province of British Columbia, "we started out by putting a lot of these 'flappers' and men in jail and we filled the jails very soon... And then we

between the state and civil society. In other words, through its promotion of public health, the government was participating in the ongoing process of Canadian nation building; only instead of building railroads, the government was building citizens.

Fundamentally, the process of nation building is about what the French philosopher Michel Foucault described as the "art of government." It is the process (at least one aspect of the process) through which individuals consent to be governed by the laws and ideals of their nation.[115] By conjoining the interests of the individual with that of the state, health information persuaded, rather than compelled, citizens to modify their behaviour. In equating personal wealth with national prosperity, and domestic happiness with political security, health literature encouraged individuals to identify their private interest as individuals with their public interest as citizens. For Roy Fraser, a professor of biology at Mount Allison University, such an equation was elementary. Fraser recommended to the DCH in 1924 that all students at all Canadian colleges and universities be required to study hygiene and public health as a way of enhancing their sense of personal and civic responsibility. Fraser reasoned,

> that modern living conditions and social relationships compel an undivided consideration of both the individual and communal elements -- that the matter of health is of sociological as well as personal importance, and that the responsibilities of good citizenship demand attention to the physical

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confined them to hospital, but they ran away." For Young the only viable solution was "the establishment of detention homes." Minutes of the 9th meeting of the DCH, Dec. 11-13, 1923. [NAC, DCH, C-9814]

[114] McLaren, *Our Own Master Race.*

[115] Michel Foucault, "Governmentality," *The Foucault Effect: Studies in Governmentality*, eds. Graham Burchell et al., (Chicago: University of Chicago Press, 1991): 87-105; from the same volume see also Colin Gordon, "Governmental Rationality: An Introduction": 1-51.

> problems of life, for the one and for the many, inseparably and reciprocally.[116]

Fraser believed that once individuals recognized that their interests and the state's interests were interchangeable, then individuals would no longer need to be told what do, but only how to do it. In essence, individuals would simply 'govern' themselves. In this way, government would not be exercised *over* the people but *through* them. This principle of "governmentality" was implicit within the health education process. It was what the Health League of Canada hoped to accomplish by encouraging Canadians to lobby government for health reforms; and it was what the government hoped to accomplish by raising the health consciousness of Canadian citizens. As Dr. J.A. Amyot (Deputy Minister of Health) explained in his opening address before the DCH in 1923, "We in this country must act on common consent. When we all agree that a thing is the best thing to do, then we do it without compulsion and that, I think, is the principle of government throughout Canada and the one we have to adhere to, whether we like it or not."[117]

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[116] Roy Fraser (Prof. of Biology, Mount Alison University, NB), "Suggestions for a Required Course In Hygiene and Public Health for Colleges and Universities", presented for consideration to the DCH. June 23, 1924. [NAC, DCH Vol. 255, reel C-9814].

[117] J.A. Amyot (Deputy Min. of DH) opening address to DCH, June 19, 1923, [NAC, DCH Vol. 255, reel C-9814].

Chapter 2: The Medium

If education was the key to health preservation, then the process through which knowledge was disseminated was necessarily an important factor in the attainment of government objectives. After all, the information distributed by the Department of Health was valuable only if it actually reached its intended audience. Making certain that the information actually reached its intended audience was only part of the challenge. In an era of expanding consumer products and leisure activities, public health promoters also had to compete for the attention of Canadians. To make its information more attractive, the Department of Health made use of all the tools of mass communication at its disposal. These tools fell into three basic categories: print, radio and film. The use of such material was not uncomplicated. Each medium offered its own unique approach to the dissemination of ideas, which in turn framed the way information could be produced and received. In other words, the production and dissemination of a short pamphlet on the evils of syphilis was a very different process from the production of a radio drama or an instructional film on the same subject. The basic medical content might be essentially the same, but the format, cost, production process and the eventual reception of the material by individual readers, listeners and viewers was quite different. Consequently, to comprehend fully the government's public health message, one must first understand the production process which took place within the Department of Health and the communication media which sold its ideas.

This chapter begins with a brief overview of the Department of Health's educational activities, followed by a more detailed look at the department's use of print, radio and film. The chapter describes how information was produced and distributed, and considers the various social, economic and political obstacles which defined and shaped the final product. In essence, this chapter attempts to excavate the material substrata of public health education. Its objective is to understand how the government's notions of health, disease and citizenship were transformed from an esoteric idea to a concrete reality.

Information, Publicity and Propaganda

As noted in the previous chapter, the Department of Health's advocacy of public health education was one its founding principles. In practice, however, its ability to promote health was determined by the vagaries of party politics and economic policy. When it was first created, in 1919, the Department of Health divided its responsibilities among ten different internal divisions, one of which was the Division of Publicity and Statistics. Once the first blush of enthusiasm gave way to the economic realities of perpetual underfunding, however, the Department was forced to prioritize its responsibilities. In 1921, after a mere two years in operation, the Division of Publicity and Statistics was discontinued.[1] For the next 15 years, publicity and education would be directed by the chiefs of the remaining individual divisions. In 1938 the division was re-

introduced as the Division of Publicity and Health Education.[2] Restructuring occurred again in 1945, when the Department of Pensions and National Health (DPNH) became the Department of National Health and Welfare (DNHW). The Liberal government's new social welfare policy was premised in part on the willingness of Canadians to place community interests ahead of their own private interests. To ensure public support, the DNHW stepped up its promotional and educational activities. The Division of Publicity and Education was once again reorganized, its staff and budget were increased, and it was renamed the Information Services Division (ISD).[3]

Because of this chequered history, the details of the Department's educational material are divided among several different divisions, many of which were themselves re-organized, disbanded and later re-introduced as new divisions. During the 1920s and 1930s, when the department was without a distinct publicity division, the majority of educational material was produced by the Divisions of Child Welfare and Venereal Disease. When these divisions were 'downsized' in 1933 and 1934, the DPNH virtually stopped producing new material. It did, however, continue to distribute what little material it already possessed. The DPNH supplemented its educational library with samples of material produced by provincial and municipal health departments, the United States and Britain, and voluntary groups (such as the Canadian Social Hygiene Council). With such a large collection of publications, the Department proclaimed itself to be a

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[1] "Report of the Department of Health, for the Fiscal year Ending March 31 1922." *Sessional Papers*. No. 12, (Ottawa: King's Printer, 1922). [Hereafter these reports will be referred to as *Sessional Papers*]

[2] The 1938 Sessional report lists F.W. Rowse as Chief of the Publicity and Health Education Division. *Sessional Papers*, 1938: 4.

[3] The 1945 Sessional Report lists J.J. Hurley as Director of Information Services Division (ISD). *Sessional Papers*, 1945: 5.

national clearing house for health educational material and it recommended that new provincial publications be cleared by the DPNH to ensure against unnecessary duplication.

Once the worst of the depression was over, and the fiscally conservative government of R.B. Bennett was replaced by the slightly more generous King government, the DPNH began to reassert its commitment to public health education. Several new divisions were added to the Department, including the Divisions of Industrial Hygiene, Epidemiology, and Public Health Engineering. Other Divisions, such as Child and Maternal Hygiene, and Publicity and Health Education were re-instated. During the late 1930s and throughout the war years, the production of new material was almost entirely restricted to items which would help the war effort. Towards this end, the Department became particularly concerned with nutrition, venereal disease, and the health of workers in munitions plants. These divisions were joined after the war by divisions of mental health, Indian health services, physical fitness and civil defense. The war also revealed the potential of radio and film to communicate ideas. While the Department had begun to experiment with the use of film and radio before 1939, the government's successful manipulation of the mass media during the war, ensured its continued use even after the war was over.

Among the first tasks undertaken by the ISD in 1945 was a reassessment of the department's educational material and an agenda for the creation and acquisition of new material. Jeff Hurley of the ISD acknowledged that some of the new material, such as the *Primer for Post-war Prosperity*, was "pretty good propaganda."[4] Privately he admitted

[4] Jeff Hurley (ISD), Nov. 28, 1945. [NAC, RG 29, Vol. 116, file 186-1-2].

to Lt. Commander R.E. Curran, that "the health literature we have smells slightly.... Most of the material was prepared five years ago and is medically out of date. Some of it has been completely condemned by the Deputy Minister of Health and he takes a dark view of the distribution of the remaining booklets."[5]

Part of the difficulty in maintaining a consistent level of quality was the lack of a clear production process. In most cases, the impetus to produce new material began with a recommendation from the Dominion Council of Health (DCH) and/or the personal initiative of the division directors. In the 1920s and 1930s when there was no Division of Publicity and Education, the majority of material was written by division employees and was vetted for accuracy by either the division chief, who was usually a medical doctor, or by an external medical expert. Once the ISD was in full operation, most of the public health material was produced by ISD employees whose training had been in the field of publicity, education and editing, rather than medicine.

While the material produced by the ISD was supposed to be approved by the appropriate experts, there was no definite procedure. After at least one nutrition pamphlet was published without first being endorsed by the Nutrition Division, the Chief of the Nutrition Division, L.B. Pett, complained that "there is no clear directive designed to assure technical accuracy and consistency of Departmental publications."[6] Similarly, Dr. Charles Roberts of the Mental Health Division, declared, "there is considerable confusion resulting from the mixing of technical and administrative procedures and from a failure to

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[5] Jeff Hurley to Lt. Cmdr. R.E. Curran (DNHW), May 22, 1945. [NAC, RG 29, Vol. 116, file 186-1-2]
[6] Dr. L.B. Pett (Chief, Nutrition Div., DNHW) to H.A. Ansley (Dir. Health Services), Oct. 7, 1952. [NAC, RG 29, Vol. 116, file 186-1-2]

clearly define the responsibility of technical divisions and of administrative divisions of the Department." Roberts believed that the entire system should be streamlined to reduce bureaucratic overlap and ensure quality. "In the end," stated Roberts, "we have to be guided by the advice of the technical people with regard to the content and by the advice of informational people as to the method of presentation."[7]

Despite Roberts's wise words, the combination of publicity agents, medical specialists and technical experts (including writers, editors, photographers, graphic designers, playwrights, radio broadcasters and film-makers) inevitably resulted in a cumbersome production process. After much discussion, the DNHW finally clarified its publication policy in 1955. All suggestions for new material were first to be cleared by the Director of Health Services who would in turn solicit the approval of the relevant divisional director. If approved, the project would be sent to the ISD to be produced in collaboration with the various technical and medical experts. When completed, the final product would be sent back to Health Services Director, who would again consult with his medical experts before granting final approval. Conflicts among medical experts would be addressed by the Director of Health Services, and conflicts among writers and production experts would be settled by the ISD director.[8]

This process, which had no doubt been operating informally for years, was not without problems. The main difficulty seemed to be in finding an appropriate balance between education and entertainment. During the pre-war era, when much of the material

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[7] Charles A. Roberts, (Mental Health Div.) to "Director of Health Services", March 17, 1952. [NAC, RG 29, Vol. 116, file 186-1-2]

was produced under the guidance of medical experts, technical accuracy was fairly easy to attain. With the creation of the Division of Publicity and Education and later the ISD, publicity experts were of the opinion that the material was of educational value only if it was actually used and remembered. Consequently, what might be sacrificed in terms of authenticity was gained in popular appeal. Not surprisingly, this perspective did not always meet with unanimous approval. For instance, after reviewing the booklet *Of Cats and People* (1951), P.E. Moore, Director of Indian Health Services, complained that the material was attractive and entertaining, but it did little to convey the dangers of alcoholism which was the pamphlet's central purpose. Sadly, there are no remaining copies of this booklet; however, Moore's comments hint at the levity with which the text dealt with the subject. Moore writes: "I personally doubt the value that would be gained in the proposed publication on alcoholism... Personally, if I have any alcohol around I do not give it to my cats."[9]

This tension between the educational objectives of the medical experts and the entertainment requirements asserted by the publicity experts was a recurring problem whose parameters varied depending on the medium involved. Print, radio and film are fundamentally different types of communication. They each entail different production procedures and therefore incur different operating costs. They also maintain a separate relationship to the broader social and popular culture. Because of these social and

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[8] "Initiation and Production of Health Education Projects - Health Services Directorate", January 1955. [NAC, RG 29, Vol. 117, file 186-1-17]. Note also memo: "Meeting on Initiation and Production of Health Publications" J.C. Young, Dec. 17, 1954. [NAC, RG 29, Vol. 116, 186-1-2]

[9] P.E. Moore (Indian Health Services) to F.W. Rowse (Acting Dir., ISD), Aug. 1, 1951. [NAC, RG 29, Vol. 116, file 186-1-2]

technological differences, the balance between education and entertainment had to be renegotiated with the introduction of each new medium.

Print

During the 1920s, the Department of Health relied almost entirely on print based material. Of these the most successful was the *Canadian Mother's Book* and the *Little Blue Book* series. While the *Canadian Mother's Book* was exclusively concerned with pre-natal, neo-natal and maternal advice, the other books in the series covered a wide range of domestic issues, including housekeeping, garbage disposal, domestic architecture, cooking, first aid, and childhood diseases.[10]

The booklets were produced by the indomitable Dr. Helen MacMurchy, Director of the Child and Maternal Welfare Council 1920-1933, and former medical inspector for Ontario schools and homes for the feebleminded. Written in a friendly, folksy style, the Blue Books offered MacMurchy's own brand of common sense advice, most of which ended with the recommendation that readers be vigilant against disease and seek medical assistance at the first sign of trouble. This literature also stressed that good health was within reach of all Canadians who were committed to its acquisition. It was to be found in nutritious food, pasteurized milk, fresh air, indoor plumbing, uncongested housing and in

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[10] Diane Dodd, "Advice to Parents: The Blue Books, Helen MacMurchy, M.D., and the Federal Department of Health, 1920-1934," *Canadian Bulletin of Medical History*, Vol. 8, (1991): 203-30; Cynthia Comacchio, *Nations are Built of Babies: Saving Ontario's Mothers and Children, 1900-1940*, (Montreal: McGill-Queen's University Press, 1993); Veronica Strong-Boag, *The New Day Recalled: Lives of Girls and Women in English Canada, 1919-1939*, (Toronto: Copp Clark Pitman, 1940); Kathryn

modern labour saving devices. Good health was also found in the efficient use of time and energy and the frugal acquisition of property. Thus, audiences were reminded that "everything that saves time and strength, from the egg-beater to the ice-box and the fireless cooker, is a good investment."[11] In effect, good health was presented as a form of domestic economy; it was simply a matter of knowing how to make sensible consumer choices.[12]

What MacMurchy's Blue Book literature apparently failed to take into account, was that equality of knowledge did not confer an equality of means. Consequently, for many readers, especially those on a limited budget, much of MacMurchy's advice was simply unobtainable. Moreover, the fact that the government was so persistent in its distribution of the Little Blue Books among immigrants, Native peoples, and the working class, suggests that their objective was as much about selling a vision of the middle class Canadian lifestyle as it was about giving useful information regarding health and home care.

Notwithstanding the questionable value of some of the advice, the government was extremely successful in distributing the information. Between 1920 and 1930 the Division of Child Welfare published 22 different Blue Book advice manuals. Although

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Arnup, *Education for Motherhood: Child-rearing Advice for Canadian Mothers*, (Toronto: University of Toronto Press, 1994).

[11] *How to Manage Housework in Canada*, (Ottawa: King's Printer, 1926): 24.

[12] Bettina Bradbury, "Women's Workplaces: The Impact of Technological Change on Working-Class Women in the Home and in the Workplace in Nineteenth-Century Montreal," *Women, Work and Place*, ed. A. Kobayashi, (Montreal and Kingston: McGill-Queen's University Press, 1994): 27-44; Ruth Schwartz Cowan, *More Work for Mother: The Ironies of Household Technology from the Open Hearth to the Microwave*, (New York: Basic Books, 1983): 172-191; On household products in the postwar years see, Joy Parr, *Domestic Goods: The Material, the Moral and the Economic in Postwar Years*. (Toronto: University of Toronto Press, 1999).

department records do not offer consistent distribution figures, the *Sessional Papers* indicate that as many as 300,000 copies were distributed per year throughout the 1920s.[13] The *Canadian Mother's Book* was especially popular. In its first year of publication over 150,000 copies were distributed throughout Canada.[14] Over the next 40 years the book was continuously revised, updated and reprinted. In 1940 the book was renamed *Canadian Mother and Child* and maintained a distribution of approximately 10,000 copies per month over the next ten years.[15] Although the booklets were produced by the federal government, the provincial governments were largely responsible for their distribution. Nevertheless, the federal department regularly advertised the Little Blue Books in newspapers, magazines and radio broadcasts. Since the booklets were primarily concerned with domestic and maternal issues, the DNHW also encouraged those organizations who most frequently came into contact with women to distribute the material. Among the many avenues of distribution were well-baby clinics, healthcare dispensaries, doctor's offices and visiting public health nurses. Finally, young mothers who failed to pick up a booklet from one of these sources were likely to be given a copy of *The Canadian Mother's Book* (and an invitation to request other booklets in the series) while they convalesced on a hospital maternity ward.

Aside from the obvious desire to reach young mothers, there was no specific policy statement to indicate that the Blue Books were intended for any particular class or ethnic group. The Department did, however, make a special effort to distribute its

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[13] In 1921-22 approximately 365,503 copies of the Little Blue Books were printed and distributed. In 1925-1926 distribution had fallen slightly to 313,717 copies. *Sessional Papers*, 1922: 37: Sessional Papers, 1925-26: 31.

literature among native peoples and new Canadians. In addition to French and English, *The Canadian Mother's Book* was translated into several other languages including Cree, Hebrew, Japanese, Chinese and Ruthenian.[16] Although the series was unabashedly nationalistic, the booklets also enjoyed a certain amount of international popularity. Throughout the 1920s and early 1930s (when the series fell victim to budget cuts), select editions of the Blue Book series were sent to India, South Africa, United Kingdom, New Zealand, West Africa, the Federated Malay States, Germany, Russia, Australia, United States, Rhodesia, France, Kenya, Gold Coast Colony, Kumasi, Madras, British Honduras, Switzerland, Siberia, Japan, Ceylon, Germany, Holland, Belgium, Magdalen Islands, Colombo, Palestine, China, Belgian Congo, and Chile.[17] Sadly, there are no archival records detailing the purpose of these transactions; however, the diversity of countries suggests that the material may have been used by Canadians living abroad, by other government or non-government groups wishing to produce similar literature, and perhaps by Canadian missionaries working in foreign fields.

In addition to the Little Blue Book series, the government also produced and distributed pamphlets and posters on a broad range of preventable and treatable medical problems. Like the Little Blue Books, most of the pamphlets were published by the federal government and were sent to provincial ministries who then distributed the

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[14] *Sessional Papers*, 1922: 36.

[15] *Sessional Papers* 1941: 161; Also *Sessional Papers*, 1943 1944, 1947, 1949, 1951.

[16] Ruthenia was a region in central Europe and is now part of the Western Ukraine. Department of Health records occassionally make references to Ruthenian immigrants. It is unclear whether departmental officials understood Ruthenians to be the same as, or distinct from, Ukranians. References to the translation of the *Canadian Mother's Book*, were found in the *Sessional Papers*, 1923, 1925 & 1933: 43, 29, 113 respectively.

[17] Canada. *Sessional Papers*. 1925, 1926, 1928, 1929, 1931, 1932.

literature to municipal health offices, health units, hospitals, doctors, public health nurses, schools, philanthropic organizations and social workers, who in turn passed the information on to their clients and patients. Posters regarding certain diseases or the value of health preservation were displayed on public transportation, schools, factories, pharmacies, doctors offices and public washrooms.

Occasionally, the department sent small leaflets covering specific information directly to large corporate employers who were then invited to insert the information into the pay envelopes of their employees. During the war, this was a particularly popular method of distributing nutritional information to munitions workers. According to one report, nutrition experts from the DPNH visited 385 different factories where they inspected workers' lunches and made recommendations for the improvement of factory cafeterias. Using the payroll inserts, the DPNH managed to distribute over 200,000 nutritional leaflets with such inspirational titles as *The Lunch Box is on the March*, *Meal Planning for Health*, *Canada's Food Rules* and a *Score Sheet for Each Day's Meals*. The object of this literature was to educate "the employees to more intelligent choice of foods" so as to ensure "the maximum output by the workers of Canada." Although nutritionists might have had the male employee in mind when creating the material, most of the advice was directed towards housewives who were presumed to be responsible for preparing the family's meals and their working husbands' lunch box.[18]

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[18] Report: "Nutrition" . Unfortunately there is no date attached to the report, however, the many references to the war and the lack of references to the Family Allowance system which was established in 1944 suggests that the report was written in the early 1940s. [NAC, RG 29, Vol. 109, file 180-26-1]

A similar method of distributing nutritional information was undertaken when the Family Allowance system was introduced in 1944. Concerned that recipients of the family allowance cheque might not know how to spend their monthly windfall of $5-8 per child, the DNHW included a brief leaflet on domestic economy and basic nutrition in each envelope. Even the envelopes were stamped with such helpful health hints as "Recreation Pays Dividends".[19] Like the payroll stuffers, the leaflets that were included with the family allowance cheques served as a source of basic nutritional information and a form of self-promotion in which the government was able to demonstrate its concern for Canada's hardworking citizens. In the case of the family allowance cheques, the government also used the information campaign to quell the criticism of those who argued that mothers would squander the money on frivolous personal items. "Our major interest at the moment" claimed Maud Ferguson (ISD) in October 1945, "is in showing the public that Family Allowances are not being handed out in an irresponsible manner... the government is anxious to see that they are used as wisely as possible."[20]

Efforts to measure statistically the overall distribution of printed matter were frustrated by the Department's inconsistent, and at times non-existent, record keeping. The Department's annual reports offer the most concise indication of distribution, but

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[19] D.M. Herron (ISD) to Dr. Doris W. Plewes (Asst. Dir. Physical Fitness Division), Jan. 15, 1949. [NAC, RG 29, Vol. 102, file 180-6-3 pt. 2].

[20] Maud Ferguson to Harry J. Boyle (Dir. of Farm Broadcasts, CBC), Oct. 12, 1945. [NAC, RG 29, Vol. 120, file 190-1-1 pt. 1]; Earlier that year, Brooke Claxton (Minister of Health and Welfare) argued that the family allowance plan would help to stabilize the economy and reduce malnutrition provided the cheques were accompanied by a thorough educational campaign to improve eating habits and dispell ignorance and indifference. See "Message from Mr. Claxton to the Nutrition Conference for Field Workers in Nutrition throughout Canada", June 6-8, 1945. [NAC, RG 29, Vol. 109, file 180-26-1]; see also "excerpt from Mrs. Fairclough's Speech in the House of Commons, June 20, 1950." [NAC, RG 29, Vol. 109, file 186-26-15]

even they are spotty. Generally, each division within the Department of Health produced and distributed its own material. Next to the Division of Child and Maternal Welfare, the Division of Venereal Disease was especially prolific. In 1922, the first year full of its operation, the Division distributed 545,161 pieces of literature; however, this impressive figure soon dropped down to an average of about 150,000 items per year until the Division was terminated in 1934. The VD Division was re-established during WWII and by 1945 its distribution of information peaked at an impressive 712,940 items. The Nutrition Division began in 1945. Its distribution of material fluctuated tremendously, ranging from 407,000 in 1945 to a mere 7,300 items in 1957. The Division of Industrial Health witnessed a steady growth in demand for information with requests increasing from 12,000 in 1942 to 65,000 items in 1948. The Division of Mental Health was probably the most prolific with approximately 2,155,000 pieces of information distributed in 1957. Finally, the ISD probably provides the best data on the informational work of the DNHW. In 1941 it claimed to distribute over 300,000 pieces of information. This number dropped down to an all time low in 1946 with a distribution of only 138,550 items. The next year, however, this figure jumped dramatically to 2,115,000. From here the figure increased steadily to an all time high in 1956 of 10,195,000 pieces of information literature. Unfortunately it is not clear whether this figure includes the information distributed by other divisions. Nor is it clear whether this figure includes magazine circulation which could greatly inflate the amount the distribution statistics.[21] [See Appendix A].

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[21] *Sessional Papers*, 1921-1960.

In addition to this form of direct distribution, the government also used the public press to promote its health messages. Some of this information took the form of simple advertising; other items were sent as press releases to be incorporated into the columns and editorials of newspapers and magazines. Press releases also had the advantage of being extremely inexpensive to produce because the newspapers shouldered most of the publication costs. As one department official confessed "press releases as a whole constitute one of our most important and effective means of publicity and information. It is the department's cheapest annual item for publicity." [22]

By the 1940s, the DPNH/DNHW was producing its own information magazines. The *Industrial Health Bulletin* ran from 1941 to 1953 with a circulation of approximately 35,000. Copies of the Bulletin were sent directly to employers and labour leaders who were asked to make the magazine available to workers. *Canadian Nutrition Notes* was introduced in 1945 and maintained a modest circulation of 8,000 until 1959 when it was discontinued. The most popular of the department's magazines was the *National Health Review*, later renamed *Canada's Health and Welfare*. The magazine was first launched in 1940 as a somewhat glorified pamphlet that advertised the accomplishments of the DPNH. In 1946 the magazine was revamped and renamed. In its new incarnation, the magazine continued to showcase government activities but supplemented them with human interest stories regarding health, fitness, recreation, nutrition and childcare. *Canada's Health and Welfare* and its predecessor were distributed via direct mail to individuals; however, the average Canadian was more likely to find copies in doctor's offices, hospital waiting

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[22] letter: J.A. Hickson (Purchasing and Supply, Fed. gov't). April 11, 1951. [NAC, RG 29, Vol. 112a.

rooms, public libraries and corporate cafeterias. Given its somewhat limited popular appeal, the annual circulation of *Canada's Health and Welfare* was surprisingly high beginning with 48,000 in 1941, climbing to 80,000 in the postwar era, and reaching over 720,000 in the late 1950s.[23] [See Appendix B].

Although printed material constituted the DNHW's most exhaustive source of educational information (both in terms of quality and quantity), it was nevertheless regularly criticized for its expense. For instance, on February 6, 1951, the *Globe and Mail* printed an article criticising the federal government for devoting close to $7 million per year to its ever-growing department of health publicity. The anonymous author exclaimed:

> ...the mails are filled with Health Department literature, written, printed and distributed at public expense. It is time this whole vainglorious splurging with public money was stopped. Parliament is maintained for the purpose of hearing and passing judgment on Government activity. Between sessions there are adequate mediums for making known what is worth while and of public interest. The flood of de luxe wastepaper which flows daily out of Ottawa long ago escaped any legitimate function of informing the public. It can only be called by another and more sinister name -- partisan propaganda.[24]

Not surprisingly, the DNHW was quick to object to this characterization of its activities claiming that the many leaflets, booklets, films and filmstrips "are benefiting countless homes and parents, and the benefits are cumulative." Moreover, "attacks on the health

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file 181-6-9]

[23] Canada. *Sessional Papers*, 1921-1960.

[24] Toronto, *Globe and Mail*, Feb. 6, 1951. [see also NAC, RG 29, Vol. 112a, file 181-6-4].

department's literature emanating from sources, which are at best cold to social welfare, may safely be disregarded."[25]

Given the much larger expense incurred from the production of radio dramas and documentary films, allegations which singled out the cost of printed material seem surprising. Of course, the cost of radio and film productions was partly offset by the CBC and NFB which produced and distributed most of the DNHW projects. Printed material was almost exclusively published by the King's Printer (or Queen's Printer after 1952), which was responsible for printing all of the government's publications. When the Liberal government was charged with wasting public funds on unnecessary publications in the early 1950s, representatives of the federal treasury and the King's/Queen's Printer promised to review all of the government's publications in the hopes of cutting costs and rationalizing the system. Given its plethora of publications, the DNHW was subject to particular scrutiny. One of the committee's recommendations suggested that the DNHW attempt to sell their educational material and thus recoup some of the production costs. Members of the ISD were skeptical of the success of such a plan, but recognized that some effort at cost cutting reform would be needed if they were to continue their publicity work. As Dan Wallace confessed in a confidential letter to Harvey Adams, "while many of the recommendations of the original publication committee were either stupid or based on a failure to study the whole problem, it is important wherever possible to meet them in order to maintain our relationship with the Treasury Board, the Economy Controller, the

[25] Toronto, *Globe and Mail*, Feb. 7, 1951. [see also NAC, RG 29, Vol. 112a, file 181-6-4].

Queen's Printer and the Standing Committee on Publications, which reviews everything we do."[26]

To demonstrate its commitment to reform, the DNHW struck up its own publication committee. The committee reviewed all of the Department's printed material, experimented with the possibility of selling health literature and discussed various methods of reducing costs. In an early draft of its final report, which was eventually tabled in March 1953, the DNHW publications committee recommended that 45% of its 181 different posters, pamphlets, booklets and periodicals continue to be distributed for free, 29% be revised or discontinued, and 26% be sold for a nominal sum. The report reiterated its strong opposition to the notion of cost recovery via publication sales, but did admit that some of the more popular booklets, such as *Canadian Mother and Child*, *Up the Years from One to Six*, *Prelude to Performance* and *Personal Protection Under Atomic Attack*, might continue to interest consumers despite the small fee.[27] However, after a year of disappointing sales, the publications committee concluded that "It is unrealistic... to say that 'government publications are easy to sell.'"[28]

In general, the DNHW argued that the sale of health literature contravened the statutory obligations of the Department. Moreover, since the publication of the material was already paid for out of tax revenue, to charge Canadians for the privilege of reading government advice literature was akin to double taxation. As an alternative to selling the

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[26] Dan Wallace to Harvey Adams, Dec. 5, 1953. [NAC, RG 29, Vol. 117, file 186-1-14]

[27] Recommendations on each individual publications is reported within this 50 page document. A summary of the recommendations is found in Appendix B. "Minutes and Recommendations of Departmental Committee on Publications," March 13, 1952. [NAC, RG 29, Vol. 117, file 186-1-14]

[28] "Report of Publications Committee" Dr. G.D.W. Cameron, G.F. Davidson and Dan Wallace. March 13, 1953. [NAC, RG 29, Vol. 116, file 186-1-3]: 10.

literature directly to Canadian citizens, G.D.W. Cameron suggested that the Queen's Printer charge the provinces for federal publications and the DNHW could offset the added costs by increasing federal transfer payments to provincial health departments. This clever, albeit bizarre, scheme had several advantages. First, both the Queen's Printer and the ISD would appear cost effective, and second, the DNHW could boast that it had increased provincial health funding.[29] Of course the committee also admitted that this plan "would seem to involve needless complication of administrative procedures and would constitute, in fact, only a fictitious sort of control."[30]

For Dan Wallace, the whole notion of cost recovery for health education publications was wrong-headed. In 1952, Wallace angrily declared;

> If we are forced to put our distribution in the straightjacket of a sales policy, this will substantially reduce the effectiveness of our health education work, force the provinces into producing their own materials and -- in my guess -- return us revenue equal to 5% or 10% of our information budget, while reducing its effectiveness by 50 %. That is not economy... This federal Department is the backbone of what is being done, inadequate though it is. If this Department is forced to limit its distribution of health and welfare material to what little can be sold, it will not be able to honour its statutory duty... Instead of giving leadership to overcome this country's miserable showing in health education we would be leading the retreat to lagging even further behind the United States than we now are.[31]

Though less vitriolic, the DNHW publications committee heartily agreed. The committee's final report ultimately concluded that since the DNHW's publication budget was only half a million dollars, or about 1/7 of 1% of the total cost of health care, it

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[29] This suggestion was made by Dr. G.D.W. Cameron, (Chair of the publications ctte and Dir. of the DNHW). Minutes Departmental Publications Ctte, Nov. 14, 1951. [NAC, RG 29, Vol. 117, file 186-1-14]

[30] "Report of Publications Committee," March 13, 1953: 5-6.

represented "a useful investment in the promotion of the health and well-being of Canadians." [32] Moreover, the committee believed that "as long as Canadian health statistics steadily improve, as long as fewer and fewer children die from preventable diseases, as long as more and more Canadians eat good food and follow good health habits, there is conclusive evidence that the total health educational effort of all governments -- of which this Department's publications represent the major part -- are worth the money expended on them."[33]

The debates over the sale of health literature offer several useful insights into the DNHW's educational programme. First, the treasury board's expectation that the Department's literature could be sold suggests that it probably had never actually read any of the material. More to the point, it demonstrates a lack of familiarity with departmental objectives and a disdain for the Department's activities. As the DNHW publications committee repeatedly argued, the promotion of good health strengthened both the physical and economic vitality of the nation. In producing and distributing information on how to attain and retain good health, the government was fulfilling its legal as well as its ethical obligation to Canadians. The notion of selling this information was antithetical to the government's objectives.

Second, these internal debates clearly demonstrate the influence of departmental politics on the production and distribution of health information. The decision to recover the cost of certain booklets and magazines transformed the look of these materials. Books

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[31] "Memorandum for the Minister: re. Proposal to sell this Department's Health and Welfare Publications" Dan Wallace, (Executive Asst.), March 23, 1953. [NAC, RG 29, Vol. 116, file 186-1-3]
[32] "Report of Publications Committee," March 13, 1953.

and magazines that were primarily intended for professionals were expected to forego extraneous use of graphics, photographs and colour.[34] Conversely, books, booklets, and magazines such as *Canada's Health and Welfare* that were to be sold to the general public were jazzed up (within reason) to make them more attractive to potential customers.[35]

Finally, the debate over cost-recovery of printed material demonstrates a failure to understand the way in which the distribution process influences the reception of information. DNHW printed matter was almost always distributed directly through federal, provincial or municipal health departments or via government approved emissaries, notably doctors, nurses, hospitals, clinics, teachers, schools, and social workers. Thus the authority of the information was conveyed by both the government's authorship and the venue or means through which the material was received. This was very different from the information received over the radio (and eventually television), where authenticity was conferred by the respectability of the announcer and the actors in the performance. The free distribution of educational literature also removed the material from the sphere of consumer culture. Since the information was both owned by and, at least in theory, available to all citizens equally, access to it remained eqitable. If government information was to be sold in commercial venues (namely bookstores),

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[33] Ibid, 16

[34] Ibid; see also Treasure Board minutes, "Principles and Proceedures Approved by Treasury Board for Control of Printing and Distribution of Government Publications: Appendix A", Dec. 17, 1954. [NAC, RG 29, Vol. 116, file 186-1-3].

[35] Discussions over improving the 'attractiveness' of certain government publications can be found in, "Report of the Publications Committee" March 13, 1953: 9; see also recommendations for individual publications in "Minutes and Recommendations of Departmental Committee on Publications". March 13, 1952. [NAC, RG 29, Vol. 117, file 186-1-14].

recipients of the material would be transformed from passive consumers of health education into active economic agents. The value of the product iwould no longer be found within the veracity of the information, but in the need and greed of the consumer. Even the prospect of selling the information to the provinces undermined the democratic principle by redefining the government's role as service provider to that of corporate manager.

Radio

In addition to its voluminous collection of printed matter, the Department also took advantage of more modern forms of communication, namely radio and film. In the 1930s and 1940s, the Department of Health was particularly enamoured with the benefits of radio as a source of information. Radio was a relatively inexpensive means of advertising government projects. Like newspaper dailies, radio broadcasts could introduce new government initiatives via news reports, in depth interviews, editorials or simple advertising. Most intriguing of all, because it was broadcast indiscriminately across national airwaves, radio was able to reach a mass audience in a way that print never could. In this manner, the government could send its message out to the greatest number of people for the least amount of money. On the other hand, because it was difficult to target a specific audience, the health department had to produce material that would appeal to all Canadians regardless or age, gender, class or ethnicity. Moreover, since radio was a commercial venture, government broadcasts had to compete with other forms

of radio entertainment, and yet for the sake of authenticity, the Department had to avoid too close an association with consumer culture.

Perhaps because of these difficulties, the federal Department of Health took several years to embrace the use of radio as an educational medium. In fact, the Department did not make serious use of radio until 1938 when it launched its surprisingly popular series of national *Health Notes*. These brief spot announcements were written by the publicity director and were designed to fit into a normal commercial time-slot. Radio stations broadcast the segments for free as a public service. Station managers were welcome to broadcast the *Health Notes* whenever they wished, but most chose to air them in the coveted time-slot next to the news.[36] The objective of the *Health Notes* was "to bring some pertinent health fact to the attention of the listener... followed by a brief announcement that health publications are available free of charge from this department."[37] In other words, like the more traditional advertisements found in Canadian newspapers and magazines, *Health Notes* were intended to serve as a constant reminder of the benefits of health and the benevolence of the government who promoted it.

Health Notes were broadcast every day except Sunday and were often assigned weekly themes which addressed either a specific problem or a more general health issue. Although the *Health Notes* covered a broad range of issues, child care was the most

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[36]F.W. Rowse to Miss Vera Rumble (Sec'y Western Broadcasting Co., Vancouver), Dec. 12 1938. [NAC, RG 29, Vol. 121, file 190-1-3].
[37] *Sessional Papers*, 1942: 152.

common topic. Some of the announcements simply reminded parents of their duty to guard their children against disease. As one *Health Note* from May 1946 warned:

> It is the right of every child to be well born and well brought up. Therefore, it is the duty of parents to provide for their children, so far as they are able, an inheritance of health, loving care and the wise training necessary to make them healthy, happy and useful members of society.[38]

Other *Health Notes* offered more specific advice on child training and child care.

> The child who has learned to be busy does not suck its thumb. Give your child plenty of love and plenty to do.[39]

> What about our babies: Mothers, keep pins, scissors, knives, and other sharp instruments out of the baby's reach at all times. Safety pins should always be closed and removed from the table on which the baby is being bathed or diapered.[40]

Other *Health Notes* discussed methods of avoiding accidents and preventing certain diseases. During the war, *Health Notes* often blurred the line between information, publicity and outright propaganda. For instance, in January 1941, the DPNH aimed its radio *Health Notes* towards industrial workers. While the primary objective might have been to stimulate workplace efficiency, workers were also encouraged to adopt a more optimistic and patriotic approach to their work. Like the other *Health Notes* the ones directed at workers also suffered from an insipid paternalism which was typical of much of the educational material produced by the government.

> Cheerfulness, it has been truly said, is the best medicine. Gloom and glumness go hand in hand with poor health. It is a vicious circle. Soldiers

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[38] "Radio Notes" May, 13, 1946. [NAC, RG 29, Vol. 1683, file 190-3-1]
[39] "National Health Radio Notes: July and August" 1945. [NAC, RG 29, Vol. 1683, file 190-3-1]
[40] "Radio Notes" May, 13, 1946.

> are taught to 'grin and bear it' when in a tight corner. It is surprising how much *better* a smile can make you feel.[41]

> There's nothing like an interest in life to keep you well. Look around you at people who are bustling about their affairs. They are *well* because they are *busy*. They have not time to sit down and become depressed over imaginary ailments. And, you will notice, it is the *busy* people who have the most friends, too.[42]

> Is it fair to inflict your suffering on your friends? Bad enough for one person to be sick, without making many miserable. The inveterate grouch and complainer is a health-threat as serious as any microbe. And such a person shows a deplorable lack of courage and consideration for others.[43]

Despite their patronizing tone, *Health Notes* were popular with both station managers and the listening audience. When they were first introduced in October 1938, 59 radio stations across Canada participated in the experiment.[44] Ten years later, 116 of the 136 public and private radio stations (90 English and 26 French) in Canada were broadcasting national *Health Notes*.[45] The longevity of the *Health Notes* is a testament to their popularity among station managers, and by extension with radio listeners. The Department of Health was also pleased at the public response. Following each *Health Note* broadcast, listeners were invited to write to the DNHW for specific health publications. F.W. Rowse recalled that the initial response "swamped our office and

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[41] National Health Radio Notes: January 1941. [NAC, RG 29, Vol. 120, file 190-1-1 pt. 1]
[42] Ibid.
[43] Ibid.
[44] *Sessional Papers*, 1940. p. 150.
[45] *Sessional Papers*, 1948. p. 121. Paul Litt states that there were 136 radio stations in Canada in 1949, of which 119 were privately owned. see Paul Litt. *Muses, Masses and the Massey Commission*, (Toronto: University of Toronto Press, 1992): 124.

production of health literature had to be speeded up to cope with it."[46] Radio's success at advertising public health literature was demonstrated by the constancy of these requests. After only one month on the air, the Department had received 298 requests for 446 pamphlets.[47] During the war, the production and distribution of literature was reduced as a cost-cutting measure; however, the *Health Notes* continued to be broadcast as an essential medium of free advertising. Despite the reduction of publications, the DNHW nevertheless received 48,580 individual requests for health literature in 1945 alone, resulting in the distribution of 98,670 English and 45,630 French copies of department literature. Rowse concluded "it is safe to say that few people in Canada have not, at some time, been made aware of the government's public health work, through hearing the radio *Health Notes*."[48]

Station managers were equally enthusiastic about the health spots. Soon after they were launched, the DPNH solicited comments from participating stations managers. Virtually all of the respondents expressed complete satisfaction with the honesty and brevity of the *Health Notes*. H.N. Stovin of the CBC stated, "We again wish to compliment your Department for the excellent way in which these bulletins are prepared. A number of very favourable comments have been received here from stations over which they are released."[49] Similarly, N. Botterill (Production Manager of CJCA, Edmonton)

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[46] F.W. Rowse, (ISD), "Radio in Health Information Services", Feb. 24, 1946. [NAC, RG 29, Vol. 120, file 190-1-1 pt. 1]

[47] chart: "Radio Letters", Oct 15-Nov. 15 1938. Unfortunately, I failed to find similar charts for other months and years. Consequently, it is difficult to gauge the relative merits of the these statistics. [NAC, RG 29, Vol. 117, file 186-1-14].

[48] "Radio in Health Information Services," Feb. 24, 1946.

[49] H.N. Stovin (Supervisor of Station Relations, CBC, Toronto) to Rowse, Oct. 20 1938. [NAC, RG 29, Vol. 121, file 190-1-3]

explained that his station aired the 'Health Spots' three times a day at regular times, "and we are more than pleased to assure you of our continued co-operation."[50]

Several respondents recommended that *Health Notes* target specific segments of the population. For instance, J.C. Penson of CFAR in Flin Flon, Manitoba, recommended that the health messages be specifically geared towards children on the grounds that "parents will be glad to cooperate when they see the children taking an active interest." Of course the downside to such a plan, Penson noted was that "any material presented to the children must be 'sugar coated'."[51] Mr. Matheson from CJCB in Sydney, Nova Scotia thought the programmes should be directed towards housewives. "So far as we are concerned, we are ready to co-operate with you in every possible way and if your talks could be of short duration we could probably intersperse them during our various women's or other home programmes, during both morning and afternoon."[52] In a letter to R.H. Thomson (President of Northern Broadcasting, Daily Press Building, Toronto), F.W. Rowse (Director of Publicity, DPNH) expressed his interest in targeting Canada's remote communities. "Northern Ontario is one of Canada's most important -- and most progressive -- fields. In no section of the Dominion, we feel, can our health message be more effective, as new communities develop and population increases in our prosperous mineral belt."[53]

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[50] N. Botterill (Production Manager of CJCA, Edmonton) to Rowse, Nov. 25, 1938. [NAC, RG 29, Vol. 121, file 190-1-3]
[51] J.C. Penson (business manager, CFAR, Flin Flon, Manitoba) to Rowse, July 27 1938. [NAC, RG 29, Vol. 121, file 190-1-3].
[52] Matheson (CJCB Sydney, NS) to Rowse, Aug. 11, 1938. [NAC, RG 29, Vol. 121, file 190-1-3]
[53] Rowse to R.H. Thomson (Pres. Northern Broadcasting, Daily Press Building, Tor.), Aug. 5, 1938. [NAC, RG 29, Vol. 121, file 190-1-3].

Other communicants offered suggestions as to the style and format of the talks. G. Gaetz (station manager of CJOC Lethbridge) explained "we feel that they [*Health Notes*] should not exceed five minutes and that they should be written down to the ordinary man on the street -- in other words, the trend sometimes is to go into such great detail in health talks that the point is missed by the average listener."[54] Harry Sedgwick of CFRB in Toronto agreed: "We would suggest that the most effective type of radio presentation to get a health message over to the public would be by the use of well-established names in the Medical World speaking on important health matters but in the language of the layman... I do not think that in matters of Health presentation it is necessary to prepare dramatic scripts or throw in entertainment in order to catch the public eye."[55] Contrary to Sedgwick's disdain for dramatic scripts, several station managers suggested than a 10 or 15 minute long dramatic broadcast would be an excellent supplement to the existing *Health Notes*. "The dramatization of health is certainly worth considering seriously" wrote Phil Lalonde of CKAC La Press, Montreal.[56] Carson Buchanan of CHAB Moose Jaw was also enthusiastic ; "the idea of... transcribed dramatizations is first class and we will be glad to make a place for them on the station."[57] Several station managers recommended that, regardless of the type of broadcast, the quality must be excellent. Both M.V. Chestnut of CKCK Regina and Carson Buchanan strongly advised the DPNH to hire a professional advertising agency to produce their radio broadcasts, particularly if they

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[54] G. Gaetz (mgr, CJOC Lethbridge) to Rowse, Aug. 1, 1938. [NAC, RG 29, Vol. 121, file 190-1-3].
[55] Harry Sedgwick (Mgr, CFRB Toronto) to Rowse, Aug. 3, 1938. [NAC, RG 29, Vol. 121, File 190-1-3].
[56] Rowse to Phil Lalonde (CKAC La Press, Montreal), Aug. 23, 1938. [NAC, RG 29, Vol. 121, file 190-1-3]
[57] Carson Buchanan (Mgr., CHAB Moose Jaw) to Rowse, Aug. 16, 1938. [NAC, RG 29, Vol. 121, file 190-1-3]

chose to create more dramatic productions. As Carson Buchanan stated, "There are so many mediocre people blathering on the radio now that if you want to have a talk listened to, it has got to be something outstanding -- at least, that has been our experience here."[58]

In spite of Chestnut and Buchanan's recommendations, most of the writing continued to be done in-house. Even after 1949 when the Department launched its dramatic series, *Here's Health* and *A Votre Sante*, most of the material was still written by ISD officers. Several of the radio productions as well as many of the booklets, posters, and filmstrip scripts were written by the ISD's two women staff members: "Mrs." Helen Marsh and "Mme." Alberte Senecal (who handled the French scripts).[59] In addition to the medical experts who ensured technical accuracy, scripts were often informally vetted by "average women" in an attempt to assure the interest of female audiences. For example, in May 1947, Dr. Brian Bird's report on the CBC's Mental Health work raised concerns about the viability of several script ideas. By way of providing a second opinion, Bird suggested "I wish you would read these stories and ask your wife and your secretary to read them and see what sort of response you get to them."[60]

Although the DNHW's efforts at dramatic presentations were generally well received, they were considerably more complicated and expensive to produce. Unlike the commercial length *Health Notes* which were written by staff members and could be read over the air by a radio announcer, *Here's Health* and its French counterpart, *A Votre*

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[58] Carson Buchanan (Mgr. CHAB, Moose Jaw) to Rowse, Aug. 1, 1938; see also M.V. Chestnust (Mgr, CKCK, Regina) to Rowse, Aug. 3, 1938. [NAC, RG 29, Vol. 121, file 190-1-3]

[59] Gilchrist to Ruth Running, May 13, 1950. [NAC, RG 29, Vol. 120, file 190-1-1 pt. 2].

[60] Although not otherwise indicated, one can assume the report was written to either the Director of the ISD or to Dr. Charles G. Stogdill, the Director of the Mental Health Division. "Dr. Brian Bird report on CBC Mental Health work for May 1947". [NAC, RG 29, Vol. 121, file 190-3-8]

Sante, were pre-recorded in a studio using actors, actresses, sound effects, music and a much larger complement of technical advisors, editors and producers. While radio stations still provided free air time and much of the production expense was subsidized by the CBC, the accumulated cost of the series over a ten-year period was estimated at $5,000,000.[61] Of course, departmental officials were confident that the ultimate benefits more than made up for the added expense.

Each performance of *Here's Health* lasted approximately 12 to 15 minutes, and like the *Health Notes* before it, *Here's Health* always ended with an invitation to write to the DNHW for publications. Station managers were also encouraged to tie-in the *Here's Health* dramatizations with other related programmes, such as panel discussions or interviews on health and welfare topics or non-government campaigns produced by voluntary groups such as the Tuberculosis Association, the Canadian Cancer Association, the Canadian Home and School Federation or the Health League of Canada.

The adoption of the dramatic format had several advantages over the short *Health Note* advertisements. With more time to develop themes and express ideas, *Here's Health* was able to cover a greater variety of topics and offer real information instead of simplistic platitudes. Some of the issues discussed included: blindness, child and maternal health, dental health, epidemiology, mental health, nutrition, medical rehabilitation, accident prevention, childhood diseases, occupational health, sanitation and public health engineering.[62] The format of radio dramas also offered greater subtlety in conveying

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[61] Harvey Adams to Directors and Chiefs of Divisions, Dec. 30, 1959. [NAC, RG 29, Vol. 1683, file 190-3-1 (Vol. 1)].

[62] K.C. Charron to E.A. Watkinson, Dec. 6, 1956. [NAC, RG 29, Vol. 121, file 190-1-1 pt. 4]

health knowledge than the older lecture style. Unlike the *Health Notes* which dictated good behaviour in the form of a medical homily, *Here's Health* sounded more like a dramatic parable in which listeners were presumed to have sufficient intelligence to figure out the meaning of the message all by themselves. While audiences were no longer positioned as the passive recipients of health advice, *Here's Health* managed to preserve the hierarchical structure of knowledge within the content of the health plays. F.W. Rowse explained that the dramas were typically presented as "an interview between a child and a doctor, between a teacher and a mother, between a child and a school nurse, or some combination of that kind...."[63] Thus the wisdom of the expert is compared to the misadventures of the non-expert. But unlike the 'straight talk,' where the audience was automatically placed in the role of non-expert, this dramatic format enabled listeners to position themselves according to their own levels of knowledge and common sense. The dramatic format offered the illusion that audiences were merely eavesdropping on someone else's conversation, but that they were not themselves obligated to act on the information. In this way, even if the quality of the performance insulted the audience's sense of aesthetics, it would not necessarily insult their intelligence.

Perhaps the most important advantage of the dramatic format over the spot announcement was its ability to excite people's interest in otherwise mundane subjects. While the ISD admitted that the spot announcements were "too general, lose power through repetition [and were] too closely identified with straight publicity," the dramatic presentations were considered more likely to attract "a national audience - if interesting"

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[63] F.W. Rowse (ISD) to Mrs. F.T. Yelland (Sec'y radio ctte. Belleville, Ont.), Jan 18 1951. [NAC, RG 29.

and to convey "suitable ideas without actual couching as publicity."[64] In other words, because health dramas maintained the tenor of being a regular dramatic performance, they had the potential to reach a much wider audience while still serving as a vehicle for information and publicity. However, finding the appropriate balance between entertainment and education proved to be one of the biggest problems of this medium. As F.W. Rowse of the ISD complained, dramatizations were "difficult to make constructive unless the story is made very harrowing." [65] Rowse feared, that in over sensationalizing the health dramas, listeners might lose sight of the essential message. Rowse recognized the need for radio presentations to offer more than the overstated prescriptions to "Keep Healthy" and "See Your Doctor." On the other hand, Rowse also warned against material which might stimulate a "morbid anxiety amounting to sickness-consciousness" or conversely, become "associated in the public mind with the all-too-prevalent blurbs for pink pills and pep pellets."[66]

Experts in the field of radio production sympathized with Rowse's concerns, but they also recognized that sensationalism was an important tool in both drama and advertising. As a later *Here's Health* producer, Sydney Brown, was to acknowledge in 1958:

> Unless our programme is arresting -- provocative enough to drive through and capture [the listener's] attention and then interesting enough to hold it, it is lost. If it is stuffed with uncoloured statistics or the dull recitation of austere facts -- no matter how important those facts may be, then it is lost. If it is presented in stilted, unfamiliar or esoteric terms it is lost.

Vol. 112a, file 181-2-2 pt. 2].
[64] F.W. Rowse, (ISD), "Radio in Health Information Services". Feb. 24, 1946. [NAC, RG 29, Vol. 120, file 190-1-1 pt. 1]
[65] Ibid.
[66] Ibid.

> If the dialogue is pompous, ponderous or ignores the commonplace idiom of the commonplace characters... it is lost.
> If it is poorly placed or lacks conflict or human interest, or suspense or at least one of the fundamentals of good story-telling -- it is lost.
> The dial may not be twisted but the listener's mind will become disengaged... Without stirring one inch from his easy chair, his attention can evaporate and be gone in that twinkling of a second it takes the conscious mind to think of something else.[67]

Producers at the CBC further complicated the process with the reminder that radio was an inherently different type of medium from print. Whereas published literature could be tailored toward a specific audience, information broadcast via radio waves was accessible to anyone within hearing range of a radio. Different time-slots might be more likely to reach housewives during the day or men in the evening, but station managers also had to consider the pre-school children who might overhear daytime programmes or older children who might still be awake during the prime-time hours of the evening. As executives at the CBC warned in 1944, "It is not the intention of the Corporation to restrict the fair presentation of controversial material. But broadcasts reach into the relatively unguarded atmosphere of the home, unlike printed material, and must therefore be carefully supervised."[68] Consequently, the CBC recommended that producers of radio scripts;

> ...remember there is no 'radio audience' as such. It is a number of 'audiences'. It is entirely different from the audience you find at your Service Club. It is three or four people sitting in the living room, or eating their dinner, or playing with the children. Think of this little group when you write your script; think of them when you say it... Be simple in your choice of words... Remember you are trying to interest your postman, your

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[67] Sydney Brown, speaking at a conference on the role of television and radio in health education. Feb. 27, 1958. [NAC, RG 29, Vol. 124, file 191-3-1].
[68] CBC, "Radio Publicity", n.d. c. 1944. [NAC, RG 29, Vol. 122, file 190-3-16]

> grocer, your milkman, as well as your professional friends.... Repetition is an important device to make facts register. Remember the listener cannot glance back at what you have just said as he can in reading an article.[69]

The CBC's recommendations regarding the structure of radio presentations introduces yet another obstacle which confronted the Department of Health's use of the medium. Because radio broadcasts were commercial ventures with their own set of internal regulations, the Department was obliged to present its material in accordance with industry standards. Thus, in addition to the writers, producers, publicity agents, departmental officials and medical experts, government material also had to obtain the approval of station managers. Although stations managers were usually more concerned with style and format, there were occasional conflicts over content. For instance, in 1943 the DPNH planned to broadcast a series of 'frank' talks about the causes, symptoms and treatment of venereal disease. CBC regulations stipulated that "the General Manager must give consent to any broadcasting on the subject of Venereal Disease." While CBC's General Manager, J.S. Thomson, agreed in principle with the proposed talks, he objected "to broadcasts containing the words 'prostitution,' 'House of Prostitution', 'bawdy house,' 'brothel,' 'sex,' 'sexual relations' and words of a similar nature that are offensive to the ear and may stimulate an abnormal curiousity in the minds of the young...."[70] Not surprisingly, the Department complained that it would be difficult to offer a frank

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[69] Ibid.

[70] Stewart Murray, (Sr. Medical Health Officer) to Dr. D.E.H. Cleveland (Acting Dir., Div. of VD Control, BC Board of Health), May 6, 1943. [NAC, RG 29, Vol. 122, file 190-3-16]

discussion about venereal disease without describing the central causes and vices which were known to perpetuate the disease.[71]

A similar problem was presented in 1949 when the Health League of Canada (HLC) acquired the Canadian distribution rights for a series of American radio dramas which dramatized the deleterious effects of syphilis. With such tantalizing titles as, *The Lips of a Strange Woman* (1948), *The Secret Enemy* (1949), and *Curtain of Silence* (1948), broadcasters worried that the salacious content might offend the sensitive ears of some listeners. More importantly it was still illegal for radio stations to broadcast any programme which referred to venereal disease unless special permission was received from the CBC's Broadcast Regulation Division. The HLC attempted to reassure potential radio programmers by emphasizing the value and discretion with which the dramas approached the subject. "All scripts are in excellent taste" declared the HLC's advertising flyer, "and their keynote is not error, but hope for the unfortunate." The advertisement explained that, "The premise is adopted that the chance to be well again, to lead a normal family life, to have healthy children, will to many infected people be a stronger incentive than fear."[72] After considerable discussion, the CBC eventually agreed to sponsor the programmes provided they were broadcast after nine o'clock in the evening. One of the important selling points of this particular series, which was originally produced by Columbia University, was the use of well known Hollywood actors, such as Eddie Albert

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[71] Ibid.

[72] John C. Scott (Publicity Dir., HLC) form letter sent to Canadian radio stations, April 5, 1949. [NAC, RG. 29, Vol. 109, file 180-13-1]

and Raymond Massey, to play the lead roles.[73] As with other forms of product advertising, commercial endorsements by famous actors and well respected scientists, politicians, religious figures or community leaders conferred respect and authority onto the product being sold, which, in this case, was the prevention and treatment of a morally controversial disease.

With all of these factors to consider, it is hardly surprising that the DNHW's dramatic performances were sometimes lacking in high artistic calibre. And yet, week after week, year after year, radio stations throughout Canada continued to present government broadcasts. As F.B. Watt of the ISD confessed in 1957, "There must be a tremendous amount of self-sustaining interest in the subject for, heaven knows, some of the scripted compromises between our medical perfectionists and the writers are anything but inspired efforts."[74]

Film

Film offered health advocates the final and perhaps most compelling medium of education. Like print and radio, film experienced its own unique history, offered a diversity of presentation formats, and entailed its own virtues and challenges. Consequently, like the other forms of information distribution, the government's efforts

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[73] Ibid.

[74] F.B. Watt (ISD) to Christian Smith (Dir. Health Ed., Dept of Public Health, Regina, Sask.), Sept. 25, 1957. [NAC, RG 29, Vol. 124, file 191-3-1]

to sell health via film was at least partially circumscribed by the nature of the medium itself and by the audience's interaction with it.

Health education films tended to fall into two basic categories: feature films and documentaries. Feature films were commercial ventures, which were usually shown in mainstream motion picture theatres. Feature length commercial health films were particularly popular during the interwar period, but were soon replaced by the more serious, if less popular, documentary films. Documentary films were primarily interested in education and were less concerned with profit. They were typically produced for or by recognized health agencies and were generally shown in non-commercial venues such as schools, universities, factories, church halls and community centres. Documentary health films can be subdivided into documentary dramas (docu-dramas) and instructional films both of which attempted to combine authentic medical advice with popular entertainment. Similar to radio dramas, docu-dramas were fully scripted and employed actors and actresses to illuminate whatever medical problem formed the substance of the film. Thus, audiences were expected to learn from the example set by the characters on the screen. Conversely, instructional films hired experts (or at least people who appeared to be experts) to deliver sound scientific information and medical advice. Instructional films were intended to be viewed as accurate, authoritative, objective and clear. Audiences were not required to read between the lines or interpret the meaning of the dialogue. Essentially audiences were positioned as passive recipients of the wisdom conveyed to them from the screen.

In the 1920s, the majority of 'health films' were feature length and were produced for profit by commercial filmmakers. Most of these early hygiene films were melodramatic and sensationalistic. Although advertised as educational, these films exploited health and disease for its dramatic appeal.[75] The most popular and controversial of these films highlighted the problems of venereal disease. Unlike the early European motion pictures which displayed a fairly relaxed attitude toward sex and sexuality, the more puritanical American state censor laws prohibited the showing of promiscuous sexual behaviour.[76] Film makers soon discovered, however, that they could portray men and women engaged in pre-marital or extra-marital affairs provided the characters were ultimately punished by contracting syphilis or gonorrhoea.[77] After being titillated by the relaxed sexual mores of the characters on the screen, audiences were then frightened away from sex by hospital

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[75] Medical historian, Martin Pernick, is engaged in an ongoing study of popular and educational health films in the United States. In his book, *The Black Stork*, Pernick examines the history of eugenics and euthenasia as revealed through the controversial feature film, *The Black Stork* (1916). The film showcases the ideas of Dr. Harry J. Haiselden, a Chicago surgeon who believed that life-saving operations should not be performed on "defective" infants. The film itself dramatizes the famous Bollinger Baby case, in which Haiselden (who is played by the real Dr. Haiselden) attempts to convince a young couple that their "defective" newborn would be better off dead. See Martin Pernick, *The Black Stork: Eugenics and the Death of 'Defective' Babies in American Medicine and Motion Pictures Since 1915*. (New York: Oxford University Press, 1996).

[76] In the early years of American cinema, filmmakers enjoyed relative autonomy and were only restricted by their imagination, budget and the limits of their black and white soundless technology. Of course, cinema owners were under no obligation to screen films which they found offensive. By the early 1920s, calls for state censorship led a group of industry insiders, to form the Motion Picture Producers and Distributers of America [MPPDA] in 1922. Led by Will Hays, a Republican Presbyterian and former Post Master General, the MPPDA included representatives from each of the eight leading movie studios and together they agreed to a self-censoring production code. Amid complaints that the MPPDA tended to ignore its own standards, Hays introduced tough new regulations in 1933, which imposed a $25,000 fine on any studio that released a film without a Production Code seal of approval. The production code remained in effect until the mid 1950s when the old industry moguls gave way to a new and more liberal generation of filmmakers. See for instance, Joel Spring, *Images of American Life: A History of Ideological Management in Schools, Movies, Radio and Television*. (New York: State University of New York Press, 1992): ch. 5, pp. 83-96; Also, Eric Schaefer, *"Bold! Daring! Shocking! True!: A History of Exploitation Films, 1919-1959*. (Durham & London: Duke University Press, 1999): ch. 4, pp. 136-164.

[77] Annette Kuhn, *Cinema, Censhjp and Sexuality, 1909-1925*, (London: Routledge, 1988).

scenes which showed patients suffering from severe rashes, chancres, paralysis, blindness, sterility, and insanity.

Hundreds of feature-length health films were made prior to World War II. Although the vast majority were produced in the United States and Britain, many of them were widely distributed throughout Canada by private film distributors or by voluntary health agencies such as the Canadian Social Hygiene Council (later the Health League of Canada). Unfortunately, few copies of the films still exist and even fewer are available in Canada. Often only the title and perhaps a short review remains. However, the sensationalistic nature of these films can be inferred from such suggestive titles as *The Naked Truth* (1924), *Sins of the Father* (1947), *The Wages of Sin* (1938), *Condemned* (1927), *Fools of Passion* (1928), *Damaged Goods* (1937), *Wild Oats* (1919), *No Greater Sin* (1939), *The Road to Ruin* (1928). A few feature films, such as *The End of the Road* (1919), and *Damaged Lives* (1933) were widely distributed in Canada and are still available to researchers at the National Archives of Canada.[78]

As the titles suggest, many of these sex hygiene films were considered quite risqué, and censor boards in both Canada and the United States regularly refused to release movies that contained lurid references to sex or venereal disease. Occasionally, distributors could appease the censors by having their films endorsed by representatives of the medical or religious community. The Canadian Social Hygiene Council (CSHC) was frequently asked to help American films pass the Canadian censor laws. In 1925, Samuel Cummins of the American Public Welfare Pictures Corporation, asked the CSHC to

endorse his 1924 film *The Naked Truth*. Cummins explained, "We are trying to make it a true story that runs in the minds and thoughts of the average layman in his crude way of doing things. That is the reason that it appealed to tremendous crowds in Chicago -- the picture itself does not suggest any particular method, but it shows one way of the many."[79] The CSHC were not impressed and *The Naked Truth* was not released for general screening anywhere in Canada.[80] The Health League of Canada (HLC) also refused to endorse the controversial American films, *Mom and Dad* (1944) and *Sins of the Father* (1947) on the grounds that they were "highly objectionable" and "not fit for public showings."[81]

Interestingly, there was little agreement between Canadian and American censor boards as to what constituted an objectionable film. *The Naked Truth*, *Mom and Dad* and *Sins of the Father*, were all widely distributed in the United States. Conversely, the 1933 film *Damaged Lives* (a joint Canadian-American production), met with approval from the Governor General, the Prime Minister, the provincial Premiers, and local boards of health,[82] but was nevertheless banned in the United States on the grounds that it was "indecent" and "immoral".[83] Occasionally, censor boards accepted a controversial film on the proviso that women and men be given separate viewings. In these cases, women would be admitted to matinee performances whereas men were granted entrance in the

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[78] Descriptions of these films can be found in Schaeffer, Appendix, 347-386. *The End of the Road*, (US: 1918), [NAC, HLC, 13-0234]; *Damaged Lives*, (Canada/US: 1933), [NAC, ISN 195693, V1 9206-0023].
[79] Samuel Cummins to Dr. Gordon Bates, Dec. 13, 1925. [NAC, HLC, MG 28-I-332, Vol. 16, file 21]
[80] CSHC, National Board Meeting, minutes Dec. 11, 1925. [NAC, HLC, MG 28-I-332, Vol. 5, file 9.]
[81] HLC, Board of Director, "Report on VD Educational Films". March 18, 1949. [NAC, HLC, MG 28-I-332, Vol. 6, file 5]; also HLC, National Exe. Ctte. Minutes March 28, 1949. [NAC, HLC, MG. 28-I-332, Vol. 1, file 19].
[82] Dr. Gordon Bates to Joseph Plotell, Feb. 29, 1940. [NAC, HLC, MG 28-I-332, Vol. 17, file 3].

evening. Often these performances were concluded with a short lecture or film trailer which elaborated on the medical themes introduced by the film.[84]

In an effort to increase interest and "[take] away any suspicion that the week's run was just box-office sensationalism" distributors would incorporate quotes from local clergy, IODE regents, the medical officers of health and the leaders of women's organizations, within the advertising.[85] Despite the efforts of public health advocates to frame these pictures as educational, film promoters recognized that the combination of sex and disease was commercially successful. For instance, American promoters of the controversial film, *Mom and Dad* (1944), set up first aid stations in the lobbies of the movie theatres and hired women to dress like nurses. The implication was that the film was so shocking that a nurse needed to be on hand in case anyone fainted.[86]

Whether they went to the cinema to be titillated by the suggestion of sexual indecency or to be horrified by the graphic images of advanced syphilis and gonorrhoea, it is clear that audiences were eager consumers of these hygiene films. While exact figures are virtually impossible to ascertain, and newspaper reviews are difficult to find without a detailed itinerary of when and where the films were shown, some sense of audience interest is revealed within the records of the HLC. For instance, between May 1920 and

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[83] clipping from *Daily News*, (city unknown) Jan. 20, 1937. [HLC, MG 28-I-332, Vol 18, file 5].
[84] For example see Samuel Cummins to Dr. Gordon Bates, Nov. 18 and Dec. 13, 1925. [NAC, HLC, MG 28-I-332, Vol. 16, file 21]; Announcement to Clergy re. *Damaged Lives* (n.d., c. 1936). [NAC, HLC, MG 28-I-332, Vol. 17, file 3]; see also Suzanne White, "*Mom and Dad* (1944): Veneral Disease "Exploitation" *Bulletin of the History of Medicine*. Vol. 62(2), Summer 1988: 256-7; John D. Stevens, "Sex as Education: A Note on Pre-1930 Social Hygiene Films" *Films and History*, Vol. 13(4), Dec. 1983: 85; Pernick, *The Black Stork*.
[85] J.A. Cowan (Publicity Manager) to Dr. Gordon Bates, [n.d., circa 1925], [NAC, HLC, MG 28-I-332, Vol. 17, file 23].
[86] White, 256.

May 1921, over 100,000 people in Toronto and Hamilton went to the cinema to see *The End of the Road*.[87] The American film, *No Greater Sin* was seen by over 300,000 Canadians in 1942.[88] *Damaged Lives* was reportedly viewed by "at least ten million people" during the first year of its release. The film also met with acclaim in Great Britain, France, Spain, Mexico, Argentina, Brazil, Chili, Australia and New Zealand.[89]

While the HLC was generally pleased with the public's enthusiasm for the hygiene films it sponsored, some health advocates and government censors worried that audiences might be misunderstanding the objective of such films. Ellis Paxton Oberholtzer, a member of the Pennsylvania State Board of Censors during the 1920s, argued that the average movie goer was ill-equipped to differentiate between decent and indecent films. Because movies were an inexpensive form of entertainment, he concluded that cinemas were largely patronized by "children as well as those of limited means." Citing a ruling from the Supreme Court of Illinois, Oberholtzer wrote that motion picture "audiences include those classes whose age, education and situation in life specially entitle them to protection against the evil influence of obscene and immoral representation."[90] For this reason Oberholtzer flatly stated that "to exploit sex diseases in the cheap theatres and present the subject in the guises of entertainment to all sorts and conditions of people, with no purpose but the making of money for the showman, meets with my reprobation."[91]

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[87] CNCCVD Exe. Ctte Minutes, May 20, 1920 and May 17, 1921. [NAC, HLC, MG 28-I-332, Vol. 1, file 9].
[88] HLC Exe. Ctte Minutes, Sept. 30, 1942. [NAC, HLC, MG 28-I-332, Vol. 1, file 12].
[89] HLC Exe. Ctte Minutes, 1934-1935. [NAC, HLC, MG 28-I-332, Vol. 1, file 11]
[90] Supreme Court of Illinois. Block et al. v. City of Chicago 1909, quoted in Ellis Paxson Oberholtzer, *The Morals of the Movie*, (Philadelphia: The Penn Pub. Co., 1922): 167.
[91] Oberholtzer, 39.

But of course, the exploitation process can work both ways. While some less scrupulous film producers were clearly using the promise of education to skirt around the censor laws, members of the Canadian, American and British Social Hygiene Councils were using the sensational combination of sex and disease to trick patrons into watching their otherwise pedantic educational films. For this reason film was thought to be particularly useful in reaching those Canadians who the government believed were most in need of education. As one film promoter enthused, "with motion pictures, even the most illiterate people can be reached."[92]

Still, many health advocates were concerned that the sensationalism of some films was overshadowing their educational value; thus they began to distance themselves and their films from the exploitation films. The challenge was to develop films which would interest the average Canadian, but educate rather than merely titillate. By the 1930s, public health advocates began to replace the feature films with more realistic documentary dramas and instructional films. Since these educational films were not intended for mass consumption they could be created with a specific target audience in mind and then shown wherever such audiences might be found. Thus films intended for factory workers were written expressly for workers and were distributed directly to factories. Similarly films on child care were written for mothers and were shown to mothers via various women organizations (such as women's institutes, home and school associations, WCTU, IODE, and local councils of women). In addition to targeting specific audiences, these educational films were able to cover a much broader range of medical problems, including

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[92] A. Welch (Photographic Stores, Ottawa) to W.S.H. LeSuer, (Dept. of Health), Nov. 27, 1920. [NAC,

nutrition, childcare, industrial safety and non-venereal diseases such as diphtheria, tuberculosis, and the common cold.

While the federal Department of Health recognized the value of film as an educational tool, it was slow to develop its own material. In the early 1920s, the Department established a small film library which it made available to reputable health organizations. The majority of the films were British and American; however, there were a few Canadian films which had been produced for various provincial governments and voluntary organizations. Most of the films in the department's library were devoted to personal hygiene and the principles of prevention. For instance, *Public Health Twins at Work* demonstrated how the combined forces of medicine, government and community action could reduce the morbidity and mortality of preventable diseases such as TB, VD, polio, and diphtheria. Similar issues were addressed in the film *Social Protective Measures*.[93] By the 1930s, health films were in high demand as a supplement to public health lectures and the Department of Health was inundated with letters from schools, universities, churches, home and school associations, and military training groups who were anxious to incorporate film into their health education campaign. Curiously, despite its earlier efforts to provide films for health talks, these later requests were flatly denied. Between 1937-1942, the Department's Deputy Minister, Dr. J.J. Heagerty, routinely told correspondents that the government did not own any health films. Such a complete reversal from its earlier efforts at film distribution is difficult to understand. It is possible

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RG 29, Vol. 119, file 188-1-1].

[93] Heagerty to W.G. Nixon (Agricultural Representative, Ontario Dept. of Agriculture), May 1, 1924. [NAC, RG 29, Vol. 119, file 181-1-1]

that the Department's earlier films had been lost or destroyed. This may explain why so few of the titles can be found today. It is also possible that the Department's film library had been transferred to the Government's Motion Picture Bureau. Whatever the reason, Heagerty referred virtually all of the film requests to the Health League of Canada. While the HLC had few Canadian films, it did at least possess a large collection of British and American films which it was willing to lend.[94]

It's possible that Heagerty's strange disavowal of the films in his collection was actually political. With the creation of the Publicity Division in 1938, the DPNH declared its intention to become "a centre for the production and dissemination of literature and other methods of educating the public on the subject of public health."[95] This new commitment to publicity inspired the DPNH to seek out new educational films and re-establish its film library. Naturally, the majority of film acquisitions were American and British, but the government was also very interested in acquiring good Canadian films to highlight Canada's own health problems and accomplishments. The government's interest in presenting a Canadian perspective on the Canadian environment was certainly not unique to the health department, but reflected an emerging sense of Canadian nationalism and a growing apprehension over the influence of American culture on the Canadian identity.

Correctly identifying film as an important cultural medium, the federal government hired the dynamic Scottish filmmaker, John Grierson, to survey Canada's fledgling film

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[94] "DNHW: Education and Information - Production and Distribution of Films - General. 1920-1947." general correspondence, 1937-1942. [NAC, RG 29, Vol. 119, file 188-1-1]

industry and to make recommendations on how to translate film into a vehicle of democratic education in the service of Canadian nationalism. The result of Grierson's final report was the establishment of the National Film Board of Canada [NFB] in 1939 and his own appointment as commissioner. Under Grierson's direction, the NFB projected an image of the world to Canada, and a reflection of Canada to itself. For Grierson, nationalism was not be found in the grandiose performances engineered by propagandists, but through the celebration of ordinary commonalties. Thus, whether it was exploring the wartime sacrifices of ordinary men and women or the mutual misery of the sick, the NFB's veneration of average Canadians and their diversity of experiences remained a constant.[96]

While NFB films may have lacked the heavy-handed didacticism of European government filmmakers, the NFB was, nevertheless, a tool for federal propaganda. Throughout the war years the NFB presented a monthly film series known as *Canada Carries On* and *World in Action*. It also produced a small number of educational films to highlight the activities of specific government departments (especially the Departments of Defence, Agriculture, Labour, Tourism and Health). Not surprisingly, most of these wartime films served wartime objectives. For instance, films such as *Thought for Food* (1943) and *RCAF Training Table* (1945) offered nutritional advice to maximize physical fitness and reduce unnecessary waste. *Hygiene for Health (1945)* instructed women in the RCAF to take special care of their personal hygiene. *For Your Information* (c. 1940), *It's*

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[95] "Policy of the Division of Publicity" Dept. of Pensions and National Health, Feb. 3, 1938. [NAC. RG. 29, Vol. 110, file 181-1-1]

Up to You (1943), *Sixteen to Twenty-Six* (1945), and *Very Dangerous* (1945) warned men and women about the methods of contracting and treating venereal disease. Once the war ended, both the NFB and DNHW were able to devote more time and money to the acquisition of films. Between 1946 and 1960, the DNHW film library grew from a mere 100 films to approximately 680.[97] The majority of the films were American, but almost 25 % were Canadian, (102 English and 57 French).[98]

The films addressed a broad range of contemporary health issues. Many of the NFB productions were produced as part of a series. This approach had the advantage of addressing specific issues in detail. It also enabled the NFB to maintain its target audience by offering new films in regular installments. Among the most popular of the health and welfare film series were: *Ages and Stages* which offered 6 films on the emotional and physical development of children from infancy to adolescence,[99] and *Mental Mechanisms*, a series of four films which identified the manifestations and possible treatment of adult neurosis.[100] Both series were internationally recognized for their thorough handling of the subject and their innovative cinematic style. Some of the films even won prizes at

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[96] Mary Vipond, *The Mass Media in Canada*, (Toronto: Lorimer, 1988): 36-37; John Grierson, "A Film Policy for Canada," Canadian Affairs, June 15, 1944, reprinted in *Documents in Canadian Film*, ed. Douglas Fetherling, (Peterborough, Ont.: Broadview Press, 1988): 51-67.

[97] A 1946 report stated that the DNHW's film library contained 100 films, of which 40 had been donated from the NFB. In 1960, the DNHW's film catalogue lists 650 films. These figures should only be considered as approximations because the DNHW regularly added new films and removed old ones. See "Progress Report on Health and Welfare Work at Film Board," April 24, 1946. [NAC, RG 29, Vol. 119, file 188-1-1] and Canada, *National Health and Welfare Film Library Catelogue*, (Ottawa: ISD, DNHW, 1960).

[98] *National Health and Welfare Film Library Catelogue*.

[99] The films in the NFB's *Ages and Stages* series are; *He Acts His Age* (1949), *The Terrible Twos and Trusting Threes* (1950), *The Frustrating Fours and Fascinating Fives* (1952), *From Sociable Six to Noisy Nine* (1953), *From Ten to Twelve* (1956), *The Teens* (1957).

[100] The films in the NFB's *Mental Mechanisms* series are; *The Feeling of Rejection* (1947), The *Feeling of Hostility* (1948), *Over-Dependency* (1949), and *Feelings of Depression* (1950).

international film festivals. Other films produced by the NFB may not have fallen under a specific series title, but they were nevertheless associated with a specific division of the DNHW. Child development and mental health were probably the most common subjects, but other films on accident prevention, childhood diseases, cancer and community health were also popular.

Canada's interest in these subjects echoed much of what was being done in Britain and the United States. As a result, many of the foreign films in the DNHW film library simply offered a different cinematic approach to a common theme; the content was essentially the same. The only exception to this seemed to be in the area of academic instruction. When the film's purpose was to describe visually the function of some aspect of the human body, or to describe the morphology of a particular disease, the DNHW appeared content to rely on foreign films. Presumably these films were deemed to offer little room for nationalistic sentiment and thus posed little threat to Canadian autonomy.

In general, however, Canadian public health advocates preferred to use Canadian public health films. Furthermore, it was not enough for the films to be produced in Canada; they should also look Canadian. "There is a desperate need of good Canadian films" declared Christian Smith of the Saskatchewan Department of Health in 1945. "As much as possible," Smith went on to say, "the health pictures produced in Canada must reflect the Canadian scene, and Canadian conditions must be met...."[101] Similarly, Kay McNevin, a Health education consultant for British Columbia argued in 1946 that "Films which have a background more or less typical of Canada are much more useful and will be

useful longer than ones which show a definite program in action in a specific locality." [102] Although McNevin failed to offer any substantive evidence, she clearly assumed that Canadian audiences would be more amenable to health information that at least appeared to reflect the Canadian experience.

Over the next decade, the NFB produced approximately 140 French and English films for the DNHW, most of which incorporated identifying symbols of Canadian nationalism, including snowy landscapes and winter sports, children singing French and Maritime folk songs, federal and provincial flags, the scarlet coated RCMP officer, the parliament buildings, Niagara Falls, the Rocky Mountains, the CPR, French habitants, and Atlantic fishing villages. Of course the most common references to Canada came through the overt reiteration of Canadian place names and institutions. While Canada may have been recognizable, some complained that the NFB's vision of the national identity failed to reflect regional diversity or the specificity of local health problems. Once again Christian Smith was quick to point out the omissions of the DNHW when he observed in 1957 that few of the DNHW films accurately reflected the health conditions in Saskatchewan.

> Very few of our films are of Canadian origin, and none has been produced in and for Saskatchewan. We find that virtually every film needs some modifying comments to make it suitable to the purpose of the discussion for which it is to be a helping tool. How much more these films are unsuited to the needs of Indian health education can be surmised... what is

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[101] Christian Smith (Dir. Health Education, Sask.) to Dr. C.F.W. Hames, (Deputy Min. of Pub. Health), Nov. 16, 1945. [NAC, RG 29, Vol. 119, file 188-1-1]

[102] Kay McNevin (Health Ed. Consultant, BC) to Gilchrist, Nov. 21, 1946. [NAC, RG 29, Vol. 119, file 188-1-1]

> the sense of showing filmed dramas of white people in various activities with which the Indian does not identify himself?[103]

Of course, film was not the only medium to weather this complaint. Both print and radio productions were subject to similar criticisms in the 1950s. For instance, at the 1953 Quebec Symposium on Adult Education, Mme. Alberte Senecal of the DNHW faced down a group of Quebec Nationalists who chastised the department for failing to acknowledge Quebec's identity within its health literature. "I was not amused," wrote Senecal to Dan Wallace. "I did not agree and I asked the man who made the suggestion to read our publications carefully and to point out to us what is contrary to the Faith, the Language and the Rights of French Canadians. As I am sure that he is too lazy to do that, I don't think that we will hear more about it."[104]

These complaints were not unfounded. Whatever the introductory or concluding scenes might show, the majority of films were shot in Ontario or Quebec, usually within close proximity to the NFB's Montreal or Ottawa studios. Most films were produced in both French and English. Usually, they were printed in English first and later dubbed into French. One way in which the NFB helped to reduce its reproduction costs was to minimize the amount of on screen dialogue between characters and instead rely on a narrator's voice over. In this way, only the narrator's voice had to be re-recorded in French and not entire scenes. Nevertheless, many French films continued to show actors

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[103] Christian Smith to Harvey Adams (DNHW, ISD), Dec. 16, 1957. [NAC, RG 29, Vol. 111, file 181-1-9 pt. 3]

[104] "Report on the meeting of Adult Education Canadian Society Symposium" (translated from French): Alberte Senecal to Dan Wallace (ISD), May 18, 1953. [NAC, RG 29, Vol. 111, file 181-15].

silently mouthing English words against an unquestionably Anglophone street scene or residence.

While its success at transforming essentially English films into French was not unproblematic, the NFB's use of an off-screen narrator offered additional cinematic benefits. Not the least of which was the prestige conferred upon the narrator. Often dubbed "the voice of God", the narrator served as an unquestioned voice of authority, whose ability to anticipate the activities of the onscreen characters demonstrated a prescient knowledge of the unfolding of cinematic events. Consequently, unlike the onscreen experts whose expertise was identified through their title, clothing, setting and introduction, the narrator's wisdom was assumed rather than earned. Secondly, since the voices of the actors could not be heard it was easy to forget that they were paid actors performing a role according to a pre-written script. Thus, the audience was presented with the illusion that they were on a sociological safari, passively observing the daily activities of ordinary individuals in their natural habitat, while their tour guide narrator identified the points of particular interest. [105]

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[105] This style of documentary film-making was typical of NFB films and marked an important transition from the dramatic style of the 1930s to cinéma vérité which gained popularity in the 1960s and is now the standard format of documentary films. Cinéma vérité stresses a 'reality' based format in which the film-maker 'objectively' records the activities of real people. The dialogue is entirely unscripted and the people on the screen are not directed to play a role, but to simply 'be themselves'. Essentially, the individuals in the film are invited to behave 'normally', as if there was no camera recording their every move and sound. This approach to documentary film-making is now standard practice, but when it was introduced in the early 1960s it was considered highly experimental. It was quickly embraced by a new generation of film-makers who were anxious to transform the documentary from a tool of propaganda to a medium of education. Needless to say, their assumption that cinéma vérité offered a wholly objective view of contemporary events was naive. See, P.J. O'Connell notes that the movement was first developed at the NFB, *Robert Drew and the Development of Cinéma Vérité in America*, (Carbondale and Edewardsville: University of Southern Illinois Press, 1992): 152; Stephen Mamber, *Cinéma Vérité in America: Studies in Uncontrolled Documentary*, (Massachussettes: MIT. 1974).

Clearly film was a seductive medium with tremendous advantages as a vehicle for health education, but it was also the most difficult to distribute. Unlike print which could be distributed via Canada Post and accessed in any venue with enough light to read by, or radio which reached right into the private homes of anyone with a receiver, film was cumbersome, expensive and largely inaccessible to the private citizen. In other words, it wasn't enough simply to send copies of the films to those groups or individuals who requested them. The films required special projection equipment as well as people who knew how to operate the technology. This obstacle was overcome with the creation of the Volunteer Projection Service which taught individuals how to run a projector and arranged for the local screening of NFB films. The NFB was particularly anxious for housewives to learn these technical skills so that they could provide assistance to organizations wishing to show films during normal daytime hours. In some communities a film council composed of representatives from philanthropic groups, trade unions, libraries, the Board of Education and the NFB were formed. These film councils helped to promote NFB films by establishing local film libraries, advertising new releases and arranging for public screenings of NFB productions.[106] Although administratively complicated, this system allowed the NFB to measure statistically the success of their films. Thus, in 1945, the NFB could state with some confidence that the 60 urban communities with a Volunteer Projection Service averaged 30-50 shows per month with an approximate audience of 100 persons per show. Thus there were about 180,000 to

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[106] "National Film Board of Canada, Volunteer Projection Service" M.P. Toombs. (Co-ordinator of Candian Distribution, NFB), Jan. 10, 1945. [NAC, RG 29, Vol. 119, file 188-1-1]

300,000 people across Canada who viewed NFB films every month.[107] Over the next few years, both the demand for educational films and the accessibility of projection technology increased exponentially. By 1952, at least 4200 schools and 15,000 organizations owned their own projection equipment.[108]

With the advent of television in 1949, film's potential as an educational medium expanded even further. However, the new technology once again altered the viewing experience. Films shown in schools, factories and church basements offered a shared public experience in which viewers could discuss the merits of the film and the value of the information contained therein. Viewing films on television was a more private, passive experience. Although considerably more people might view a given programme, because the experience took place in the privacy of one's own home there was less opportunity for the free exchange of ideas and the possibility of misinterpretation increased. Secondly, since pre-television film producers had some control over the venue in which the film would be shown, they could create films which specifically targeted certain audiences. Thus, films concerning the effects of venereal disease in men could show quite graphic images of genital chancres without fear of offending female audiences. Television may have captured a much larger audience, but the greater diversity of viewers presented many of the same limitations faced by radio. Consequently, films which might be shown on television faced the same rules of self-censorship as radio. The films had to be accurate, entertaining, inoffensive, uncontroversial, and commercially viable.

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[107] Gordon Adamson (Supervisor, Industrial Div. NFB) to J. Hurley (DNHW), Feb. 13, 1945. [NAC. RG 29, Vol. 119, file 188-1-1]

This tension between education and entertainment, mass audience versus target audience, occasionally placed the DNHW, NFB and CBC television at odds with each other. The DNHW wanted to show films that would inspire viewers to alter their behaviour and improve their health. Thus DNHW preferred audiences to view health films under the supervision of qualified health consultants who could answer questions and stimulate discussion after the film was over. Conversely, the NFB and CBC simply wanted to show their films to the greatest number of viewers. Since the NFB produced the films for the DNHW, and incurred some of the production costs, it felt it had some autonomy over the distribution of its films. As a result, some films which the DNHW felt should be restricted to professional audiences or to supervised audiences, were broadcast on CBC television. In the late 1950s, Christian Smith voiced these concerns in a letter to Harvey Adams (Director of the ISD). Smith writes:

> Apparently the department is under a handicap in that any pictures it sponsors must be produced by [the] NFB, which contributes to the cost and has a proprietary interest henceforth. So far [the] NFB appears to have assumed it can do pretty well what it likes with such films.... I still think that NFB is too much concerned with statistics and not enough with quality. It leaves me cold when I hear the commissioner say that 13,000,000 people saw NFB pictures in a recent year. What I want to know concerning the health pictures is how many people were able to see these films in circumstances conducive to high retention of information and an enlarged understanding of the subject as related to themselves and their communities.[109]

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[108] Graeme Fraser (Asst, Gen. Mgr., Crawley Films), Nov. 17, 1952. [NAC, RG 29, Vol. 124, file 191-3-1]

[109] Christian Smith to Harvey Adams (DNHW, ISD), May 23, 1957. [NAC, RG 29, Vol. 111, file 181-1-9 pt. 3]

Smith also objected to sharing the Department's health films with the CBC because he feared that audiences would misunderstand the meaning of the films and then be saturated with information they didn't wholly comprehend. "Let the CBC make its own health documentaries," declared a petulant Smith, "or work with NFB on them, not use our tools and spoil them for us."[110]

Smith was not alone in his misgivings regarding the indiscriminate broadcasting of health films on television. Dr. Jules Gilbert of Montreal agreed that "the best education is that made from person to person, and it loses in depth what it gains in breadth when it is offered to groups and especially to whole communities." Unlike Smith who was strangely possessive of DNHW health films, Gilbert was more circumspect. He argued that television by its nature was an inefficient receptacle for the conveyance of ideas since audiences were under no compulsion to watch or pay attention. "In my opinion," writes Gilbert, "educational films are a means of educating groups and even then they should be used with certain precautions. Theatres considerably increase the diffusion of any film on health education and TV is really a means for the masses, the efficiency of which is uncertain and the assessment almost impossible." Ultimately, Gilbert felt that health advocates would simply have to accept the inherent inadequacy of their labours. "After all," observed Gilbert, "people go to movies for amusement and not to learn something (the same could be said of TV) and I doubt very much that educational films are ever very

[110] Ibid.

popular. To give you my opinion, therefore, I am tempted to say: 'whether or not your films are shown in theatres or on TV it will not do much either way, good or bad.'"[111]

Conclusion

Although Gilbert's words were certainly discouraging, they were also insightful. For Gilbert recognized what many members of the Department of Health seemed to overlook; regardless of its packaging, health education was not a form of popular culture. It was a form of educational propaganda. The objective was to encourage Canadians to modify their behaviour in accordance with the prescribed wisdom of the federal government and its medical advisors. Potential recipients may have been divided according to age, sex, language, class, and occupation, but they were all positioned as passive recipients of the information provided. Yet, what at first appears to be a heavy-handed model of social control is rendered more complex after studying the actual process of information production and dissemination. The tools of mass communication were not uniform, but were circumscribed by a variety of social, cultural, economic and political elements which influenced both the producer's and the recipient's ability to interact with them. Thus, the government's ability to produce health information was determined by both material factors, such as the cost and availability of the different forms of communication technology, and by more amorphous considerations such as the changing trends of popular culture, medical science and social exigency. The government's desire

[111] Jules Gilbert to Harvey Adams. May 22, 1957. (translated from French). [NAC. RG 29. Vol. 111. file

to dictate good health was further shaped by the internal dynamics of the medium itself and by the editors, artists, writers, actors, recording technicians, directors, producers and cameramen who transformed the government's ideas into a sellable product. Finally, health information was once again transformed when it left the hands of government distributors and reached the eyes and ears of Canadian citizens. At this stage the information was distilled through myriad factors which helped to frame an individual's interest and comprehension of the material. These factors include the venue in which the information was read, heard or watched, the ability of individuals to understand the content, the extent to which they identified with the target audience, and their willingness to participate in the preservation of their own health.

From the government's perspective, the only way to make health attractive to all Canadians was to cast its net widely. It offered general advice for mass audiences and specialized information for specific groups. It blended the science of health prevention with the psychology of marketing and the technology of mass communication to produce a hybrid of education and entertainment. The aim was not simply to inform, but to motivate; not only to tell Canadians how to take care of their health, but to make them want to do so. "Health education... is more than publicity, public relations, and the distribution of leaflets," stated one internal report, "health education is the process of guiding public action into highways blazed by scientific knowledge."[112] In other words, explained C.W. Gilchrist, (Director of the ISD), "Health education is a means to an end,

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181-1-9 pt. 3]

[112] Minutes of the Fourth Federal-Provincial Health Education Conference, Appendix C, Ottawa, Oct. 13-15, 1952. [NAC, RG 29, Vol. 111, file 181-1-9, pt. 2].

not an end in itself. It is a continual job of selling."[113] While Gilchrist and his colleagues at the Department of Health may have seen this process as a straightforward exchange of information between a knowledgeable government and an ignorant public, it is clear that the final message was shaped by a variety of material and ideological forces which were largely beyond the government's control, not the least of which was the public's own ability to accept or reject the government's bill of goods.

[113] C.W. Gilchrist, "untitled Speech" see also *Health*, March/April 1948 [NAC, RG 29, Vol. 109, file 180-18-1].

Chapter 3: Monsters and Microbes

In 1952, a special conference of Canadian federal and provincial health educators met in Ottawa to discuss new strategies of health promotion. Organizers explained that it was their mission to "translate the findings of the laboratory into language and activity understood and accepted by the public." Finding the correct tools to communicate their ideas was one part of the equation. Persuading audiences to take the message seriously was something else again. Essentially, the public health message had to convey three sets of ideas. First, it had to explain why disease was bad. Next it had to demonstrate that science held the answer to prevention. Finally, and most importantly, health information had to convince audiences to act on the advice being offered to them. To achieve these three objectives, health educators dramatized their ideas as parables which pitted the evils of disease against the enlightened purity of science. Success or failure was determined by the individual. Those who ignored their health got sick, thus contributing to the problems of society. Those who put their faith in science remained healthy, thereby advancing the cause of progress.

The basic structure of this parable changed very little during the period under investigation, but the metaphors used to describe diseases, doctors and patients varied according to the shifts and trends of Canadian culture. Some images reflected contemporary concerns over work, war, and foreigners. Others drew upon more generalized notions of gender, race and class. Collectively, the metaphors of health and

disease describe the era's preoccupation with the problems of modernity, and the role of individuals in deciding the fate of nations.

Each of the next three chapters will examine the visual allegories which public health promoters created to define the relationship between diseases, doctors and patients. Although the chapters deal with each subject separately, in practice the images were fully integrated to give a complete and seamless sense of the entire public health picture. This chapter will focus on the changing images of disease. The chapter begins with a brief overview of the early monster metaphors which formed the central trope for twentieth century disease images. The remainder of the chapter will show how these earlier images were reconfigured to suit a twentieth century audience.

Early Images of Disease

Perhaps the most enduring image associated with death and disease in European culture is that of the Grim Reaper; the cloaked skeleton who carries a scythe for the harvesting of human souls. More than just a frightening depiction of death, the image of the Grim Reaper serves as an expression of one culture's understanding of both the aetiology and the experience of death and disease. The figure dates back to the 14th century when most of Europe and Asia were being ravaged by the plague. In its outward appearance, the Grim Reaper looked like a simple peasant, but the costume belied the danger within. The Reaper's skeletal remains were evidence of the wastage of disease and

decomposition. Its sightless eyes suggested the randomness of death, and despite its search for souls, the Reaper's fearsome visage offered little assurance of God's mercy.[1]

Although the image of the Grim Reaper has persisted among Euro-centric cultures, other representations of death and, more specifically, disease have also emerged. Like the allegory of the Grim Reaper, later images of disease also drew upon a common cultural currency of fact and fiction which enabled individuals to express vividly both their objective understanding of disease as well as their subjective experience of illness. Despite their scientific inaccuracies and tendency towards hyperbole, these metaphoric representations of disease and illness should not be dismissed as merely the irrational musings of the scientifically illiterate. Instead, they should be recognized as an attempt to reconcile contemporary scientific knowledge with popular anxieties regarding sickness and health. In the twentieth century, Canada's public health educators reinforced these anxieties by comparing disease to a variety of modern-day monsters, including foreigners, fascists and communists. With these culturally specific metaphors, public health advocates hoped to evoke an emotional response to disease prevention which would ultimately stimulate popular concern for any number of specific medical problems.

The use of illustrations in the human sciences dates back to the time of Aristotle; however, anatomical art did not develop as a standard teaching aid until the sixteenth century. The Renaissance's celebration of the achievements of 'man' encouraged both

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[1] For early images of death see, Joseph Leo Koerner, *The Moment of Self-Portraiture in German Renaissance Art*, (Chicago: University of Chicago Press, 1993): esp. ch. 13 & 14; Leonard Kurtz, *The Dance of Death and the Macabre Spirit in European Literature*, (New York: Columbia University Press, 1934); James M. Clark, *The Dance of Death in the Middle Ages and the Renaissance*, (Glasgow: Jackson, Son and Co., 1950); Special note should be made of Hans Holbein's woodcuts, "The Dance of Death"

artists and scientists to contemplate the wonders of the human form. Yet, it took medical scientists another two centuries to integrate the insights gleened from pathalogical anatomy and anatomical illustration into their research. According to Jacalyn Duffin, physicians of the early modern era saw disease as a disorder of the living body. Thus anatomy, which only classified the organs of dead bodies, was assumed to hold little insight for the practicing physician. Duffin argues that this narrow definition of medical science was challenged in the eighteenth century when scientists finally began to link anatomical abnormalities with specific disease symptoms. Once doctors began to accept the notion that disease could exist independently of any visible symptoms, they became increasingly reliant on the detailed observations of anatomists and medical illustrators.[2]

While the general public were not entirely ignorant of these scientific developments, science itself formed but one voice in a chorus of culturally relevant information. For non-scientists, the knowledge derived from faith, family, popular culture and personal experience was likely to be at least as compelling as that gained from science. Furthermore, in their role as potential patient, lay audiences were less likely to achieve the same level of detached objectivity as that valued by scientific observers. For non-scientists, illness is fundamentally a private experience of pain, isolation, economic loss, and the possibility of death or permanent debility. Obviously, scientists who fall ill share these same responses; however, in their capacity as researchers, disease is primarily understood as a biomedical process. This distinction between the subjective experience of

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which were produced between 1497 and 1543. Examples can be found in W. Holler, *"The Dance of Death" by Hans Holbein*, (London: J. Coxhead, 1816).

illness versus the relatively objective observation of disease is readily apparent in the popular representations of disease.[3]

In popular culture, disease is most often portrayed as some form of fearsome creature. In ancient Greece, both disease and medicine were embodied in the image of the serpent. Asclepius, the Greek God of healing, was represented by a snake coiled around a staff. This image, which is still used to symbolize Western medical science, captures a sense of both the earthly and the ethereal. While the staff may suggest the physician's power to thwart the dangerous snake, the snake's appearance of choking the staff suggests a more equitable struggle between the forces of health and disease. The image is further complicated by the conflicting role of the serpent in Greek mythology. J. Schouten explains that, "the serpent stood for the life of the earth in its totality; that is to say, life, dying and rising from the dead; hence its being sometimes cursed as the arch-enemy of man, sometimes venerated as the great and divine saviour."[4] Asclepius's special insight into the mysteries of disease came from his willingness to live among the serpents

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[2] Jacalyn Duffin, "Imagining Disease: The Illustration and Non-Illustration of Medical Texts, 1650-1850," *Muse and Reason: The Relation of Arts and Sciences, 1650-1850*, eds. B. Castel, J.A. Leith and A.W. Riley, (Kingston: Queen's Quarterly, 1994): 85.

[3] My use of the terms 'subjective' and 'objective' are not unproblematic. The patient's experience of disease is regarded as subjective because it is unique to that individual and defies external quantification. The physician's observation of disease symptoms is regarded as 'objective' because the physcian's interpretation of the symptoms is based on an aggregate of medical and scientific investigations. It can be argued, however, that the physician's observations are also subjective because the presentation of disease symptoms are never uniform, and therefore require the personal interpretation of the individual physician. For discussions regarding the patient and physician's divergent experience and interpretation illness see Arthur Kleinman, *The Illness Narratives: Suffering, Healing and the Human Condition*, (New York: Basic Books, 1988); Robert M. Veatch, "Lay Medical Ethics," *The Journal of Medicine and Philosophy*, Vol. 10, No. 1, (Feb. 1985): 1-5; Roy Porter, "The Patient's View: Doing Medical History from Below," *Theory and Society*, Vol. 14, No. 2, (March 1985): 175-198; Paul Atkinson, *The Clinical Experience: The Construction and Reconstruction of Medical Reality*, (Westmead, Eng.: Gower Pub, 1981).

[4] J. Scouten, *The Rod and Serpent of Asklepios: Symbol of Medicine*, (Amsterdam: Elsevier Pub. Co., 1967): 37

in the bowels of the earth. For Asclepius, "it was precisely in the realm of the dead that the mystery of life and of recovery lay hidden."[5]

The association between serpents and disease continued to capture the imagination of Western culture long after Judeo-Christianity supplanted the polytheistic culture of the ancient world. For Judeo-Christians, the serpent was mythologized as the seductive devil who persuaded Eve to ignore God's edict by eating from the Tree of Knowledge. In this story, the snake is both malevolent and beguiling. In the Middle Ages, snakes were thought to bring plagues and other infectious diseases. Snake parts, such as the tongue, tail and horn, were sometimes used as amulets to ward off disease and to treat infection.[6] Raymund Crawfurd's 1914 study of disease iconography in literature and art found that stories of disease carrying serpents, snakes and hydras were often infused with religious significance.[7] Stories from early Christian hagiography frequently described how mere mortals bravely conquered venomous serpents and dragons. In many of these legends the casting out of demons was conflated with the purging of disease; consequently many of the dragon-slaying Saints were also hailed as divine healers.[8] For instance, St. Patrick,

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[5] Ibid; For other discussions regarding Asclepius and serpent symbols see, Nathan W. Williams, "Serpents, Staffs, and the Emblems of Medicine," *Journal of the American Medical Association*, Vol. 281, No. 5, (Feb. 3rd, 1999): 475; Judith Anne Stanton, "Aesculapius: A Modern Tale," *Journal of the American Medical Association*, Vol. 281, No. 5, (Feb. 3rd, 1999): 476-7; J.E. Bailey, "Aesculapius: Ancient Hero of Medical Caring," *Annals of Internal Medicine*, Vol. 124, (1996): 257-263.

[6] Scouten, 85; Williams, 475; F.E. Russell, *Snake Venom Poisoning*, (Philadelphia: J.B. Lippincott Co., 1980).

[7] The hydra is a mythical snake (often portrayed as a water snake) who possesses more than one head. If the head of a hydra is cut off, the hydra simply grows a new one which makes the hydra virtually impossible to destroy. Raymond Crawfurd, *Plague and Pestilence in Literature and Art*, (London: Oxford University Press, 1914): 2-3; Gillian Bennett also talks about the significance of snakes in folklore in *Traditions of Belief: Women and the Supernatural*, (New York: Penguin, 1987).

[8] Peregrine Horden, "Disease, Dragons and Saints: The Management of Epidemics in the Dark Ages," *Epidemics and Ideas: Essays on the Historical Perception of Pestilence*, eds., Terence Ranger and Paul Slack, (Cambridge: Cambridge University Press, 1992): 45-76.

the patron Saint of Ireland, reputedly rid the island of its snakes rendering it a safe and therefore healthy environment for its inhabitants.[9] St. Margaret of Antioch became the patronress of birthing mothers and newborns after she was swallowed by a dragon who promptly died of indigestion.[10] St. Marcellus, a 5th century holy man, destroyed the dragons of Italy and cured the villagers of their ailments.[11] St. Anthony is famous for having been tormented by demons and healing the sick. In artistic renderings, St. Anthony's demons are portrayed as gruesome monsters, (see figure 3.1).[12]

Peregrine Horden has argued that the dragon stories of medieval folklore offer important insights into the early European's understanding of disease. According to Horden, dragons were not merely the foul beasts of folklore, they were metaphors describing the physical embodiment of disease. Horden suggests that both the appearance and lifestyle of dragons personified the early European conception of disease. Typically dragons were described as large foul beasts who preyed upon the most vulnerable members of a community without apparent reason or provocation.[13] The dragon allegory also suggests that disease was believed to exist apart from the individuals who became its victims. Even stories which represented disease as a form of divine retribution for the commitment of sins or as a test of personal devotion, accepted the ontological view that disease was an affliction which originated outside the body.[14]

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[9] David Hugh Farmer, *The Oxford Dictionary of Saints*, (Oxford: Clarendon Press, 1978): 312-314.
[10] Ibid, 260-1.
[11] Horden, 51-3.
[12] Ibid, 19-20.
[13] John Vinycomb, *Fictitious and Symbolic Creatures in Art: With Special Reference to Their Use in British Heraldry*, (London: Chapman and Hall, 1951): 59-62.
[14] See for instance, Charles E. Rosenberg, "Introduction," *Framing Disease: Illness, Society, and History*, ed. Charles E. Rosenberg and Janet Golden, (New Brunswick, N.J.: Rutgers University Press, 1992);

Whether it came in the form of demons or dragons, early Europeans seemed resigned to the notion that disease was an unpredictable and inevitable force which wreaked havoc on the physical and social order of individuals and communities. This perception was re-enforced by the successive waves of devastating plagues and epidemics which periodically gripped Europe throughout the last two millennia. The most notorious of these epidemics occurred between 1346-50 when approximately one-quarter to one-third of the total European population died as a result of bubonic or pneumonic plague.[15] Killing rich and poor alike, the disease disrupted the normal social order. This was compounded by the collapse of several powerful family dynasties and the rising prosperity of gravediggers, undertakers and fumigators.[16] During this era, popular representations of the plague emphasized both the horror and the randomness of the Black Death. Many of the images took the form of a macabre carnival in which the normal order of society was turned upside-down and exuberant skeletons danced among the living corpses of the meek and powerful.[17]

A second and important theme which is evident in plague art is the association between disease and strangers. Although many saw the plague as a form of divine

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Owsei Temkin, "Health and Disease," *Double Face of Janus and Other Essays in the History of Medicine*, (Baltimore and London: The Johns Hopkins University Press, 1977): 419-440; Henry Sigerist, "The Special Position of the Sick," reprinted in *Culture, Disease and Healing: Studies in Medical Anthropology*, ed. David Landy, (New York: MacMillan Pub. Co., 1977): 388-394; Guenter B. Risse, "Health and Disease: *Encyclopedia of Bioethics*, ed. Warren T. Reich, Vol. 2, (New York: Simon and Schuster, MacMillan, 1978): 579-585.

[15] William H. McNeill, *Plagues and Peoples*, (New York: Anchor Books, Doubleday, 1976): 149

[16] Brian Pullan, "Plague and Perceptions of the Poor in Early Modern Italy," *Epidemics and Ideas*: 117; Colin Jones, "Plague and Its Metaphors in Early Modern France," *Representations*, Vol. 53, (Winter 1996): 98; William Eamon, "Plagues, Healers and Patients in Early Modern Europe," *Renaissance Quarterly*, Vol. 52, no. 2, (Summer, 1999): 474-486.

[17] Louise Marshall, "Manipulating the Sacred: Image and Plague in Renaissance Italy," *Renaissance Quarterly*, Vol. 47, no. 3, (Autumn, 1994): 485-532; see reference 1.

retribution for the commitment of sins, others targeted particular groups of people as harbingers of disease. Not surprisingly, the finger-pointing merely highlighted pre-existing social tensions. Thus the rich blamed the poor for their slovenly habits, and the poor blamed the rich for hoarding food and medicine. City-dwellers blamed sailors and journeymen for transporting disease from one community to another. Farmers blamed urbanites for their polluted cities and low moral standards. Of all the people blamed for causing the plague, the Jews were the largest group to be singled out for persecution. Accused of poisoning local water-supplies, thousands of Jews were tortured, burned and killed by mobs of anti-Semites. One estimate suggests that by 1351, just four years after the plague had begun, virtually all the European Jews had either died or fled to Eastern Europe (especially Poland and Russia) where their professional skills were more highly valued.[18]

Although the association between disease and strangers may seem less fanciful than the serpents, dragons and ghouls previously mentioned, there are in fact many similarities. In each of these representations disease appears as an autonomous entity who exists apart from, and in opposition to, 'normal' (i.e. healthy) human society. Disease pursued its victims with blind malevolence, inflicting pain, suffering and death on the people and communities it visited. Disease disrupted the normal social and physical order. It challenged the power of individuals to determine their own fate and made a mockery of

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[18] Andrew Nikiforuk, *The Fourth Horseman: A Short History of Epidemics, Plagues, Famine and Other Scourges*, (Toronto: Penguin Books, 1991): 47-48; Ann Carmichael, *Plague and the Poor in Renaissance Florence*, (Cambridge: Cambridge University Press, 1986); David Herlihy, *The Black Death and the Transformation of the West*, (Massachusetts: Harvard University Press, 1997); Eamon, 479.

human achievement. In short, disease was the quintessential "other" whose portrayal as an irrational monster or mysterious stranger seemed highly appropriate.

This sense that disease was an external affliction persisted within popular renderings of medical illness. Cartoonists from the eighteenth and nineteenth century frequently relied on monster images to illustrate the strange, malicious and irrational nature of disease. Thomas Rowlandson's painting, *Ague and Fever* (c. 1792), shows a pale, shivering patient trying to warm himself in front of a fire while his body is tormented by the monstrous demons of his affliction. While the patient grimaces in discomfort, a stout physician sits at a table in a corner studying a vial of liquid, apparently indifferent to the sufferings of his patient (figure 3.2).[19] Rowlandson's drawing illustrates the growing separation between doctor and patient, disease and illness which was taking place towards the end of the eighteenth century. Monster metaphors also appear in Francisco Goya's painting, *The Sleep of Reason* (figure 3.3), James Gillray's depiction of gout (figure 3.4), and George Cruikshank's caustic portrayals of a woman with cholic and a man with a headache (figures 3.5 and 3.6).[20] In each of these paintings, the affliction or disease arrives in the form of a devilish tormentor. With the exception of Goya's portrayal of madness (which is both personal and political), these renderings of disease clearly convey the sense of pain and helplessness which can be inflicted by illness. The focus of the

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[19] Thomas Rowlandson, *Ague and Fever*, (c. 1792), reprinted in Carl Zigrosser, *Medicine and the Artist*, 3rd edition, (New York: Dover Pub., 1970): plate 85.

[20] Francisco Jose de Goya, *The Sleep of Reason Produces Monsters*, (1797-1798), *Medicine and the Artist*: plate 79; James Gillray, *The Gout*, (c. 1799), *Medicine and the Artist*: plate 86; George Cruikshank, *The Cholic*, (1819), *Medicine and the Artist*: plate 56; George Cruikshank, *The Headache*, (c. 1819), *Medicine and the Artist*: plate 87.

artist's concern is with the sensations of illness as experienced by the patient, rather than with the success of science at identifying the disorder.

The discoveries of modern science were not, however, entirely absent from the popular imagination. William Heath's cartoon drawing entitled *Thames Water* (c. 1828) suggests a growing recognition of the dangers posed by microorganisms (figure 3.7). The painting shows the shocked expression of a refined lady as she looks through a microscope at a droplet of Thames water. Within the enlarged image of the water droplet there is a confusion of bizarre aquatic creatures, which Heath describes in the subtitle as "Monster Soup". Once again the image of the monster is utilized to convey a sense of fear and horror. Heath re-enforces the association between monsters and micro-organisms in a caption which he attributes to Milton and dedicates to the London Water Companies who, claims Heath, "brought forth all monstrous, all prodigious things, hydras and gorgons and chimeras dire."[21] Unlike Milton's mythical monsters, however, Heath's microscopic creatures were rendered all the more terrible because, as the horrified lady in the picture discovered, these monsters actually existed (although their actual form was clearly subject to artistic interpretation).[22]

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[21] William Heath, *Thames Water*, (c. 1828), *Medicine and the Artist*: plate 60.

[22] *Thames Water*, represents a surprisingly early attempt to portray microorganisms for a popular audience. The organisms were first observed by Antony Leeuwenhoek, a Dutch shopkeeper, who produced simple microscopes in his spare time. Leeuwenhoek published his highly detailed findings in 1683. In the mid 1700s, Lazzaro Spallanzani's investigations into the reproduction of microbes (or "animacules" as they were called) fueled Enlightenment debates regarding the relationship between God and nature, science and theology. By the time Heath drew his caricature in 1828, the existence of microbes was well established, but it was another 50 years before Robert Koch proved the causal connection between microbes and disease. According to many historians, the existance of microorganisms did not enter the popular imagination until scientists such as Robert Koch, Louis Pasteur, Joseph Lister and others began to apply their knowledge of germs to the prevention of disease. See for instance, Bert Hansen, "The Image and Advocasy of Public Health in American Caricature and Cartoons from 1860 to 1900," *American Journal of Public Health*, Vol. 87, (1997): 1798-1807; Naomi Rogers

Another important distinction between Heath's image and that of earlier drawings was the inversion of size and power. Whereas earlier metaphors derived their power from their size and/or demonic sensibilities, Heath's microorganisms were so small that they could be seen only with the aid of a microscope. Part of the horror of these creatures was the recognition that, because of their infinitesimal size, they were able to live unseen within the food and water people consumed. Although the causal connection between microorganisms and disease had yet to be established, Heath's drawing demonstrates that that the creatures beneath the microscrope were considered to be revolting and abhorrent. Finally, Heath's drawing clearly acknowledges the role of modern science in transforming the way individuals saw and therefore interpreted the world around them.[23] Ironically, science's efforts to discover order in the universe ultimately seemed to confirm the popular notion that the world was controlled, at least in part, by mysterious, irrational and apparently malevolent forces.

The popular assumption that disease was a strange and malevolent force persisted throughout the nineteenth and much of the twentieth centuries. Public health advocates further perpetuated the notion by their tendency to equate disease with poverty, crime and immorality. Diseases such as cholera, typhoid, dysentery and tuberculosis were commonly

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describes the efforts of public health advocates to demonize microbes as monstrous houseflies. see Naomi Rogers, "Germs with Legs: Flies, Disease and the New Public Health," *Bulletin of the History of Medicine*, Vol. 63, no. 4, (Autumn, 1989): 599-617; Nancy Tomes argues that earlier associations between physical cleanliness and spiritual purity eased the transition from the moralistic to the scientific interpretation of disease. See Nancy Tomes, *The Gospel of Germs: Men, Women, and the Microbe in American Life*, (Cambridge, Mass.: Harvard University Press, 1998).

[23] In his review of medical cartoons in the American popular press, Bert Hansen argues that the images both advanced and reflected the current state of popular scientific knowledge. See, Hansen, "The Image and Advocacy of Public Health in American Caricature and Cartoons from 1860 to 1900," 1798-1807; Bert Hansen, "New Images of a New Medicine: Visual Evidence for the Widespread Popularity of

identified with the rotting waste which polluted the streets, water and air, and the squalid people who were forced to live amongst the refuse. To the middle classes, poverty and disease were inextricably bound together.[24]

There were several theories which attempted to explain why the poor were more susceptible to infection. The most obvious and generally sympathetic theory argued that the working classes were too poor to afford the nutritious food, fresh air and clean water which was the privilege of the wealthier classes. Moreover, their cramped living quarters, congested work spaces and especially the physically intensive labour which consumed most of their waking hours made them easy targets for debilitating infections. Other, less charitable opinions, suggested that the poor contributed to the spread of disease through their ignorance, intemperance and immorality. Thus, disease was seen as a combination of economic and environmental factors or what John Pickstone refers to as "dearth" and "dirt".[25] In other words, for the disciples of germ theory, disease was not inevitable nor entirely random; rather it found its victims among those people whose lifestyle rendered them especially susceptible to illness.

While middle class demagogues debated who or what was responsible for the squalid living conditions of the working class, social reformers and public health

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Therapeutic Discoveries in America after 1885." *Bulletin of the History of Medicine*, Vol. 73, (1999): 629-678.

[24] The historiography exploring the links between disease and poverty is voluminous. See for example, Michael B. Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America*, (New York: Basic Books, 1996); Bettina Bradbury, *Working Families: Age, Gender, and Daily Survival in Industrializing Montreal*, (Toronto: McClelland and Stewart, 1993); Terry Copp, *Anatomy of Poverty: The Condition of the Working Class in Montreal, 1897-1929*, (Toronto: McClelland and Stewart, 1974): 88-105; Gareth Stedman Jones, *Outcast London: A Study in the Relationship Between Classes in Victorian Society*, (Oxford: Clarendon Press, 1970); Ellen Ross, *Love and Toil: Motherhood in Outcast London, 1870-1918*, (Oxford: Oxford University Press, 1993): 179-194;

advocates attempted to 'clean-up' the physical and moral environment. Their initiatives called for reforms in both the public and private sphere. First, the government was expected to take greater responsibility in ensuring the quality of food, air, water and housing. Next, individuals were encouraged to apply the principles of sanitation and personal hygiene within their own homes. They were also pressured to give up those personal vices, especially drinking and prostitution, which were believed to weaken the body and invite disease.[26]

This effort to cleanse both the physical and moral environment of the public and private spheres suggests a rather interesting marriage between the Enlightenment's emphasis on balance and order, and the nineteenth century's belief that progress was achieved through rational efficiency. For both scientists and moralists, cleanliness, whether physical or moral, was the assertion of order over chaos, of health over disease. The conceptual links between dirt and disease, cleanliness and health, were sufficiently well established by the mid-nineteenth century that for most non-scientists, the introduction of germ theory in the 1880s was simply an extension of what the general public already believed to be true. Moreover, since the general public never gave up its

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[25] John V. Pickstone, "Dearth, Dirt and Fever Epidemics: Rewriting the History of British Public Health, 1780-1850" in *Epidemics and Ideas*: 126.

[26] John Eyler, "The Sick Poor and the State: Arthur Newsholme on Poverty, Disease, and Responsibility," *Framing Disease:* 275-296; Naomi Rogers, *Dirt and Disease: Polio Before FDR*, (New Brunswick, N.J.: Rutgers University Press, 1992); Robert Hudson, *Disease and Its Control: The Shaping of Modern Thought*, (New York: Praeger Press, 1983); Nancy Tomes, "The Private Side of Public Health: Sanitary Science, Domestic Hygiene, and Germ Theory, 1870-1900" *Bulletin of the History of Medicine*, Vol. 64, no. 4, (1990); Gertrude Himmelfarb, *The Idea of Poverty: England in the Early Industrial Age*, (NewYork: Vintage Books, 1985): esp. parts 2 & 3; Edwin Chadwick, *The Sanitary Conditions of the Labouring Population of Great Britain*, (Edinburgh: Edinburgh University Press, 1965); James Phillips Kay-Shuttleworth, *The Moral and Physical Conditions of the Working Class*, 2nd. ed. (New York: August M. Kelley Pub., 1970); Anthony S. Wohl, *Endangered Lives: Public Health in Victorian Britain*, (London: J.M. Dent and Sons, Ltd., 1983).

conviction that disease was associated with unseen malevolent forces, it was relatively easy to accept the notion that disease was produced by microscopic germs who thrived wherever dirt and decay were allowed to fester.[27]

Modern Images of Disease

Most of these themes persisted into the early twentieth century and many of the earliest pamphlets produced by or for public health advocates relied on the familiar monster metaphors of earlier eras. For instance, the Metropolitan Life Insurance Company produced a series of pamphlets in the 1910s and 1920s which recalled the medieval images of serpents and dragons. In the pamphlet *Taking Your Bearings* (c. 1920), an illustration entitled "Charting Your Course through Life", asked readers to imagine themselves as ship captains navigating their way around the reefs of pneumonia, the pirates of tuberculosis, and the mythical sea-serpents of cancer, diabetes, heart disease, appendicitis and obesity (figure 3.8).[28]

In another MLI pamphlet, sickness is described as the last remaining 'foe of mankind'. "Disease is a many-headed hydra," declared the pamphlet. "Ignorance is a monster that takes a tribute of thousands of lives yearly." The pamphlet reassured its readers that the MLI "has been sending out expeditions of discovery to find new ways to conquer these foes."[29] Illustrations throughout the pamphlet supplement the text by

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[27] Tomes, "The Private Side of Public Health," 528-9.
[28] Metropolitan Life Insurance Co., *Taking Your Bearings*, (MLI: Ottawa, c.1920): 6-7.
[29] Metropolitan Life Insurance Co., *Adventures for Health*, (MLI: New York, 1930): 3

likening tuberculosis to dragons and diphtheria to minotaurs. The defenders of health, who included the MLI, public health nurses, hospitals, and municipal public health initiatives such as school health programmes, sewage systems, water treatment plants, milk pasteurization, food inspection and urban playgrounds, are represented as knights in shining armour, valiantly protecting the public good.[30]

In each of these pamphlets, disease is represented as an archaic foe whose strength threatened to overwhelm anyone who was unmindful of their health. The danger posed by these monstrous diseases was apparent in their immense size, their obvious power and by their insensitivity towards the plight of their victims. The danger was also apparent in the monster's irrationality. Whether it appeared as a dragon or a devil, the monster represented those elements of the natural and spiritual world which defied logic by fostering chaos. Disease, whatever else it might be, was a harbinger of social and physical disorder. Interestingly, both pamphlets abandoned the images of monsters once they started to discuss the achievements of modern medicine. The shining armour, shields and swords of medieval knights were replaced by the white coats, stethoscopes and black bags of modern doctors and scientists. Similarly, the fire-breathing dragons were replaced by images which reflected a more contemporary understanding of germs and disease.

Although the traditional monster image of disease was an effective way of conveying danger, its association with medieval mythology seemed incongruous with the

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[30] Ibid; Many of the era's most famous medical scientists were caricatured as dragon slaying saints. For example, Robert Koch was likened to St. George slaying the serpent of tuberculosis. See. David Leibowitz, "Scientific Failure in an Age of Optimism: Public Reaction to Robert Koch's Tuberculin Cure," *New York State Journal of Medicine*, Vol. 93, No. 1, (Jan. 1993): 43; Georgina Feldberg, *Disease and Class: Tuberculosis and the Shaping of Modern North American Society*, (New Brunswick. N.J.: Rutgers University Press, 1995): 114.

self-confident optimism of modern science. For twentieth century scientists, disease could no longer be conceptualized as a bizarre, irrational monster, because the discoveries of modern science had revealed disease to be the product of infinitesimally small microorganisms whose behaviour followed the same logical patterns as any other living organism. In other words, germs might look strange and their powers of destruction were certainly impressive, but unlike serpents and dragons, germs were visible, predictable and perhaps even controllable. To perpetuate the old monster image of disease not only misrepresented what was known about disease aetiology, it undermined the revolutionary significance of germ theory. The metaphoric association between disease and dragons, hydras and Grim Reapers continued within much of the popular literature; however, these fanciful images typically served as a reminder of the historic dangers posed by disease rather than the contemporary successes of science. The challenge for twentieth century public health artists was to create images which endorsed the wisdom and authority of science without lulling the public into a false sense of security. After all, scientists might understand the aetiology of disease, but they had not destroyed it. Its power to inflict pain and suffering on its hapless victims was still formidable (figure 3.9).

One new approach to representing the germs of disease was through photography. Developed in the early 1800s, photographic imaging was quickly adopted by both artists and scientists as a method of immortalizing a moment in time. Following the first public exhibition of Louis Daguerre's photographic process at the Paris meeting of the Academie des Sciences and the Academie des Beaux-Arts in August 1839, enthusiastic observers

predicted that the invention would revolutionize the way scientists observed the physical world. The chemist, J.L. Gay-Lussac exclaimed that photography "will furnish the nucleus around which new researches and new discoveries are made."[31] Prior to the development of photography, scientific illustrations were produced by highly skilled artists and lithographers. While their detailed drawings of the minutiae of micro-organisms were often much clearer than the early photographic images, scientists praised the photograph's semblance of objective reality which was unadulterated by the "fallibility of the observer."[32] As one reviewer naively commented in 1864, "Photography is never imaginative, and is never in any danger of arranging its records by the light of preconceived theory."[33] The history of photography would seem to belie this statement. The choice of subject matter, the visual context which frames the image, the contrast of shadow and light all require a degree of artistic interpretation. Even in science, the appearance of realism is achieved only after the subject matter has been carefully selected, prepared and positioned by a photographer.[34]

Techniques for capturing microscopic images were developed as early as 1840. Initial efforts were hindered by their inability to provide adequate light to the slide without damaging the specimen, which was eventually resolved by the addition of a dark blue

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[31] Jon Darius, *Beyond Vision: One Hundred Historic Scientific Photographs*, (Oxford: University of Oxford Press, 1984): 10-11.
[32] Ibid, 11.
[33] Ibid, 11.
[34] Studies of the history of medical illustrations include, Barbara Maria Stafford, *Body Criticism: Imagining the Unseen in Enlightenment Art and Medicine*, (Cambridge, Mass.: M.I.T. Press, 1987); K.B. Roberts and J.D.W. Tomlinson, *The Fabric of the Body: European Traditions of Anatomical Illustrations*, (Oxford: Clarendon Press, 1992); Jacalyn Duffin, "Imaging Disease": 79-108; Sander L. Gilman, *Picturing Health and Illness: Images of Identity and Difference*, (Baltimore and London: The Johns Hopkins University Press, 1995); 9-32.

filter. By 1845, Alfred Donné and Leon Foucault of Paris published *Cours de Microscopie*, the first anatomical atlas using photomicrographs.[35] Despite the improvements in technique and the assertion of objective realism, nineteenth century photography continued to lack the clarity and texture of the hand drawn lithographs. Its greatest success was in producing portraits of patients. Throughout the late nineteenth century, physicians collected hundreds of photographs detailing both the ordinary and extraordinary rashes, tumours and traumas of their patients.[36] Often the images were touched up and colour tinted to aid in the identification of the particular curiosities. By the time the Canadian government began to publish health literature for public consumption in the 1920s, improvements in photographic technology had greatly enhanced the quality of the image, and the conventions which came to define the frame and composition of medical photography were well established.[37]

In Canada's public health literature, the use of photographic images of diseased organs and microorganisms helped to familiarize audiences with human anatomy and microbiology. The photographs also offered Canadians a window into the 'real' world of science and technology. The photographs suggested an air of authenticity which graphic drawings, no matter how accurate, could not replicate. The genuineness of the image was

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[35] Darius, 22-23.

[36] Sander L. Gilman, *The Face of Madness: Hugh W. Diamond and the Origin of Psychiatric Photography*, (New York: Brunner/Mazel Pubs., 1976); For a rich source of early medical photography see, Janet Golden and Charles Rosenberg, *Pictures of Health: A Photographic History of Health Care in Philadelphia, 1860-1945*, (Philadelphia: University of Philadelphia, 1991); also note the review article by Jacalyn Duffin, "Medicine Through the Lens of a Camera," *Queen's Quarterly*, Vol. 98, no. 4, (Winter 1991): 865-873; Duffin claims the first Canadian medical photo illustration was produced in 1845 in the *British American Journal of Medical and Physical Science*. See Duffin, "Imagining Disease": 102.

[37] Daniel M. Fox and Christopher Lawrence, *Photographing Medicine: Images and Power in Britain and America since 1840*, (Westport, Conn.: Greenwood Press, 1988): 23-27.

further enhanced by the tendency to enclose the microscopic photographs within a circular frame, rather than the more traditional square or rectangular frame. The circular framing suggested that the image was a precise duplicate of what scientists saw when they looked through the lens of a microscope.

Cinematic renderings of microscopic images were also enclosed in a circular frame, but unlike the still images seen in pamphlets, cinematic photomicroscopy could convey movement. Watching the organisms propel themselves through their two dimensional universe offered fairly convincing proof that germs were in fact living creatures. Among the earliest films to use cinematic photomicroscopy in Canada's health film repository was an American series entitled simply, *Health*. Produced by MIT and Eastman Ltd. in the 1920s, these black and white silent films covered a variety of health topics including, nutrition, hygiene, first aid, and disease prevention. The series also included several films specifically devoted to different aspects of human physiology which contained some amazingly sophisticated footage of bacteria, blood cells and cell division.[38]

In addition to showing images of actual germ cells these films also presented audiences with the rare opportunity to see into the world of science. Photographs of science labs, test tubes, Bunsen burners, microscopes and white-coated scientists helped to verify that the microscopic images fell within the realm of science and therefore met the

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[38] Films in the *Health* series are divided into various sub-series entitled *Food, Hygiene, Safety and First Aid*, and *Physiology*. The dates of the films vary and some films do not include dates at all. The earliest date is 1920; the last is 1932. The films showing animated photomicroscopic images include, *Health: Physiology: The Living Cell*, (Mass., U.S.: Department of Biology and Public Health, M.IT. and Eastman Co., c. 1929); *Health: Physiology: Bacteria*, (Mass., U.S.: Department of Biology and Public Health, M.IT. and Eastman Co., 1920); *Health: Physiology: The Blood*, (Mass., U.S.: Department of Biology and Public Health, M.IT. and Eastman Co., c. 1929). [All films in this series can be found at the NAC, VI 8611-0020].

scientific criterion of authenticity. For those unfamiliar with microbiology, these symbols of science offered reassurance that scientists had both the skill and the technology to appreciate the significance of the otherwise alien creatures who lived beneath the microscope. Thus photomicroscopic images offered a realistic portrayal of germ cells which confirmed the specialized knowledge of science without unduly revealing the mysteries of their work.

The objective in showing photographs of microorganisms was most certainly educational; however, for many lay observers, the images may have seemed more mysterious than illuminating. For audiences who were unfamiliar with the world of microbiology, the images of cork-screw shaped spirochaetes, elongated tubercle bacilli, and oval shaped gonococci may have seemed closer to the abstract art of Joan Miró than to other living creatures in the natural world. Even the names of these germs sound alien. In a sense, these single cell organisms were reminiscent of the monsters of an earlier time. They were strange, apparently irrational, creatures who lived surreptitiously amongst humans, attacking without warning, feeding off human flesh. Although tiny, the microscope demonstrated that these microorganisms were pervasive. Their virtual invisibility simply made them seem more dangerous. Despite these attempts to introduce lay audiences to the real world of science, such images may have rendered the scientific world more foreign (figure 3.10).

Most public health literature employed a combination of photographic evidence and metaphoric caricatures. In film and radio productions, the mystery and danger of microbes was accentuated by the accompanying music. Radio dramas were especially

dependent on musical accompaniment to evoke an emotional response from their audience. Radio scripts also relied on colourful verbal descriptions to convey a sense of the awesome qualities of germs. In the Health League of Canada's 1935 radio drama, *Germs*, a young girl named Goldie, asks her mother, Ruth, to tell her "a story about germs." Ruth, who is also a practicing physician (an unusual occupation for a fictional wife and mother), attempts to explain:

> Well, darling, germs are like those awful goblins and gnomes you have seen so many pictures of in your fairy tale books, only they are much too tiny for us to see unless we look through a microscope, and then some of them are terrible to look at.... every time anyone is sick it is because some of those nasty little germs have been at work somewhere in their bodies.... When you get a cold, that's a germ that's popped into your nose or throat or gone down into your chest when you weren't looking and gets started to work.

Goldie is dutifully impressed with the story and asks her mother several questions. "But where do they come from?" she queries. "Almost anywhere," responds Ruth:

> You remember I wouldn't let you take that sliver out of your hand this morning with that old needle? Well, he [the germ] might have been on that needle, so we had to get a clean needle and put it in boiling water. But if he did get in and some of his naughty brothers and sisters came with him, there are thousands of good fairies in our blood stream to fight them right away.

"Real fairies in our blood?" Goldie asks in amazement. "They act like good fairies dear," explains Ruth, "They are not all shiny with wings like the fairies you know about, but they are wee little white cells and we call them white blood corpuscles and they fight with all

their might to kill the bad germs, but sometimes they are not strong enough and the germs win the battle and then you get very sick."[39]

Ruth's description of germs as "those awful goblins and gnomes" from fairy-tale books which are "terrible to look at" is certainly reminiscent of the microbe as monster trope. But unlike monsters, this portrayal of germs assumes a level of moral agency. Germs are constructed as mischievous tricksters who "popped into your nose and throat," who live on the tip of a needle, and whose army of "naughty brothers and sisters" battle the "good fairies" of the white blood cells. In this description, germs are not irrational monsters, but are a coordinated group of villians who consciously strategize about the best way to spread contagion. The story suggests that individuals must be equally clever if they are to defend themselves against these demonic microbes.

This description of health and disease is clearly overly simplified, and perhaps allowances should be made for the fact that the character of Ruth is explaining the "story of germs" to her young daughter. Nevertheless, it should also be remembered that this radio drama was written for an adult audience, not a group of preschoolers. Consequently, Goldie's childish questions should be considered as a substitute for the general ignorance of the radio audience. Goldie's mother, the knowledgeable physician, provides an explanation which is both simple and entertaining. She offers a modicum of instruction in microbiology, while advocating preventive medicine in terms that would be immediately familiar within contemporary popular culture: a classic struggle between good and evil.

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[39] *Germs*, (HLC: Canada, 1935), [NAC, MG 28, I-332, 128-17].

Many dramatizations of health and disease constructed similar story-lines. In the 1924 silent film, *Confessions of a Cold*, disease is represented by an evil sprite, who bares a striking resemblance to the devil as well as derogatory stereotypes of Jewish physiognomy. With the help of inter-titles, the sprite unburdens his soul to the viewing audience. He describes in simple detail all the different ways in which he spreads infection and the various ways in which humans can protect themselves. He boasts of the "Accomplishments of the Unbenevolent Order of Common Colds", which include keeping children out of school, undermining work-place efficiency by keeping workers off the job and stealing money out of the pockets of sick workers. Moreover, the Cold sprite tricks people into ignoring their cold symptoms, thus drawing them into "the depressing valley of serious illness" which includes influenza, sinus infection, tuberculosis, nasal infection, ear infection and pneumonia.[40]

Confessions of a Cold encouraged audiences to imagine germs in anthropomorphic terms which envisioned health and disease as a battle between good and evil forces. The Cold sprite repeatedly draws upon this metaphor. The sprite declares "... the battle cry of all colds is "Attack while the enemy is weak!" and "[t]he best defence is a good offense. Be healthy! Sleep enough and eat sensibly." A similar metaphor was constructed in the 1951 Walt Disney animation film, *How to Catch a Cold*. This film, which was aimed at both children and adults, portrays germs as huge masculine football players, whose size

[40] *Confessions of a Cold*, (USA, 1924), [NAC, V1 8208-096].

and offensive strategy easily outmanoeuvred the weakened defenses of the run-down human body.[41]

Other films and pamphlets, especially those that were produced during the 1940s, utilized similar war-like themes. In 1942, a poster entitled "War Brings Epidemics" showed a photographic image of a healthy young boy sitting in a field of daisies. Though the pictures seems pleasant, the boy looks anxious. In the distance, behind the child, storm clouds have gathered and the horizon is filled with the menacing shadows of armoured vehicles and uniformed soldiers. The poster implies that the future is bleak for those children who are not "protected against diphtheria, smallpox, whooping cough, scarlet fever."[42]

The American film, *Preventing the Spread of Disease* (1940), offers a similar visual allegory. The film opens in a darkened bedroom where a once vibrant young girl now lies listlessly in bed. The narrator solemnly intones; "Poor Barbara, what has happened to her that she lies there so hot and feverish, so miserable with suffering and pain? Her body is just like a little country that has been invaded by an enemy army." Suddenly the quiet bedroom scene is invaded by the superimposed figures of German soldiers who march across the still body of 'poor Barbara'. The narrator continues, "But the army in this case is not big soldiers. This invading army is so tiny it can be seen only through a microscope. Its soldiers are the germs of communicable disease." Here the scene cuts to a scientist looking through a microscope where we too see an enlargened

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[41] *How to Catch a Cold*, (Walt Disney: USA, 1951), [NAC V1 9712-0029].
[42] Poster: "War Brings Epidemics" (1942), [NAC, HLC, MG 28-I-332, Vol. 91, file 91-13, Toronto Toxoid Week, 1942].

image of a live multicellular organism.[43] The association of microbes with enemy armies is clear. In this rendition, germs are considered doubly frightening because they combine the sexually charged image of adult men attacking the body of a young girl with contemporary anxieties over Germany's aggressive fascist army.

Following in the tradition of the medieval Grim Reaper, the germs in these films and radio plays are portrayed in masculine terms. They are seen as soldiers, football players, gnomes, goblins, and sprites. Even when gender is not obvious from their physical description, germs are invariably designated with the pronoun "he". The masculine nature of germs was also asserted through the behavioural attributes which were ascribed to the germs. They are strong, clever, fierce and aggressive. As violence is generally understood as a male prerogative, germs can be recognized as masculine even when no other gender signifiers are apparent. The repeated analogies to war, crime and social chaos clearly links disease with the aggressive qualities that are traditionally associated with men.

The one notable exception to this typically masculine metaphor, concerns the germs of syphilis and gonorrhoea. Although women were equally susceptible to, and endangered by, venereal disease, public health literature most often associated the disease with the heterosexual misadventures of philandering men. Consequently, the germs of syphilis and gonorrhoea were typically caricatured in the form of an exotic temptress. Sometimes the disease took the form of a ghastly skeleton or withered hag who was tarted up in the lurid colours and revealing styles of contemporary prostitutes. More commonly,

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[43] *Preventing the Spread of Disease*, (USA, 1940), [NAC, V1 8208-097].

the germs were embodied in the figures of the glamorous young women who frequented night clubs, drank martinis, smoked filtered cigarettes and flirted with men (figure 3.11). According to the health literature, the sexual liberties offered by these women always came at a high price. In addition to the physical discomfort associated with venereal disease, men suffering from syphilis or gonorrhoea faced the humiliation of having to confess their sins to their physicians, wives and future sexual partners. If left untreated, the disease endangered men's progeny and would eventually erode their physical fitness, sexual virility and powers of reason. Few diseases could so effectively wither the essence of men's masculine identity. In packaging the disease in the form of a seductive woman, public health advocates simultaneously chastised men for their moral laxity and condemned the apparent sexual autonomy of modern young women.[44]

Whether they appeared as aggressive masculine bullies or alluring femme fatales, the power of germs to destroy the security of both the individuals and the state, was indeed impressive. An excerpt from the bulletin of the U.S. National Safety Council which was reprinted in a MLI pamphlet neatly encapsulates what many of the pamphlets, films and radio broadcasts asserted.

> WHO AM I?
> I am more powerful than the combined armies of the world.
> I have destroyed more men than all the wars of the nations.
> I am more deadly than bullets, and I have wrecked more homes than the mightiest of siege guns.
> I steal, in the United States alone, over $300,000,000 each year.

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[44] Jay Cassel, *The Secret Plague: Venereal Disease in Canada, 1838-1939*, (Toronto: University of Toronto Press, 1987): esp. 75-89; Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in The United States Since 1880*, (New York: Oxford University Press, 1987): esp. 23-37; Eric Schaefer, *Bold! Daring! Shocking! True!: A History of Exploitation Films, 1919-1959*, (Durham and London: Duke University Press, 1999): esp. 18-21; Lesley A. Hall, *Hidden Anxieties: Male Sexuality, 1900-1950*, (Cambridge: Polity Press, 1991): 32-39, 40-62.

I spare no one, and I find my victims among the rich and poor alike, the young and old, the strong and weak. Widows and orphans know me.
I loom up to such proportions that I cast my shadow over every field of labor, from the turning of the grindstone to the moving of every railroad train.
I massacre thousands upon thousands of wage earners a year.
I lurk in unseen places and do most of my work silently. You are warned against me but you heed not.
I am relentless.
I am everywhere -- in the house, on the streets, in the factory and at the railroad crossings and on the sea.
I bring sickness, degradation and death, and yet few seek to avoid me.
I destroy, crush or maim; I give nothing but take all.
I am your worst enemy.[45]

In other pamphlets, audiences were reminded that diphtheria is a "serious menace" capable of killing thousands of children.[46] Smallpox "...lurks about us, everywhere, ready to strike..."[47] and has been responsible for "... vast epidemics [which] disfigured and maimed literally millions of people."[48] Typhoid is described as "a very tiny and prolific germ with many legs," yet even "water as clear as crystal [and] milk as white as snow, may be literally teeming with millions of [these] murderous destroyers of life and health." It was said that "during the South African war, there were more deaths among the soldiers from enteric, which is another name for typhoid fever, than there were from bullets."[49]

The supernatural strength of the germs was rendered all the more incredible because they were so very small, thus suggesting that at least where microorganisms are concerned, it was not size, but numbers that really mattered. It was, in fact, the ability of

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[45] "The Health of Workers," (MLI: USA, 1919): [MLI, 0-HW-11]: 20.
[46] "Diphtheria Prevention," draft pamphlet (1935): [NAC, MG 28-I-332, Vol. 89, file 12].
[47] Radio HLC, "Let's Talk About Health - Smallpox" (c.1941-44) [NAC, MG 28-I-332, Vol. 129, file 2].
[48] Dr. Gordon Bates to Mrs. M.H. Purser re. virtues of innoculation, "The Home-maker" *Globe and Mail*, May 8th, 1943: [NAC, MG 28-I-332, vol. 90, file 2].

microbes to reproduce at an accelerated rate which accounted for the magnitude of their destructive power. In the HLC radio broadcast, *Germs or Bacterium* (1939/40), the narrator explained that "Bacteria increase in number by dividing in half thus forming two. After a time under suitable conditions of moisture and warmth, each of these two cells also divides and so the process continues... This division may take place as often as every half hour so you see that in 24 hours many millions of bacteria might result from the presence of one."[50] In *The Outlaw Within* (1951), NFB film makers employed a similar motif to describe the horrors of cancer. Starting with one seemingly innocuous white blood cell, graphic animation demonstrated the process of mitosis. As the cells began to divide more rapidly, the musical accompaniment became increasingly discordant. In case audiences failed to appreciate the horror of what they were witnessing, an ominous sounding narrator, offered his own colourful description of the dreadful scene:

> Sometimes something happens to start [the cells] growing... Uncontrolled, dividing and multiplying without plan or reason -- outlaws -- breaking all the rules of the body of which they are a part -- they grow and grow. They multiply beyond all normality, invading healthy tissues, healthy organs, growing, spreading throughout the body to start new destructive colonies.[51]

The scene bears a striking similarity to a scene from *Fantasia*'s "The Scorcerer's Apprentice" (1940) in which Mickey Mouse is overwhelmed by the rapid regeneration of menacing brooms. In both films, the horror of the scene is premised on the loss of productive control and the militant efficiency of evil. No doubt such scenes had particular

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[49] HLC radio broadcast #3: "Typhoid - the Preventable Disease" (HLC: 1934/5): [NAC, MG 28-I-332, vol. 128, file 17].
[50] *Germs or Bacteria*, (HLC: 1939/40): [NAC, MG 28-I-332, vol. 129, file 1].

resonance for those viewers who had so recently survived the Great Depression (which was caused, in part, by the overproduction of consumer products) and the Second World War (which was caused, in part, by the overproduction of European fascists).

Even without the eerie music and dire warnings of narrators, the multiplication of microbes and white blood cells conjures up a military image. The reproduction of identical germ cells presents an impression of uniformity that is efficiently working towards a particular end. This helps to explain the destructive power of minuscule microbes. By banding together and working in unison, germs were able to attack unsuspecting individuals with the same swift and deadly force as the German army. Militaristic references offered script writers and graphic artists an enduring metaphor for twentieth century audiences. In constructing germs as an enemy army, audiences could quickly recognize the imminent threat posed by contagious diseases. The experience of two world wars in which propaganda demanded the united participation of both recruits and civilians also encouraged public health recipients to adopt a more dynamic approach to disease prevention. If disease was an enemy army comprised of millions of destructive germs, then individuals had to do their part to prevent contagion and to fight infection when it occurred. As one pamphlet implored in 1937: "Canadians have shown how they can fight against a human foe. Disease is in our midst -- a far more dangerous enemy. In organizing to fight it, we have everything to gain and nothing to lose."[52] The RCAF film,

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[51] *The Outlaw Within*, (NFB: Can, 1951): [NAC: VI 9712-0033].

[52] "Health Conservation: A National and Economic Necessity." (HLC: 1937): [NAC, MG 28-I-332, Vol. 146: file VD survey of Toronto]. Given the publication date on this pamphlet, the reference to Canada's fighting mettle probably pertained to Canada's participation in WWI, or perhaps the Spanish Civil War which was then in progress.

For Your Information (c. 1942), made a similar appeal to its female audience. "In order to win this war we must not only fight our enemy on the battle fronts, but also on the home front. We have to fight not only a visible foe, but also an invisible one. This is not an enemy in the form of troops, tanks or guns, but it is an enemy destructive and dangerous to our war effort. This enemy which we all face is venereal disease."[53]

This same type of military metaphor was used to explain the human immune system. As the narrator instructed in an untitled HLC radio broadcast about diphtheria;

> [T]hose germs which attack the human body constitute invading armies of different kinds of extremely minute and very simply constituted living creatures.... Whenever they attack us a battle ensues between the army of defending soldiers which our body maintains in its bloodstream and the invading disease germs.... When the defending army of the blood fights the invading army of disease, the life of the patient hangs in the balance. If the bloodstream army wins the patient recovers; if the invading disease army wins, the patient dies.[54]

Far from being irrational monsters, the germs in this scenario are highly structured and efficient. The ultimate defeat of the invading germs is only obtainable via an equally well-coordinated immune system.

In some films and pamphlets, the military metaphor was emphasized through the graphic use of repetitious pictograms. Occasionally, the pictographic designs used drawings of actual soldiers to represent the armies of infectious diseases. More commonly, the drawings used repetitious images to give a sense of regimentation. A wonderful example of this can be seen in the MLI pamphlet *A Four Point Plan* (1944).

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[53] This film concerned the prevention and treatment of venereal disease in women and was intended exclusively for female audiences. *For Your Information*, (Can., RCAF, c. 1942). [NAC, 13-0061].

The booklet uses multiple pictographic symbols to convey visually the morbidity and mortality rates of childhood intestinal diseases, infectious diseases, puerperal fever, diphtheria, appendicitis, pneumonia, and influenza. The militaristic uniformity of the images suggests that the strength of these diseases lies in the multiplicity of the germs and the efficient manner in which they attacked an individual's immune system (figure 3.12). Other images showed drawings of hospitals, hospital beds, children's faces, skeletons, dead babies, and pneumococcus bacterium to communicate a sense of the ominous severity of the problem of communicable disease (figures 3.13 and 3.14).[55]

Interestingly, the booklet used the same pictographic formula to represent the forces of health. In *A Four Point Plan* an army comprised of health educators, safety engineers, statisticians, housewives, nurses, home economists, social workers, doctors industrial leaders, school administrators and public health officials are portrayed as a united front (figure 3.15). Each group wears its own professional uniform, but they all march together as an allied army. Other images in the same pamphlet show a line of public health nurses standing at attention and rows of citizens watching educational films.[56] The uniformity of these simple images closely mirrors the images of germs and diseases which are portrayed elsewhere in the pamphlet. The implication would seem to be that the best way to defeat the organized armies of disease was via the coordinated armies of science.

To differentiate between the increasingly similar icons of health and disease, pictographic images were colour coded. White icons signaled health. Black icons

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[54] Radio Talk No. 7, HLC (NAC, MG 28-I-332, Vol. 90, file 90-7: "Diptheria. Talks/Papers, 1932-1936"].

[55] "A Four Point Plan" MLI pamphlet (MLI: US, c. 1944): [MLI, 1944-HW-01]: p. 11 & 15

represented death and disease. The racial implications of identifying germs with 'blackness' should not be dismissed as a simple method of codification. Amongst Judeo-Christian cultures whiteness has long been associated with innocence, purity and goodness, just as the evils of ignorance, crime and disease have been symbolized by references to darkness. In the first half of the twentieth century, linguistic metaphors which linked goodness with whiteness and evil with darkness were frequently used to define the racial differences between white Anglo-Saxons and non-white Africans and Asians. Popular social hygiene books such as *Light on Dark Corners: Searchlight on Health* (1894) by B.G. Jefferies and J.L. Nichols', *In Darkest England and the Way Out* (1890) by Charles Booth (founder of the Salvation Army), and *The Black Candle* (1922) by Emily Murphy (Canada's first woman magistrate), ensured that the allegories of goodness and light, darkness and evil became common themes in the contemporary parlance of social hygiene.[57]

The metaphorical association between the darkness of disease and the darkness of non-white people was strengthened by statistical surveys which linked foreign germs with

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[56] Ibid.

[57] B.G. Jefferis and J.L. Nichols, *Light on Dark Corners: Searchlight on Health*, (Naperville, Ill. J.L. Nichols, 1894) and its revised version, *Safe Counsel or Practical Eugenics*, (Chicago, Ill.: D.S. Kent Co., 1927); Charles Booth, *In Darkest England and the Way Out*, (London: Salvation Army, 1890); Emily Murphy, *The Black Candle*, (Toronto: T. Allen, 1922); Other books which relied on light and dark metaphors to describe the so-called 'social evils' of prostitution, delinquency, crime, disease and eugenic deterioration include, Ernest A. Bell, *Fighting the Traffic in Your Girls*, (U.S.: G.S. Ball, 1910); A.W. Beall, *The Living Temple: A Manual on Eugenics for Parents and Teachers*, (Whitby, Ont.: A.B. Penhale, 1933); Dr. Mary Wood-Allen, *What a Young Girl Ought to Know*, (Philadelphia, PA: J.C. Winston, 1897); Historians who have examined the message and metaphors of early twentieth purity literature include; Mariana Valverde, *The Age of Light, Soap and Water: Moral Reform in English Canada, 1885-1925*, (Toronto: McClelland and Stewart, 1991): 34-43; Anne McClintock, *Imperial Leather: Race, Gender and Sexuality in the Colonial Contest*, (London: Routledge, 1995): 31-36, 207-231; Michael Bliss, "Pure Books on Avoided Subjects: Pre-Freudian Sexual Ideas in Canada," Canadian Historical Association, *Historical Papers*, (1979): 89-108.

foreign-looking people. Moreover, the association was not purely linguistic. As noted in Chapter 1, the federal government was anxious to defend Canada's borders against immigrant applicants who harboured undesirable germs. Such policies, however necessary from a public health perspective, added fodder to the fiery imagination of xenophobic North Americans who already perceived immigrants, especially those from the non-preferred countries of Asia, Southern Europe and Eastern Europe, as a dangerous menace.[58]

Despite the anti-immigrant apprehensions of the Department of Health and Dominion Council of Health, few of the government's films, pamphlets or radio dramas made overt links between germs and racial difference. Most literature employed the more subtle techniques of black and white pictograms, or the appearance of foreign-looking diseased patients to convey a sense of the foreignness of germs. Two important exceptions include the films *Confessions of a Cold* (1924) and *The Road to Health* (c. 1936). In addition to its Jewish-looking cold sprite, *Confessions of a Cold* also employs an overall-clad black man to represent the dangers of health ignorance. The scene shows the disheveled young man offering health advice to a well dressed young white woman who suffers from a mild cold. The cold sprite gleefully warns: "Don't pay any heed to the advice of persons whose actual medical knowledge is zero or less." The sprite explains that such advice can lead to a further deterioration of health and a higher risk of

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[58] Alan M. Kraut, *Silent Travelers: Germs, Genes, and the "Immigrant Menace,"* (Baltimore and London: The Johns Hopkins University Press, 1994); Robert N. Proctor, *The Nazi War on Cancer*, (Princeton, N.J.: Princeton University Press, 1999); Donald Avery, *"Dangerous Foreigners": European Immigrant Workers and Labour Radicalism in Canada, 1896-1932*, (Toronto: McClelland and Stewart, 1979); Irving Abella, *None is Too Many: Canada and the Jews of Europe, 1933-1948*, (Toronto: Lester

complications.[59] Although the film's health advice seemed sensible, it was the use of visual allegories which made the film memorable. In contrasting the vulnerability of a young white woman to the devious machinations of a Jewish devil and an ignorant black man, the film relied on pre-existing social and racial stereotypes which would have been eminently familiar to contemporary viewers.[60]

The second film to make overt use of racialized images was the 1936 British film, *The Road to Health*. In this black and white animated film, viewers were introduced to the dangers of venereal disease and the various public and private agencies which were helping to prevent and treat the disease. In simple animation, the film shows large numbers of busy men and women walking along a road labeled "health". On the horizon are the bright pastoral homes of a middle class community. In the foreground are several crooked side roads labeled "Prostitution [and] Immorality," "Delinquency," and "Drink [and] Broken Homes." Periodically, women and men are shown leaving the 'road to health' and wandering down these side roads towards the shadowy area marked "Venereal Disease." On closer inspection "Venereal Disease" is shown to be a gloomy jungle where the stooped bodies of dark-skinned figures languish in perpetuity. Fortunately, hope and health eventually arrive in the form of a statuesque white man who holds the "Torch of Knowledge." The torch dispels the darkness revealing a large Romanesque bridge. The pillars of the bridge which are labeled "Government," and "Local Authorities," support several arches entitled, "Laboratories," "Treatment Centres," "Institutions and Homes,"

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and Orpen Dennys, 1982); Barbara Ann Roberts, *Whence They Came: Deportation in Canada, 1900-1935*, (Ottawa: University of Ottawa Press, 1988).

[59] *Confessions of a Cold*, (USA, 1924).

"Nurses, Doctors, and Almoners." From on top of the bridge, the Aryan man, who held the torch, blows his trumpet which is heard by the dejected people who populate the venereal jungle. The people follow the sound of the trumpet; their path lit by the "Torch of Knowledge." As the men and women leave the jungle, their dark skin returns to white and they resume their place along the bright (and white) road of health. Now the entrance to each of the crooked side roads is blocked by hazard signs and four impressive white statues entitled "Stable Families," "Early Marriages," "Emotional Control," and "Knowledge of Life Sciences."[61] (figures 3.16 and 3.17).

Although the film is limited to black and white images, the selection of colour-coded images clearly relies on racialized metaphors. Health is represented by whiteness: white roads, white statues, white bridges, white people. Knowledge is perceived as a torch which brightens and whitens all who are touched by its light. The use of classical motifs for the statues, bridges and the torch carrying, toga-wearing man clearly links these figures, and the institutions they represent, to the very foundations of Western Civilization. Inspiration for *The Road to Health*, was likely derived, in part, from the international spectacle of Germany's Olympic Games in which the associations between health and athleticism, whiteness and civilization, were so visibly celebrated. In contrast to these bright images, disease and its victims were clouded in darkness. The jungle was chaotic and forbidding. The people within it were listless, dejected and black. The film's use of space is also interesting. In placing the bright pastoral town above the dark venereal

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[60] For a critical analysis of Jewish physignomy see, Sander Gilman, *The Jew's Body*, (New York & London: Routlege, 1991): esp. 169-193.
[61] *The Road to Health*, film (UK, c.1936). [NAC, V1 9712-0025].

jungle, the film created a spatial hierarchy which privileged the man-made institutions of western civilization over the primitive and chaotic elements of nature.

The use of black and white images in films and pictograms is significant, but it would be a mistake to dismiss the films as purely racist propaganda. In an era filled with derogatory stereotypes of monkey-faced Africans, opium smoking Asians, and garlic-eating Italians, there can be little doubt that the above mentioned health films could have been much more explicit in their racism. Instead, the colour-coded metaphors of goodness and light, evil and darkness were used to construct a hierarchy of difference which was already well established in the existing culture. Disease became metaphorically linked to all that was dark and evil in society, joining other social groups who had also been relegated as outside the pale. In one sense, this is just another rendition of the microbes as monster analogy, except here the metaphor has been drawn from more contemporary anxieties concerning dangerous foreigners and racial 'others'.[62]

This racialized interpretation of disease clearly resonated with twentieth century audiences, some of whom seemed to find it difficult to distinguish between fact and fiction in the discourse of disease. For instance, in the winter of 1922, medical students from the University of Laval brought the semiotic language of microbiology to the streets when they masqueraded as members of the Ku Klux Klan to raise awareness about the dangers of tuberculosis. The students wore white hoods on their heads and marked the double

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[62] Catherine Carstairs, "Deporting 'Ah Sin' to Save the White Race: Moral Panic, Racialization, and the Extension of Canadian Drug Laws in the 1920s," *Canadian Bulletin of Medical History*, Vol. 16, no. 1, (1999): 65-88; Daniel J. Malleck, "Its Baneful Influences are Too Well Known': Debates over Drug Use in Canada, 1867-1908," *Canadian Bullentin of the Medical History*, Vol. 14, no. 2, (1997): 263-288; Anne McClintock, *Imperial Leather: Race, Gender and Sexuality in the Colonial Contest*, (New York: Routledge, , 1995): 104-111, 214-219.

cross insignia of the Tuberculosis Association on their white lab coats. They paraded a human effigy hanging from a scaffolding and carry a life size coffin. Their placards declared, "La Tuberculoise Condemnee a Mort" and the side of the coffin stated, "On vendra des timbres pour l'enterrer." Clearly, the lynched dummy was meant to represent tuberculosis, not a racial category. But, in a period which constructed disease as an epiphenomenon of ethnic difference, the Laval medical students were able to draw an easy parallel between their campaign to extirpate tuberculosis with the Klan's efforts to eradicate foreigners.[63]

In the postwar, post-holocaust era, fear of racial and ethnic diversity seemed to dissipate, at least as far as the Canadian public health literature was concerned. Many of the most virulent infectious diseases had also begun to disappear thanks to mandatory vaccination programmes, the introduction of antibiotics (especially penicillin in 1941), the standardization of food and water safety codes and an overall rise in the standard of living. With the dangers posed by invading foreign microbes largely under control, public health advocates began to look inwards, at the diseases which originated from within the victim's body: namely cancer and mental illness. Unlike contagious diseases, cancer and mental illness are not ailments which patients catch, but are illnesses which patients unwittingly produce. Moreover, the symptoms of these ailments are largely invisible. Only patients who were suffering from the acute stages of these disorders were likely to be outwardly marked by the symptoms of their disease. Thus, like the communists and homosexuals who formed an invisible, and largely imaginary, fifth column within the

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[63] New Item: "Anti-TB Demonstration" (c. 1922): [NAC, V1 8902-0072].

nation state, cancer and mental illness were imagined as a form of physiological sedition which destroyed what was healthy and perverted what was normal.

As with its prewar literature, postwar public health advocates constructed their biological metaphors out of contemporary themes. In the critically acclaimed NFB documentary *The Outlaw Within* (mentioned earlier in this chapter), cancer is described as a renegade cell who "breaks all the rules" and refuses to conform to the activities of other normal cells. [64] The "outlaw" cell eventually leaves the confines of its starting point and spreads throughout the body, "to start new destructive cells." The film accompanies a single scientist as he doggedly searches for the origins of the disease. Alone in a darkened laboratory, the tired oncologist is seen looking at slides of enlargened cells. Slowly the cellular images begin to grow, enveloping both the laboratory and the researcher. Soon viewers are being transported through a dark and alien cosmos, where eerie discordant music leaves little doubt as to the awesome and ominous nature of this microscopic universe. The journey is accompanied by an authoritative narrator who reinforces the wonders of what viewers are witnessing.

> This microscopic unit of life, so small the naked eye cannot see it, is an immense and complex universe to be explored. Science is piercing deep into this universe. Discovering within it new constellations, exploring its nature and its force. Every avenue of research is converging on the secrets of the cell because here, in this pinpoint world so vast and challenging to the imagination, is locked the mystery of life and the riddle of cancer.[65]

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[64] *The Outlaw Within* (an abridged version of *Challenge: Science Against Cancer*) won top honours at the New York competition of the Associated Film Writers and the International Film Festival in Venice. It was nominated for an Academy Award for best documentary in 1951.

[65] This dialogue is taken from the abridged version of *Challenge: Science Against Cancer*. See, *Canada Carries On: The Outlaw Within*, (Prod. Guy Glover, Dir. Morton Parker, Can.: NFB, 1951), [NAC, VI 9712-0033].

The images accompanying this dialogue were indeed impressive. An information package compiled by the Information Services Division [ISD] of the Canadian Department of National Health and Welfare [DNHW] boasted that the film's outstanding animation sequences were created by a team of medical artists, who spent several months constructing "thousands of detailed anatomical drawings." The package explains that the artists used an "aerosol process" to create the impression of flying through a multidimensional subcellular space. The information sheet explains;

> A drop of some paint-like substance was let fall onto a flat sheet of liquid. The camera then recorded the strange and beautiful diffusion of patterns. No artist could have created such awesome movement. It was ideal for suggesting the mysterious laws of matter, those forces of nature which govern the sub-microscopic depths of the living cell as well as the astronomical furies of the sun's corona.[66]

This blending of art and science leaves viewers with the distinct impression that the microscopic world is as much metaphysical as biological. The alien forms which inhabited this cellular universe were rendered all the more disturbing because everything was equally bizarre, making it impossible to differentiate between the healthy cells and the diseased ones. Even more distressing was the fact that this entire universe, including the cancerous outlaws, lurked invisibly within the very fabric of the body.

Mental health films and radio broadcasts were, if anything, more successful in their ability to unsettle audiences with the 'creepiness' of mental disease. The questioning titles of films such as *Who is My Neighbour?* (1946), *Who is Sylvia?* (1957), *What's On Your Mind?* (1947), and radio dramas such as the *In Search of Mental Health* series suggested

that mental illness was not always easy to identify. The invisibility of the disorder was further emphasized by the seemingly normal appearance and demeanor of those who suffered from the affliction. For instance, Margaret, the central protagonist in the NFB documentary, *The Feeling of Rejection* (1947), was described simply as a "quiet competent girl". Margaret, however, turned out to be suffering from a debilitating neurosis which prevented her from developing 'normal' social relationships.[67] Similarly, Anne, the main character from the film *Breakdown* (1951) was introduced as "a healthy normal girl." Anne's friends, family, neighbours and co-workers considered her to be a responsible adult who was perfectly sane -- right up until the point where she started hearing voices and making mud pies in the backyard of her parent's home (figure 3.18).[68]

Ten-year-old, Sheila Marshall was also presumed to be completely normal. "Sheila?" exclaimed her mother, "of course nothing's wrong!... I brought her up to be well behaved and quiet and obedient and nice... I know Sheila's just a lovely little girl!" Sheila's teacher would seem to agree. "She's always so quiet" explains the teacher, "She does what she's told. She hands in her work. She does everything just right. A model pupil." Upon further investigation, however, it becomes apparent that Sheila's outwardly 'normal' demeanor hides an inwardly troubled child. Sheila turns out to be painfully shy. Her only friends consist of a box of buttons whom Sheila thinks of as playmates. The narrator explains that Sheila's seemingly "nice" parents have undermined her self-confidence with "harshness and discouragement" with the result that Sheila has learned to

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[66] This information package was distributed to members of the press during the premiere of *Challenge: Science Against Cancer*. March 1951. [NFB #7, 02-130].
[67] *The Feeling of Rejection*, (Can.: NFB & DNHW, 1947).

"retreat, submit, do whatever's asked -- anything to avoid trouble." "An unhealthy habit it is," warns the narrator, "an unhealthy way to adjust to the difficulties of living."[69]

No doubt the appeal of these documentaries can be partly attributed to the post-war enthusiasm for melodramas and psycho-thrillers such as *Now Voyager* (1942), *Spellbound* (1945), *The Men* (1950), *Three Faces of Eve*, (1957) and of course *Psycho* (1960). While Hollywood film-makers were clearly inspired by the emergence of psycho-theory, documentary film-makers and radio dramatists found creative inspiration in the fictional characters and story-lines of popular films. Several of the films and radio plays discussed here and in the next few chapters bare a striking resemblence to other mainstream dramas. Shy Sheila and her buttons is not unlike Laura from the Tennessee William's play, *The Glass Menagerie* (1944). Margaret's character, from the *The Feeling of Rejection* (1947), is similar to the role played the following year by Oliva de Havilland in the Oscar winning film, *The Snake Pit* (1948). In fact, these two films were sufficiently alike that a psychiatrist at Liken State Hospital in the United States ordered both films from the NFB distribution office thinking that they were both part of the NFB's Mental Mechanisms series.[70] The popularity of these dramas demonstrates the era's penchant for self-reflective introspection, and illustrates its uneasiness with the chaos of emotions which lie beneath even the most benign exterior.[71]

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[68] *Breakdown* (Can.: NFB and DNHW, 1951). [NAC, V2 8205-0034].
[69] *The Girl by the Door*, (written by Rita Greer, Prod. Esa W. Young: CBC, 1953), [NAC, R-11012].
[70] NFB, "The Feeling of Hostility: A Report on the Distribution, Promotion, Utilization and Reception of the Film," Ottawa, July 1950: 23. [NFB archives, file 07-103].
[71] For a discussion of the infiltration of Freud on popular culture see, Stephen Farber and Marc Green, *Hollywood on the Couch: A Candid Look at the Overheated Love Affair between Psychiatrists and Moviemakers*, (New York: William Morrow, 1993); also Nathan G. Hale, Jr., *The Rise and Crisis of*

Towards the end of the 1950s, the sense that disease was a nebulous entity which lived invisibly within the bodies of seemingly healthy individuals, became a common theme in much of the health literature. The National Tuberculosis Association deliberately played with these themes in several of their films. In *Are You Positive?* (1957), audiences are encouraged to mistrust their ability to detect tuberculosis in themselves and in others. The narrator insists that people with tuberculosis cannot be identified just by looking at them. Moreover, the disease itself is indifferent to age, sex, race and class. "TB's target is anyone and everyone," states the narrator. To emphasize his point, the narrator demands, "Look to your right. Look to your left. Look to yourself. If you're a typical audience, one out of every three of you is tuberculin positive." During this dialogue a white circle is shown on the black screen. The white circle is joined by two other circles: one yellow, one brown. But unlike the colour-coded images from earlier literature these symbols of difference are not proof of disease, they are only proof that the disease could truly be anywhere. As the white circle resumes its random search for diseased persons, it briefly lights up the face of a brown-skinned woman. "One!" declares the narrator. Next the white circle illuminates the face of a brown-skinned man. "Two!" announces the narrator. But the white circle continues its search. At last the spot stops and grows larger as though moving towards the viewer. "Three!" exclaims the narrator, "You! Wherever you are, may be tuberculin positive!" Finally, just when viewers are ready to distrust the health of all those around them, the narrator switches tactics by asking the audience to

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Psychoanalysis in the United States: Freud and the Americans, 1917-1985, (New York: Oxford University Press, 1995): esp. 276-299.

second-guess their own apparent good health. "Feel wonderful?" he asks, "Confident in your health? How do you know? Can you afford not to know? -- Are you positive?"

In 1961, the American film, *Merry-Go-Round*, asked similarly unsettling questions. In this Kafkaesque health film, a tired middle-aged woman doctor works against time, vainly pleading with her patients and the various health authorities to take the problem of tuberculosis seriously. She explains that one in five Americans harbour the deadly disease. "Who has it?" she wonders. In response to her question the audience is shown images of people who are young and old, rich and poor, male and female, black and white. The doctor's desperate search is mocked by the repeated images of a young girl who joylessly sings;

Here we go round the mulberry bush,
the mulberry bush,
the mulberry bush.
Here we go round the mulberry bush,
And the next one out...
is you!

In the film's final scene, the girl's song ends abruptly. The music stops. The lights go out. But for the audience, the answer remains a mystery. Who has tuberculosis? Is it the doctor? the girl? us? In failing to identify the location of the disease, the audience is forced to conclude that the disease could be anywhere, within anyone.[72]

The ability of disease to hide within the unsuspecting bodies of even the most innocuous individuals conveniently mirrored contemporary anxieties over the possibility that communist spies and sexual predators walked invisibly among the citizenry. In 1959,

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[72] *Merry-Go-Round* (USA, TBA, 1961), [NAC, V1 8506-0123].

a CBC television documentary entitled *The Unseen Enemy*, went so far as to suggest that some diseases could be deliberately spread by enemy agents. The programme focused on an outbreak of Asian flu which occurred in Don Mills, Ontario in the summer of 1957. The film showed pictures of apparently healthy white children splashing around in a backyard wadding pool. The wholesomeness of this suburban scene is disturbed by the narrator's caution. "At this moment," warned the narrator, "these children happily playing in the summer sun are becoming the victims of an unseen enemy. Some of them will defeat this enemy -- some of them will not." According to the documentary, the virus originated in Asia, but it soon spread to India, Russia, Africa, and South America before arriving in the United States and Canada. "How did the virus get into Don Mills in the first place?" asks the narrator. "This is a sub-division in an upper middle class area," he protests, "and is not the sort of place one would expect to find epidemic virus diseases." The narrator explains that the virus was brought to Don Mills by local business executives who had been traveling in South Africa. The invisibility of the disease and the appearance of middle class respectability masked the dangers which threatened the health and safety of the community. While there was no suggestion that the disease was spread deliberately, the narrator raised the specter of sedition, when he suggested in his conclusion that disease is an ideal means of infiltrating a country and paralyzing its defences. "You can see how a deliberate infection by an enemy would be a terrible weapon of war," states the narrator.

> In addition to natural epidemics we can also be faced with attempts by an enemy to use the weapons of biological warfare. Infected persons sent into an area, disease caring insects, aerosol sprays and water contamination are only a few of the ways of infecting human beings and their animals and

> crops. These are problems that the government and civil defense personal are constantly on the alert to meet... The unseen enemy still remains one of medical science's biggest challenges.[73]

Conclusion:

Like the older images of serpents, dragons, and grim reapers, twentieth century pictures of disease represent an amalgamation of popular knowledge about disease and contemporary anxieties about illness. Even as lay audiences came to accept the scientific interpretation of disease, fears about the pain, suffering and helplessness associated with illness continued to colour how disease was portrayed. Moreover, because disease can never be entirely divorced from the social environment which creates and sustains it, metaphors of health and disease tend to be culturally specific. In the 1920s and 1930s, North Americans were torn between a variety of conflicting desires. On the one hand they were impressed by the emerging urban culture and were intrigued by the sights, sounds and tastes of imported foreign cultures. On the other hand, they were disturbed by the faster pace of urban life, by the loss of traditional moral values and by the visible expansion of racial and ethnic diversity within the population. These anxieties were represented in public health literature through images which portrayed germs as exotic women, bizarre foreign agents, aggressive masculine thugs and various other dark forces.

In the 1940s, the war in Europe and Japan presented public health illustrators with an obvious metaphor to describe the microbiotic battles which took place between

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[73] *Explorations: Unseen Enemy*, (Can.: CBC television, July 30th, 1959), [NAC, V1 8501-026]

invading foreign germ cells and defensive white blood cells. Throughout the prewar and wartime period, germs were understood as a distinct foreign threat. They were imagined to be infinitesimally small monsters whose highly organized strategies of attack could cause chaos in the bodies of anyone who allowed their own internal defense mechanisms to become tired, feeble and disorganized. By the end of the war, the visible threat posed by enemy armies and landed immigrants was supplanted by a belief that the more insidious threat to national security was the one caused by social, sexual and political non-conformity. Anxieties over this amorphous threat to the body politic were reproduced in public health literature in the form of nebulous germs cells who invisibly infiltrated the bodies of unsuspecting citizens and immobilized their natural defences.

Although the specific nature of disease changed over time, certain common themes remained. Whether germs were imagined as burly German soldiers or obscure microscopic cells, all of the images were framed within a modernist construct in which small things loomed large, the strong and rational grew weak and feeble, and the appearance of order was no guarantee against the production of chaos. Still, despite this evidence of modernist angst, public health literature maintained a persistent confidence in the ability of doctors, scientists and even lay individuals to overcome disease and achieve health.

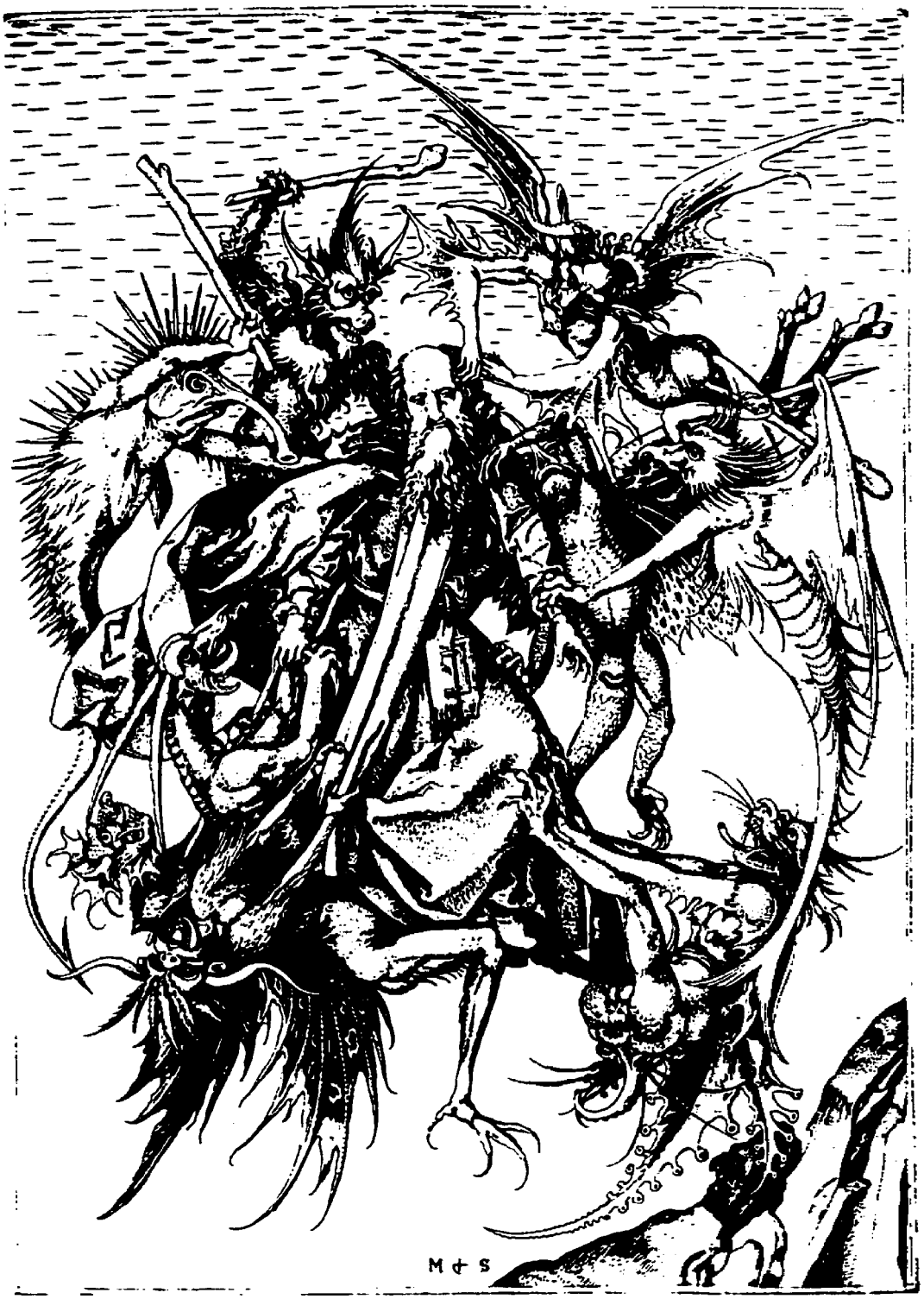

Figure 3.1 - "The Tribulations of Saint Anthony" (c. 1470-75), by Martin Schongauer

Figure 3.2 - "Ague and Fever" (c. 1792), by Thomas Rowlandson

Figure 3.3 - "The Sleep of Reason Produces Monsters" (1797-1798)
by Francisco José de Goya

Figure 3.4 - "The Gout" (c. 1799), by James Gillray

Figure 3.5 - "The Cholic" (1819), by George Cruikshank

Figure 3.6 - "The Headache" (c. 1819), by George Cruikshank

Figure 3.7 - "Thames Water" (c. 1828), by William Heath

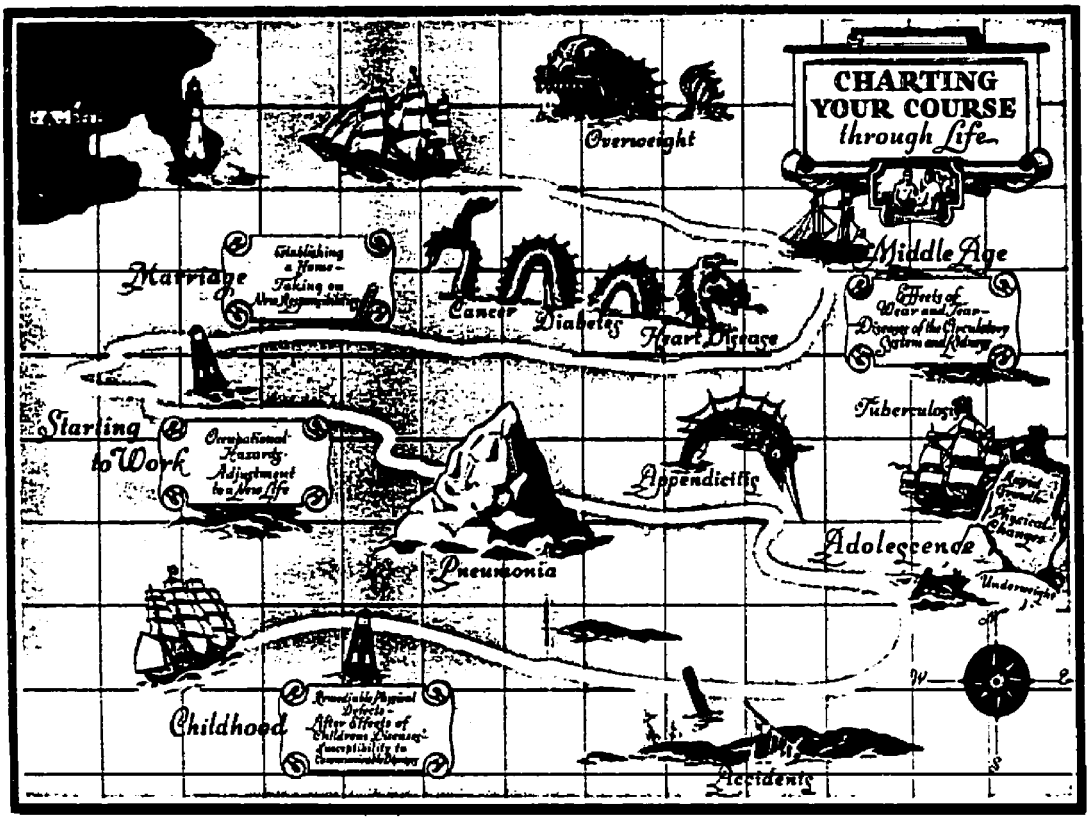

Figure 3.8 - "Charting Your Course Through Life" (c. 1920). *Taking Your Bearings*, (MLI pamphlet, c. 1920).

Figure 3.9 - "He Stoppeth One in Three" (CSHC pamphlet: c. 1930).

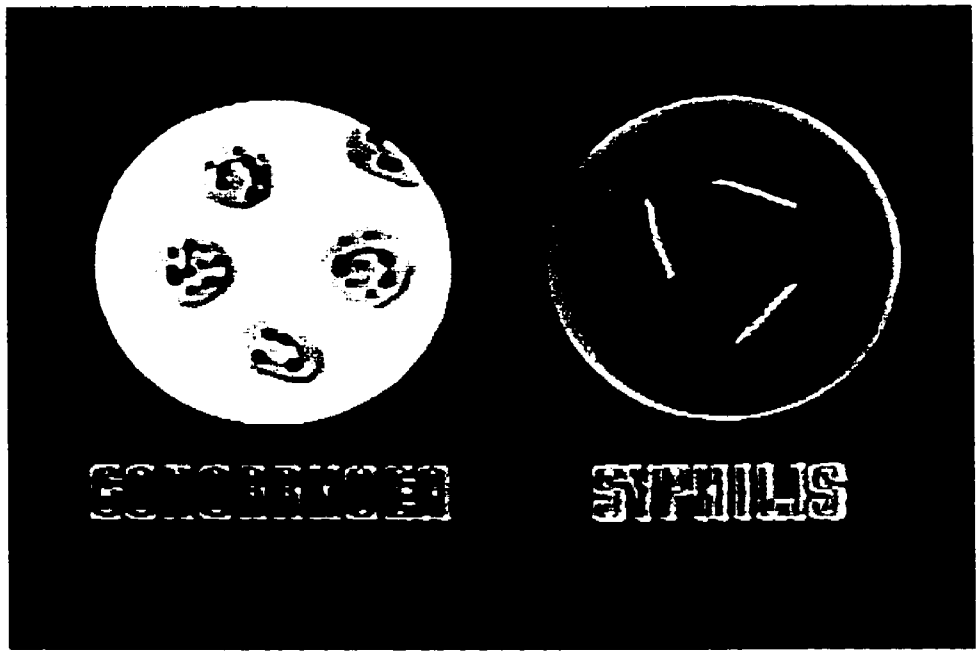

Figure 3.10 - Graphic representations of the germs of venereal disease, from the film, *Very Dangerous*, (NFB, 1945). On the left are the oval shaped gonococcae of gonorrhoea. On the right are the cork-screw shaped spirochaetes of Syphilis.

Figure 3.11 - A symbol of venereal disease, the exotic, orientalized woman awaits her next victim. *Very Dangerous*, (NFB, 1945).

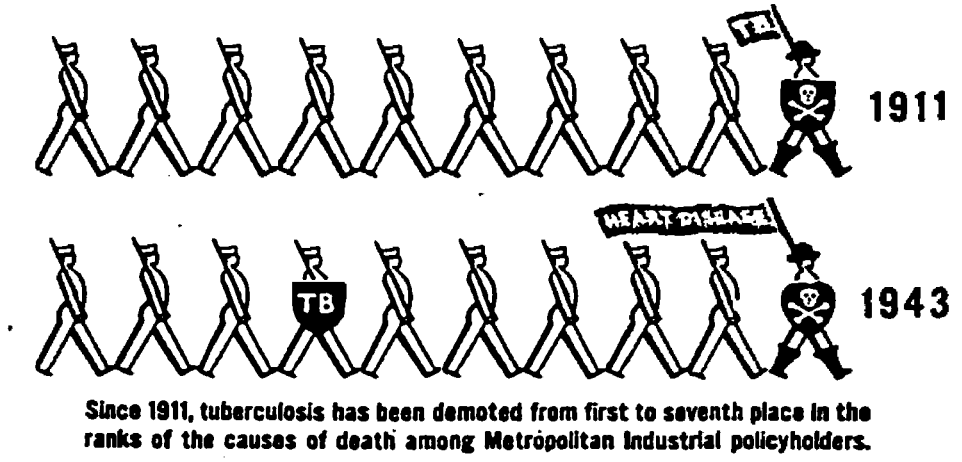

Figure 3.12 - The uniform efficiency and destructiveness of Tuberculosis (above) and Heart Disease (below), are rendered as marching soldiers. *A Four Point Plan*, (MLI pamphlet, 1944).

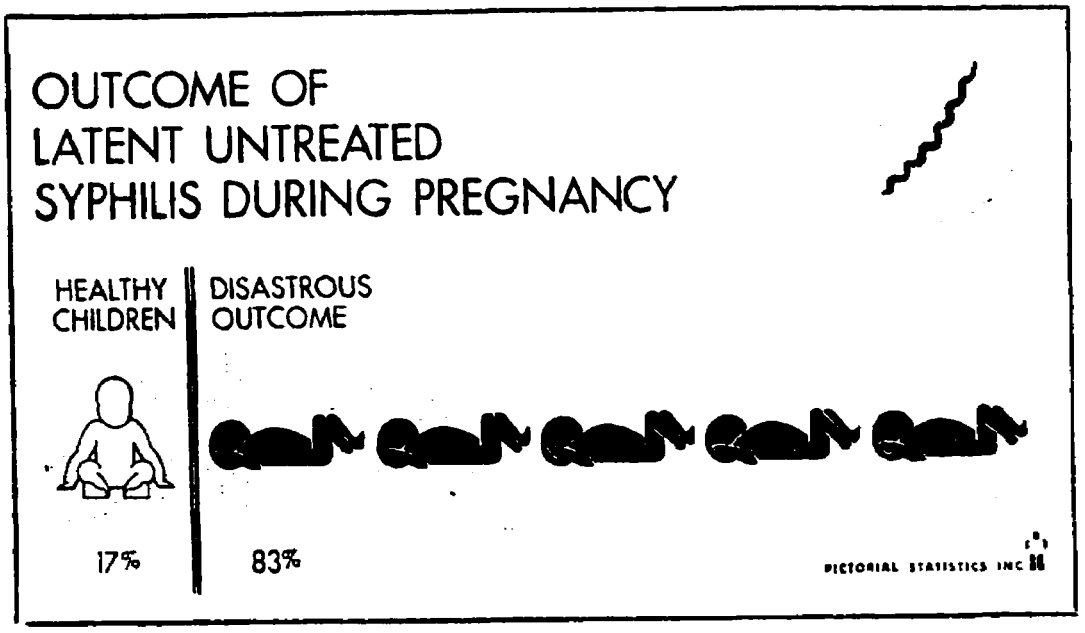

Figure 3.13 - The uniformity of the disease is rendered more aggressive by its ability to kill infants. *Stamp Out Syphilis!* (HLC, pamphlet: Survey Graphic, July 1936).

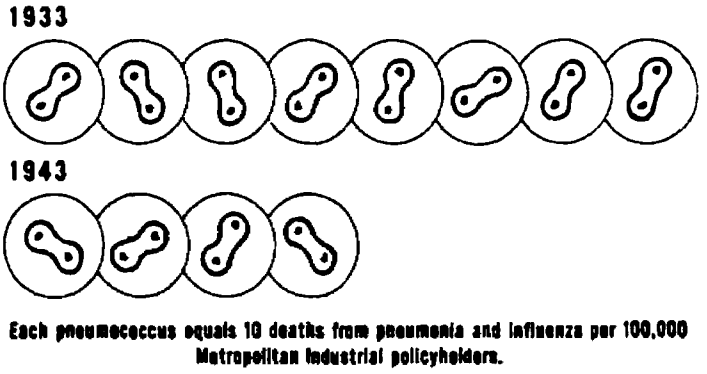

Figure 3.14 - Germs of pneumonia and influenza are represented by the repeated images of stylized pneumococcus. *A Four Point Plan*, (MLI pamphlet, 1944).

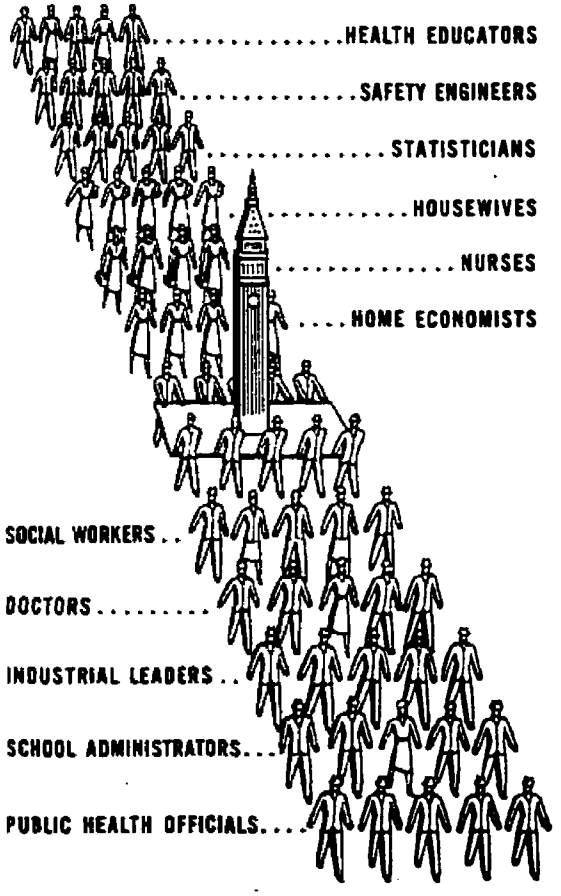

Figure 3.15 - The forces of health are represented in the same manner as the forces of disease, which suggests a similar uniformity and efficiency. *A Four Point Plan*, (MLI pamphlet, 1944).

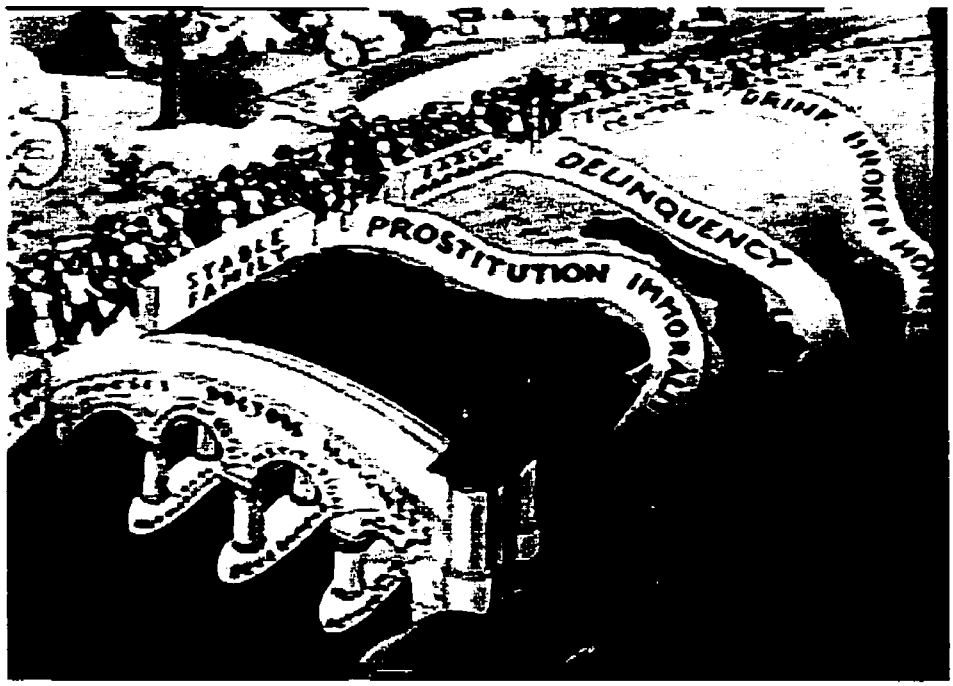

Figure 3.16 - People shown traveling along the road to health. The venereal jungle appears in black at the bottom. *The Road to Health*, (UK, c. 1936).

Figure 3.17 - Dark figures languish in the venereal jungle. *The Road to Health*, (UK, c. 1936).

Figure 3.18 - Anne was "a healthy normal girl," who nevertheless suffered a 'complete' mental breakdown. *Breakdown*, (NFB, 1951).

Chapter 4: The Dispassionate Professional

The danger and uncertainty conveyed through the images of germs and disease, stands in stark contrast to that of science and its practitioners. Whereas disease appeared as the enemy of order and progress, science was its champion. Doctors and scientists represented all that was admirable in the modern world, but their portrayal in the health literature was often more ambivalent. In contrast to the menacing mystery of disease, doctors and scientists were enigmatic figures, who, in addition to being skilled and intelligent, were also self-absorbed and self-sacrificing, compassionate yet aloof. Sometimes they appeared as heroic individuals, at other times they were simply faceless professionals.

In October 1945, the Hon. Brooke Claxton, then Minister of the Department of National Health and Welfare (DNHW), attempted to capture the spirit of the profession in his speech commemorating the opening of the University of Ottawa's Faculty of Medicine. Claxton declared,

> The good doctor must have the exact knowledge of his profession as it develops from day to day and he must have the skills necessary to apply that knowledge most effectively. His character must inspire confidence. His manner must be attractive. He must never stop working, searching after truth. But if he must have the true zeal of science, he must still more have the rich warmth of humanity. Because he will know so much of suffering and of disappointment he must be stout in heart and buoyant in spirit. He should be a man of broad culture and progressive outlook, so that he must hear the strong call to serve his fellow men. Then every act of service will become a source of happiness and every service performed will be an added stone in the growing structure of his own character.[1]

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[1] Hon. Brooke Claxton (Min. of DNHW), "The Good Doctor," presentation to the University of Ottawa. October 30, 1945. [NAC, RG 29, Vol. 109, file 180-13-1]

For Claxton, medicine was more than a mere occupation; it was a vocation. It called upon men whose character combined intelligence, resolution, self-sacrifice and compassion. It entailed a yearning for personal enrichment and a desire to serve the greater public good. It balanced the cold determinism of academic reason with the warm sympathy of human kindness. Academic instruction helped to harness these intuitive talents by training students towards a socially productive end. At university, young doctors and scientists were offered the academic and practical skills of their trade, but it was their innate personal qualities which enabled them to master the art of their profession.

Claxton's emphasis on aptitude and personality illustrates one of the fundamental contradictions of medical science. Science may be founded on a bedrock of pure reason, but both the process and the application of scientific investigation are a product of subjective interpretation. This tension between the science and art of medicine appeared as a recurring theme in Canada's public health literature. Though rarely consistent in its presentation, images of science and medicine tended to de-emphasis the subjectivity of the individual doctor or scientist and instead played up those qualities which distinguished doctors and scientists from ordinary citizens. In this way, the subjective virtues of intelligence, instinct, compassion and selflessness came to be identified with the profession as a whole rather than with specific individuals. By emphasizing professional identity over individual personality, public health literature presented audiences with a very narrow image of doctors and scientists. Such a one dimensional image offered few insights into

the actual world of science and medicine, and instead highlighted the complexity and authority of scientific knowledge.

In general, doctors and scientists were portrayed in health literature in one of two ways. Either they were featured as the centre of the story or they appeared as one of the many nameless experts who served the sick. Since public health material was designed to influence the behaviour of ordinary citizens, most of the literature focused on the plight of the patient. There was, however, some interest in profiling the life and work of such notable scientists as Louis Pasteur, Robert Koch, and Paul Ehrlich whose research helped to transform the practice of modern medicine. The biographies were usually presented as inspirational tales of adventure, in which the heroic men (and occasionally women) of science struggled against ignorance and adversity on the frontiers of scientific knowledge.

Although doctors and scientists were often portrayed in heroic terms, individual practitioners rarely played a leading role in the health films, pamphlets and radio broadcasts distributed in Canada. Most doctors and scientists were portrayed as anonymous figures in dimly lit laboratories or sterile hospital clinics. They appeared without names, families or personalities. Their individuality was entirely subsumed by their professional affiliation and by the tools associated with their trade. But the familiar images of lab coats and x-rays, microscopes and stethoscopes did more than simply identify the profession; they also symbolized many of the qualities which the discipline most highly valued, such as insight, technical know-how, practical experience and professional objectivity. These images became part of the visual discourse which defined and legitimated the profession's cultural hegemony.

This chapter explores the often conflicting images of scientific experts. The chapter begins by examining the portraits of those doctors and scientists who were lionized for their famous discoveries. The chapter goes on to describe the less celebrated, but more common images of the ordinary expert. In both sets of images, the enlightened authority of science is predicated on its success at thwarting disease, and its ability to inspire faith in the lay public.

The Heroic Men of Science

The portrayal of doctors and scientists as dedicated and compassionate experts is a relatively recent phenomenon. Throughout much of the nineteenth century, medical practitioners were lampooned as ineffectual quacks whose skill primarily consisted in discovering new ways to torture and/or humiliate their patients. With the advent of germ theory in the 1880s, and the string of therapeutic breakthroughs which followed shortly thereafter, both science and its practitioners began to be envisioned in more laudatory terms. Bert Hansen's survey of American political cartoons reveals that Americans were enthusiastic consumers of scientific information and quickly became familiar with the signs, symbols and language of science.[2] By the early twentieth century, doctors and scientists regularly appeared within the pages of popular fiction. In the 1920s, '30s and

[2] Bert Hansen, "New Images of a New Medicine: Visual Evidence for the Widespread Popularity of Therapeutic Discoveries in America after 1885," *Bulletin of the History of Medicine*. Vol. 73. (1999): 629-678; Hansen, "The Image and Advocacy of Public Health in American Caricature and Cartoons from 1860 to 1900," *American Journal of Public Health*. Vol. 87. No. 11. (Nov. 1997): 1798-1807; Hansen. "America's First Medical Breakthrough: How Popular Excitement about a French Rabies Cure in 1885

'40s, popular biographies of the great 'men of science' were reproduced in books, booklets, films, radio and even comic strips.[3]

At the forefront of popular science writers was Paul de Kruif. De Kruif's career began as a 'microbe hunting' immunologist at the prestigious Rockefeller Institute. During his tenure at the Rockefeller, de Kruif became concerned that administrative politics, commercial interests and the career ambitions of some scientists were hindering research. De Kruif voiced his criticisms in a series of essays entitled "Our Medicine Men" which he published anonymously in *The Century Illustrated Monthly Magazine* in 1922. De Kruif's rather unflattering portrait of the Rockefeller Institute and its researchers led to his resignation and launched his literary career. In 1923, de Kruif joined forces with the American novelist, Sinclair Lewis. Lewis' Pulitzer Prize winning novel, *Arrowsmith* (1924) was inspired by de Kruif's experiences as a researcher, by the scientists de Kruif had known and by de Kruif's personal philosphy regarding the integrity of the scientific process. In exchange for his knowledge of science, Lewis offered editorial guidance on what was to become de Kruif's best selling book, *Microbe Hunters*, which was published in 1926. *Microbe Hunters*, described the life and work of fourteen scientists whose

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Raised New Expectations for Medical Progress." *American Historical Review*, Vol. 103, No. 2, (April 1998): 373-418.

[3] Fictional works featuring doctors or scientists include, but are by no means restricted to, George Bernard Shaw, *The Doctor's Dilemma*, (1906; London: Penguin books, 1975); Ralph Connor, *The Doctor: A Tale of the Rockies*, (Toronto: Westminster, 1906); Sir Arthur Conan Doyle, *The Adventures of Sherlock Holmes*, (London: John Murray, 1937); Sinclair Lewis, *Arrowsmith*, (New York: Harcourt Brace, 1924). *Arrowsmith* won the Pulitzer Prize for fiction in 1925, however, Lewis' declined to accept the award; See also Jay Tepperman, "The Research Scientist in Modern Fiction," *Perspectives in Biology and Medicine*, Vol. 3, (1960): 550-553; Examples of Hollywood films include, *The Story of Louis Pasteur*, Dir. Wilhelm Dieterle, (USA: Warner Bros. Pictures, 1936); *Yellow Jack*, Dir. George B. Seitz, (USA:, MGM, 1938); *Men in White*, Dir. Richard Boleslavsky, (USA: MGM, 1934); *Dr. Ehrlich's Magic Bullet*, Dir. Wilhelm Dietiele (USA: Warner Bros. Pictures, 1940); and *Marie Curie*, Dir. Mervyn LeRoy, (USA: MGM, 1943).

discoveries in the field of microbiology helped to revolutionize Western science and medicine.[4]

De Kruif described his scientists as true pioneers who battled alone against the persistent ignorance of the public and the petty politics of academe. Louis Pasteur for example was characterized as a tireless worker who laboured in relative obscurity while "the public made vast jokes about his precious microbes" and "the world of science was against him." Antony Leeuwenhoek was described as an uneducated janitor whose "almost idiot love for grinding lenses" led his neighbours to conclude that "he was a bit cracked." Even family members sometimes despaired of their self-absorbed but brilliant husbands and fathers. Leeuwenhoek's daughter, Maria was bewildered by her "dear silly father." Mme. Pasteur was described as "one of the most famous and long-suffering and in many ways one of the happiest wives in history." Robert Koch's wife "saw little [of her husband] and worried and wished he would not go on his calls smelling of germicides and of his menagerie of animals." Seemingly oblivious to the world beyond their microscopes, de Kruif's scientists sacrificed everything in their pursuit for knowledge. Leeuwenhoek worked with "the fanatical persistence of a lunatic" and "the silly curiousity of a puppy" until "his hands were cramped with holding his microscope and his eyes [were] full of that

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[4] A detailed account of De Kruif's collaboration with Sinclair Lewis is described in his autobiography. See, Paul de Kruif, *The Sweeping Wind*, (London, Rupert Hart-Davis, 1962): esp. 60-143; For articles describing the collaboration between Paul de Kruif and Sinclair Lewis see, Charles E. Rosenberg, "Martin Arrowsmith: The Scientist as Hero," *American Quarterly*, Vol. 15, no. 3, (1963): 447-458; Ilana Lowy, "Immunology and Literature in the Early Twentieth Century: *Arrowsmith* and the *Doctor's Dilemma*," *Medical History*, Vol. 32, no. 3, (1988): 314-332; W.C. Summers, "On the Origins of the Science in *Arrowsmith*: Paul de Kruif, Felix d'Herelle and Phage," *Journal of Medicine and Allied Sciences*, Vol 46, no. 3, (July, 1991): 315-332; E. Chernin, "Paul de Kruif's *Microbe Hunters* and an Outraged Ronald Ross," *Review of Infectious Diseases*, Vol. 10, no. 3, (May-June, 1988): 661-667.

smarting water that comes from too-long looking." Pasteur "became deaf and dumb and blind to the world of men."[5]

While de Kruif's microbe hunters seemed to possess an almost superhuman dedication to their work, their physical descriptions were the antithesis of the typical male hero. Emile Roux, who investigated the diphtheria germ, was described as a "hawk-faced consumptive," who had a "sallow bearded face... like the face of some unearthly bird of prey." Pasteur was said to have a "snub nose and broad forehead." His legs were "stumpy" and he wore his "glasses awry on his nearsighted face." Pasteur's feeble stature was compounded by a stroke which left him partially paralyzed at age 45. Some of the most vivid and contradictory descriptions were saved for Robert Koch. Hailed as the German "Death Fighter," Koch was variously depicted as "a lone wolf searcher," a "hesitating, entirely modest genius," "a greenhorn doctor," an "unscientific backwoodsman," "a maniac," "a sarcastic, spiteful little German ogre" and a "pedantic, but careful, truth-hunting little czar of microbe hunters...." Notwithstanding these fearsome descriptions, Koch was physically portrayed as a tired, timid old man. In describing Koch's first momentous presentation of his studies on the tubercle bacillus before the Physiological Society of Berlin in 1882, de Kruif writes, "a bespectacled wrinkled small man rose and put his face close to his papers and fumbled with them. The papers quivered and his voice shook a little as he started to speak." Although only 39 at the time of the presentation, Koch sounds like a frail old man. This image was re-inforced

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[5] Paul de Kruif, *Microbe Hunters*, (New York: Harcourt Brace and World, 1953): 63, 70, 5, 6, 10, 62, 117, 9, 11, 69.

by de Kruif's frequent references to Koch's "short-sighted eyes," the "huge wrinkles over the bridge of his nose," and the "crows-feet round his eyes."[6]

From their physical descriptions de Kruif's microbe hunters seem to physically unremarkable, unattractive, tired and prematurely old. Their appearance stands in stark contrast to the youthful virility normally attributed to heroic figures. In de Kruif's portraits, however, the heroism of the scientists is reserved for the laboratory. In the public world they may seem weak, but in the world of science they are fearless hunters who take daring risks, make bold and sometimes reckless plans. If they tend to ignore the niceties of polite society or forget their commitments to friends and family, it is because they serve a higher purpose: saving humanity from the terrors of murderous microbes.

By current standards of historical writing, *Microbe Hunters* appears strong on hyperbole but weak on supporting evidence.[7] Nevertheless, de Kruif's dramatic tales of the investigative process clearly resonated with modern audiences. His colourful portrait of the hardworking, self-sacrificing scientific puritan became a kind of literary template for other science biographies, including those which were created by or for public health promoters. In the late 1920s, the Metropolitan Life Insurance Company commissioned Grace Hallock to write a series of pamphlets entitled *Health Heroes*, which attempted to inspire children with an admiration for the accomplishments of such luminous figures as Louis Pasteur, Robert Koch, Walter Reed, and Florence Nightingale.[8] In 1948, the Health

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[6] De Kruif, 191, 192, 60, 66, 96, 107, 117, 120, 135, 135, 186, 137,113.

[7] Gerald L. Geison, dismissed De Kruif as a "muckraking journalist" and gave little credence to the veracity of his biographies. See Gerald L. Geison. *The Private Science of Louis Pasteur*. (Princeton, N.J.: Princeton University Press, 1995): 226.

[8] The booklets were written by Grace Taber Hallock and C.E. Turner and were widely distributed throughout the United States and Canada. French and English copies of the booklets can still be found at

League of Canada produced *Heroes of Health*, a short booklet aimed at Grade 8 students. The booklet detailed the accomplishments of "workers in the field of health" and promised to describe the "wonderful story of how the whole world is one in its intimate connection with both disease and health."[9]

Like the stories written by Paul de Kruif, the biographical sketches contained within these public health booklets described individuals who were inquisitive, intelligent, compassionate, self-sacrificing and hardworking. Unlike de Kruif's microbe hunters who tended to be a bit rough around the edges, the heroes described in the public health booklets were thoroughly respectable and entirely accessible. They were imagined as otherwise ordinary individuals who managed to accomplish extraordinary things. For instance, young readers were told that Louis Pasteur was "kindly and modest and warm-hearted, not proud and cold and haughty as we sometimes imagine great men to be [and]... He never forgot that he used to be a humble peasant lad, even when he became one of the

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the National Library of Canada and at various university libraries in Canada, but a complete set of the booklets has yet to be found in Canada. Existing titles include: Grace T. Hallock and C.E. Turner, *Health Heroes: Louis Pasteur*, (New York: Metropolitan Life Insurance Co., 1925). Grace T. Hallock and C.E. Turner, *Health Heroes: Walter Reed*, (New York: Metropolitan Life Insurance Co., 1926); Grace T. Hallock and C.E. Turner, *Health Heroes: Robert Koch*, (New York: Metropolitan Life Insurance Co., 1932); Grace T. Hallock and C.E. Turner, *Health Heroes: Edward Jenner*, (New York: Metropolitan Life Insurance Co., 1926); Grace T. Hallock and C.E. Turner, *Health Heroes: Edward Livingston Trudeau*, (New York: Metropolitan Life Insurance Co., 1926); Grace T. Hallock and C.E. Turner, *Health Heroes: Florence Nightengale*, (New York: Metropolitan Life Insurance Co., 1928); Elizabeth Toon discusses the history of these pamphlets in her Ph.D. dissertation, "Managing the Conduct of the Individual Life: Public Health Education and American Public Health, 1910 to 1940," Ph.D. Dissertation, University of Pennsylvania, 1998: 256-269.

[9] This short booklet briefly describes the life and work of William Harvey, Edward Jenner, James Young Simpson, Florence Nightengale, Louis Pasteur, Joseph Lister, Robert Koch, Edward Livingston Trudueau, Walter Reed, Madame Curie, and Frederick Grant Banting. In addition to these eleven biographical sketches, the booklet offers a list of 29 "great names in the long line of workers in the field of health from Moses (1250 BC) down to our own day." Of the 29 names, nine are from Great Britain, six are from the United States and one is from Canada. See Health League of Canada, *Heroes of Health*, (Toronto, 1948). [University of Toronto, Thomas Fisher Rare Book Room]

most famous men in the world."[10] In contrast to this Pollyanna image, Gerald Geison's recent biography of Pasteur describes him as a "once feared and brutal scientific conquistador" who in his later years "took on the appearance of a frail, wise, and melancholy old sage."[11] While Geison's Pasteur may be more human, he is also less noble, and perhaps less worthy of the hero-worship that the public health promoters advocated. Historical accuracy, however, was clearly beside the point.

The objective of these colourful biographies was to draw attention to science and the noble work of its practitioners. The stories served as a patriotic call to arms, in which citizens were encouraged to join the battle against disease by embracing the principles of healthy living. Not surprisingly, the stories also aided the commercial interests of the various advocacy groups who produced and distribute them. The Metropolitan Life Insurance Company encouraged their field agents to distributed health booklets as part of their door-to-door sales pitch. The booklets encouraged potential policy-holders to see the insurance company as a compassionate firm whose interests were primarily scientific rather than economic.[12]

The Health League of Canada also attempted to hitch their philanthropic wagon to the rising star of science. In 1936, Dr. Gordon Bates (Director of the Health League of

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[10] Hallock and Turner, *Health Heroes: Louis Pasteur*, 3-4.

[11] Geison suggests that Pasteur's heroic image was not cultivated until after his death. Geison argues that Pasteur laid the foundaton for the myth by downplaying the work of others who contributed to his own. Pasteur also tended to use highly rhetorical language to bolster his public image and villianize his enemies. Finally, Pasteur's physical infirmities presented a superfiscial image of a frail gentleman. Geison, 262-272, (the quote cited in the text appears on page 270).

[12] The Metropolitan Life Insurance Co. encouraged field agents to follow a pre-written script when selling life insurance door-to-door. The scripts told agents exactly when and how to present potential customers with the health booklets. Copies of these scripts are printed in *The Metropolitan Prospecting and Selling Plan*, (Ottawa: Metropolitan Life Insurance Co., 1940); and *Getting Acquainted*. (Ottawa: Metropolitan

Canada) was so enamoured by the Hollywood film, *The Story of Louis Pasteur* that he agreed to co-sponsor its theatrical release in Canada.[13] Bates hired publicity expert B.M. Tate to help him promote the film. Tate and his associates acknowledged "the value of the picture as propaganda for public health work in its broad aspect," and recommended that "the most effective publicity value of the picture can be gained by bracketing Pasteur and the Health League together in such a way that every person who sees the film will feel that today the Health League of Canada is carrying on the noble pioneering struggles which Pasteur waged in his day."[14] Tate encouraged Bates to write to Canadian employers urging them to advertise the show to their employees on the grounds "that the picture offers an unprecedented opportunity to implant in the minds of the thoughtless rank and file, under the guise of entertainment, the foundation of a genuine public health consciousness."[15]

To ensure that at least some of this "genuine public health consciousness" was directed towards the Health League, Tate persuaded Warner Brothers Studios to allow a short trailer to be added to the Canadian version of the film. The trailer was intended to "exploit the emotional impact made by the climax of the film" and would "carry the audience's thought directly to the work of the Health League in Canada." Tate promised

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Life Insurance Co., 1933). Both booklets were found at the Metropolitan Life Insurance Co. of Canada Archives.

[13] In a private letter to Roly Young of the *Mail and Empire* Bates gushed, "I cannot imagine any better method of portraying the romance, the drama, and the heroic struggle which has filled the colourful history of the public health movement, than this pictorialization of the gripping career of Louis Pasteur.... The Health League of Canada today stands for the ideals enunciated by Pasteur in his day." Dr. Gordon Bates (HLC) to Mr. Roly Young (*Mail and Empire*), March 23, 1936. [NAC, HLC, MG 28-I-332, Vol. 17, file 17-3]

[14] B.M. Tate (Central News Bureau) to Gordon Bates, March 20, 1936. [NAC, HLC, MG 28-I-332, Vol. 18, file 18-3]

that this "psychological device will transfer the audience's admiration and enthusiasm for Pasteur over to the Health League of Canada by showing the League as being today in the same relation to health as Louis Pasteur was in his day. This will introduce the Health League to thousands of people when their minds are in the most receptive possible state."[16] To complete its promotion of a film that Warner Brothers stressed was strictly an entertainment film, Tate recommended that the Health League set up a simple display in theatre lobbies and hire a uniformed nurse to distribute pamphlets advertising the benefits of pasteurization.[17]

Bates' promotional campaign was highly successful. The *Toronto Daily Star* described *The Story of Louis Pasteur* as "a tense, smashing drama, replete with action and romance."[18] *Saturday Night's* film reviewer was equally enthusiastic about the film's cinematic merits and dramatic message, although she apparently forgot the film's title.[19]

> *The Life of Louis Pasteur* contains... a lesson for all of us. And just in case you missed the lesson there were members of the Health League posted outside distributing leaflets filled with quiet exhortation. That is the extraordinary thing about the Pasteur film; it makes its didactic lesson almost as exciting in the end as its dramatic values and leaves you with a deeper understanding of the passionate respect which during the past

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[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] *Toronto Daily Star*, 4 April, 1936: 10.
[19] Mary Lowry Ross, the film reviewer for *Saturday Night Magazine*, was not the only person to have trouble remembering the title of *The Story of Louis Pasteur*. Both B.M. Tate and Gordon Bates referred to the film as *The Life of Louis Pasteur*. It is not clear why they all made the same error. The most likely explanation is that Bates made the original mistake and repeated it in his correspondence with Tate and in the promotional literature he sent to newspaper and magazine editors, including Mary Lowry Ross. Copies of Bates' promotional review in which he refers to the film as *The Life of Louis Pasteur*, can be found in NAC, HLC Coll., MG 28-I-28, vol. 17, File 17-3: "Moving Picture Films, Louis Pasteur Films, 1936-40-52"]. B.M. Tate makes the same error in his letter to Bates. See B.M. Tate (Central News Bureau) to Gordon Bates, March 20, 1936. [NAC, HLC, MG 28-I-332, file 18-3].

> century has attached to the very name of science; a respect all the more deeply rooted because it developed out of skepticism and confessed bigotry and ignorance.[20]

Encouraged by the popularity of the film, the Health League produced a series of radio broadcasts in the early 1940s which dramatically detailed the work of various health heroes.[21] Similar in tone and style to Paul de Kruif's *Microbe Hunters*, and no doubt inspired by the spate of Hollywood biographical feature films from the late 1930s, the Health League's radio dramas drew direct links between the scientist's fight against disease, Canada's fight against the Germans and the Health League's fight for public approbation.[22] In his introductory comments to *The Death of Yellow Death*, the narrator explained that each of the radio plays "deal[s] with medical progress, the advancement of science and especially with the prevention of disease in which the Health League of Canada is vitally interested." "Listen to this story," urged the announcer, "then consider what the Health League of Canada has accomplished in ridding our own Dominion of Canada of such diseases as typhoid, diphtheria and bovine tuberculosis -- and decide whether such work should not be encouraged to complete success by your cooperation."[23]

Like Paul de Kruif's *Microbe Hunters*, the stories told in these radio plays attempted to impart a sense of the excitement of science by playing-up the drama of disease and the dynamism of the scientists. Dramatic tension was carefully orchestrated by

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[20] Mary Lowry Ross, *Saturday Night Magazine*, Vol. 51, (11 April 1936): 8.
[21] According to an internal memo dated September 1941, the 13 radio dramas in this series were produced by Canadian playwright, Rai Purdy and were broadcast by about 40 different radio stations across Canada. [NAC, HLC Coll., MG 28-I-332, Vol. 129, file 129-2].
[22] Examples of Hollywood films include, *The Story of Louis Pasteur*, (1936); *Yellow Jack*, (1938); *Men in White*, (1934); *Dr. Ehrlich's Magic Bullet*, (1940); and *Marie Curie*, (1943).
[23] Introduction to *The Death of Yellow Death*, (Health League of Canada, 1945), [NAC, R-4000].

the accompanying music and the guiding voice of the narrator. Speaking with hushed reverence, the narrator described the lonely machinations of the hardworking scientist. However, his solemn voice would quickly change to breathless anticipation as he described the final moments leading up to the scientist's climactic/ultimate discovery.

Like other efforts to popularize science, the series did its best to humanize and exault the individual scientist. For instance, in *The Magic at Saranac Lake* (1941), Dr. Edward Trudeau is presented as a brave and selfless man who, upon being diagnosed with tuberculosis, undertakes a lonely quest to find solace in the Adirondack mountains. Trudeau initially undertakes the trip to spare his wife, Charlotte, the trauma of watching him die a slow and wasting death. Charlotte remains at home in New York, where she frets over her husband's absence but vows to "to be as brave as he." After some time has passed (just how much time is unclear) Trudeau makes a surprising return home. He is fit, robust and fully recovered. Trudeau claims that he was cured by the fresh mountain air and he is anxious to prove his theory. This time, Charlotte insists on going with him. "The first winter was rough" the narrator explains, "but they were joyfully happy." Trudeau resumes his medical practice and initiates experiments to demonstrate the correlation between a healthy environment and the restoration of physical health. Although she admires her husband, Charlotte rarely endorses his plans. She bemoans the death of the lab rabbits and worries that Trudeau's plan to build a tuberculosis sanitorium will lead them into bankruptcy. Unlike Charlotte, Trudeau understands the sacrifices that must be made when serving the greater good. Trudeau ignores his wife's misgivings and continues his mission to save victims of tuberculosis from their grim fate. The dramatic

scenes which transpire between Trudeau and Charlotte help to portray Trudeau as a considerate, loving and patient man. Charlotte's role as the anxious but devoted wife serves as Trudeau's foil. Her loneliness in New York, her concern for the rabbits and her anxiety over money are all obstacles which Trudeau must resolve or ignore in order to achieve his goals. Meanwhile, Charlotte's concerns are dismissed as the self-centred musings of someone who lacks the courage and the vision to see the bigger picture.[24]

Similar themes were developed in the radio broadcast, *The Work of Louis Pasteur* (1941). The opening scene begins with Mme. Pasteur gently chastising her absentminded husband who has worked in his laboratory all night. The narrator explains that in 1850 Pasteur was "already known as a brilliant scientist" and "a man of prestigious mental and physical power" who "laboured tirelessly for hours on end." The narrator's comments were perhaps a little premature, given that by 1850, Pasteur was only 28 and had yet to embark on any of the research projects that would eventually make him famous.[25] Pasteur's scientific maturity is reinforced by the sound of his voice which possesses the deep, unsteady resonance of an elderly gentleman. Mme. Pasteur also sounds like a senior citizen. Moreover, aside from the prefix "Madame" before Marie Pasteur's name, neither character maintain the pretense of being French; both sound thoroughly North American. Pasteur's lack of accent is interesting because scientists were so often characterized as European, especially German. In omitting his French accent, it becomes easier to imagine Pasteur as a home-grown Anglo-North American hero. Perhaps the ongoing war in Europe, and English Canada's resentment of the Vichy government's

[24] *The Magic of Saranac Lake*, (Health League of Canada, 1941), [NAC, R-4000].

capitulation to Germany, rendered both French and German scientists less palatable heroes.

The passion and compassion of this Anglo sounding Frenchman are revealed through his relationship with the devoted Mme. Pasteur. Pasteur is regularly heard apologizing to his wife for missing meals and staying up late, but unlike Trudeau's wife who is fretful and discouraging, Mme. Pasteur is entirely supportive of her husband's work. After all, she declares to Pasteur, "I love you and your work is so important not just to you, but to the whole world!" With his wife's support and God's grace, Pasteur vows to solve the problems of disease and poverty. Sure enough, after what seems to be merely a few late nights in the laboratory, Pasteur discovers the microbiotic "criminals and murderers" responsible for fermentation, and develops a cure for hydrophobia. Despite his reputation as a "great scientist" Pasteur remains humble. His pity for human suffering makes him reluctant to test his treatments and he must be persuaded by colleagues to try his new rabies vaccine on the young Joseph Meister.[26]

Unlike the Pasteur described by Paul de Kruif, this Pasteur is not a self-important showman. He is a dedicated, almost self-effacing, elderly gentleman who cherishes his wife, is respectful of God, and is committed to the alleviation of suffering through the intelligent application of science. While the radio version of Pasteur's life is consistent with de Kruif's portrayal of a brilliant scientist whose physical and social inadequacies are overcome by superior intellectual energy, the references to God present an interesting new twist. When de Kruif published *Microbe Hunters* in 1926, the public debate over the

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[25] Geison, *The Private Science of Louis Pasteur*: 22-50.

role of God in science was heated and acrimonious. Conservative Christians worried about the social implications of replacing the moral authority of the Bible with the spiritual vacuum of science. Liberal Christians, who were no less afraid of secularization, saw science as a testament to the intricacy of God's creation and welcomed the possibility that science could serve God by alleviating disease, poverty and ignorance. In 1925, just one year prior to the publication of de Kruif's book, the well publicized "Scopes Monkey Trial" galvanized public debate around the question of faith and science by reducing the problem to a simple polemic regarding the wisdom of teaching evolutionary theory to school children. De Kruif's manuscript, perhaps unwittingly, participated in this debate by describing science as an entirely human endeavour. De Kruif's scientists were rugged individualists (at least intellectually rugged) who saw Truth in science, shunned dogma in any form and believed that suffering was not a part of the human condition but was a product of human ignorance. The popularization of this idea, which either totally ignored God or characterized him as a kind of absentee spiritual landlord, was precisely what concerned fundamentalist Christians at this time. By the 1940s, however, concerns over the secularizing effects of science had largely given way to the more immediate problem of war. Once again, God, who was always popular in a fight, was called upon to join science and the Allied forces in fighting for victory.

The radio plays produced by the Health League of Canada (HLC) reflected this new alliance with periodic references to the faith of its heroes. For instance, *The Traitor in White* (1941), chronicles the efforts of a fictional physician and professor to discover

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[26] *The Work of Louis Pasteur*, (Health League of Canada, 1941), [NAC, R-4000].

the cause behind an outbreak of typhoid fever at a Quebec boarding school. Several times during the programme we hear the characters pray to God for a solution to the mystery. Their work and prayers are eventually rewarded with the revelation that the school's milk handler was unwittingly contaminating the school's unpasteurized milk with typhoid germs. Thereafter the school administration resolved to always pasteurize their milk.[27] The marriage between faith and healing is similarly pronounced in the 1942 radio broadcast, *Greater Love Hath No Man* (1942), which describes the work of Father Damien amongst the natives of a Hawaiian leper colony. The broadcast is unusual in that science plays a relatively small role, however, Father Damien's selfless devotion to the victims of leprosy and his tireless efforts to improve their quality of life sits comfortably beside the heroic portraits of the medical scientists.[28]

In addition to the quiet assurance that faith and science are not incompatible, both of these radio plays can be read as a form of political propaganda. In *Traitor in White* audiences are encouraged to believe that the dairy industry's interest in pasteurization stemmed from their genuine concern for public safety and not from their desire to create a milk marketing monopoly. Moreover, in situating the drama in Quebec, the HLC was also offering a covert criticism of Quebec's failure to introduce mandatory pasteurization legislation. Similarly, Father Damien's efforts to improve the quality of life for terminally ill Hawaiians through co-operative social planning could be read as an endorsement of the government's increasingly pro-active approach to social welfare policy.

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[27] *The Traitor in White*, (Health League of Canada, 1941), [NAC, R-4000].
[28] *Greater Love Hath No Man*, (Health League of Canada, 1942), [NAC, R-4000].

Other radio broadcasts in the series offered equally diverse interpretations. In *The Magic Bullet* (1945), Paul Ehrlich is introduced as a "Great Jewish Scientist" who "helped Germany gain high honours but who has been rewarded by [words garbled] persecution in human history." While the statement was clearly intended to be an indictment of the holocaust, the statement itself is misleading. Paul Ehrlich died in 1915, twenty-five years before Hitler introduced his "final solution" to Germany's "Jewish problem." Nevertheless, in an era devastated by war, Paul Ehrlich's portrayal as a persecuted Jewish German scientist no doubt appealed to North American audiences who were eager to condemn Germany's callous disregard of human life.

A patriotic subtext is similarly apparent in the 1945 radio play, *The Death of Yellow Death*. The story describes Walter Reed's gruesome experiments on human guinea pigs to confirm that mosquitoes were the cause of yellow fever. The drama makes much of the fact that the American soldiers who volunteered to be infected with the frequently fatal illness refused to accept any form of remuneration. "If we die," declared one crusty sounding soldier, "well, there's no one to worry about us." Impressed by their devotion to science, Major Reed responded, "I have nothing to say. Your action touches me deeply. Gentlemen, I salute you!" Reed's tribute to the selfless bravery of the soldiers offered homage to all of the young men (and women) who had volunteered to fight the nation's battles. The drama's failure to recognize the participation of Spanish immigrants, or to acknowledge the pre-existing work performed by Cuban physician Dr. Carlos Findley (who had already concluded that yellow fever was transmitted by mosquitoes) helped to characterize Reed's work as a purely American discovery. The drama's

veneration for the volunteers who refused to be compensated for their participation in the experiment highlights the altruistic bravery of American soldiers while ignoring the power dynamic which exists between officers and recruits.[29] Finally, the radio drama's uncritical endorsement of human vivisection suggests that within the realm of science and medicine, the end can justify the means. In this case, the tortuous experiments performed by Walter Reed that resulted in at least four deaths (one scientist, one nurse and two Spanish volunteers), served the higher purpose of solving the mystery of yellow fever which in turn enabled the United States to remain a military presence in Cuba and later helped to expedite the building of the Panama Canal.[30]

Regardless of the political subtext, the primary message behind these dramas was to honour science and salute the courageous men who battled ignorance, dogma and disease in the pursuit of it. Ignorance, especially when it was sustained by institutional dogma, represented the most significant obstacle in the path of scientific progress. When Paul Ehrlich declared "Why can't we make little magic bullets to shoot at germs in the

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[29] De Kruif mentions the participation of Spanish immigrants but implies that they volunteered for mercenary reasons. Lawrence Altman and Susan Lederer both mention that the Spanish volunteers were offered $100 dollars for their participation. Given the state of poverty in which most refugees lived, it is hardly surprising that they accepted the money. Altman reports that some of the Spanish volunteers who were rejected from the experiment wept because they were no longer eligible for the money. Because of their presumed immunity most residents of Cuba were considered unsuitable for the experiments. See Lawrence K. Altman, *Who Goes First?: The Story of Self-Experimentation in Medicine*, (Berkeley, Ca.: University of California Press, 1987): 129-158; Susan E. Lederer, *Subjected to Science: Human Experimentation in America before the Second World War*, (Baltimore: Johns Hopkins University Press, 1995): 19-24, 131-136; Nancy Stepan, "The Interplay between Socio-Economic Factors and Medical Science: Yellow Fever Research, Cuba and the United States," *Social Studies of Science*, Vol. 8, (1978): 397-423.

[30] American scientist Dr. Jesse Lazear died on September 25th 1900, twelve days after he had willingly exposed himself to a mosquito suspected of carrying the disease. Clara Maass was a twenty-five year old nurse from New Jersey who died on August 24th 1901 after volunteering to be infected. According to Lawrence Altman, Maass' death drew heavy criticism in the United States. Altman, 155. Lederer, 19-24, 131-136; Stepan, 397-423.

human body?" his colleagues retorted with the pat answers of the academic establishment: "Magic bullets?!" they protested, "The idea is fantastic! Crazy!" Ehrlich, however, was undaunted by his detractors. "Every new idea sounds fantastic at first" responded Ehrlich, "but I'm going to work on it. I'm sure it can be done!" Like other scientists in the series, Ehrlich's dedication to his work was matched by his superior work ethic. The narrator explains that Ehrlich "was a tireless worker who had virtually no other interests. Often he would spend 18 hours a day in his laboratory -- searching, experimenting. His young colleagues use to marvel at his ability to stick to his work." When another scientist (who clearly lacked Ehrlich's dedication) invited him to out to a party, Ehrlich exclaimed, "there's a party going on right here in this test tube." Later, when Ehrlich showed the same colleague how injections of an arsenic compound into mice rendered them insane but otherwise healthy, the young colleague jokes, "You ask me, the cure is worse than the disease." Frustrated with this obtuse response, Ehrlich impatiently retorts, "Oh my goodness, don't you understand? If this compound will do that, surely now I can find one that will affect the germs and nothing else!" "Well maybe," hesitates the doubtful scientist. Ehrlich then confides his hope that "such a compound might have the same effect on the spirochaete." The colleague, who confesses his ignorance regarding the newly discovered syphilis germ (this admission can be read as a lack of both personal and academic familiarity with the disease), once again chides Ehrlich for his investigative enthusiasm: "Hmm," ponders the friend, "seems rather visionary." "I know," explains Ehrlich, "but I'm going to test it. I'm going to keep trying different arsenic compounds 'till I find one that'll work. I know what you're thinking, I'm as crazy as the mice. But

you'll see my friend, you'll see!" Ehrlich was as good as his word. While other colleagues and even members of his own research team complained about the repeated failures and mounting research costs, Ehrlich admonished them for their lack of fortitude. "We must keep going... Nothing is obvious in science. We can't stop 'til we've tried everything." Ehrlich's tireless search for an arsenic compound that would treat syphilis without harming the patient met with success on the 606th try.[31] The moral of the story is clear. Progress is achieved by visionary men who are willing to endure long hours, forego personal pleasure and ignore the unenlightened disputations of less progressive individuals. This image of Paul Ehrlich as a driven researcher who never had time for a social life is contradicted by Paul De Kruif who characterizes him as "a gay man... [who] smoked twenty-five cigars a day... was fond of drinking a seidel of beer (publicly) with his old laboratory servant and many seidels of beer with German, English and American colleagues."[32]

Finally, in *The Work of Lord Lister*, (1942), audiences were again reminded of the ways in which the dedicated men of science revolutionized the practice of medicine and ushered in the modern era. The story begins with a short dramatization in which an elderly court physician is chastised for failing to change his bloody clothing before rushing to the bedside of King George IV. Notably, the King's annoyance stemmed from the doctor's disheveled appearance and not from any concern regarding the transmission of germs. This story, which may well have been apocryphal, highlights the abysmal standards of cleanliness which were practiced among even the most prominent physicians

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[31] *The Magic Bullet*, (Health League of Canada, 1942), [NAC. R-4000].

in the pre-antiseptic era. Once again the ignorance of the medical establishment is challenged by the vision of an indefatigable medical scientist. After vowing to reduce the high rate of post-operative infections, Joseph Lister, an aspiring surgeon, devoted the next ten years of his life to research. "He scarcely had time for anything else apart from his work," intones the narrator. Lister's moment of insight finally arrives after reading about Pasteur's work with microbes. "Almost immediately" Lister sees the relevance of his work and the next day begins to test his theory that dressings soaked in carbolic acid would prevent infection. Like other radio dramas, the time lag between the formation of the hypothesis and the successful completion of experimentation is compressed to sustain audience interest. What in reality transpired over the course of several years happens virtually overnight in the radio dramas. The many years in which Lister tested his ideas on animals is ignored and we are led to believe that human testing began almost immediately. The questionable ethics of such a quick adoption of human research subjects is glossed over by the repeated assertion that Lister was a compassionate man, whose first priority was to alleviate the suffering of surgical patients. Sadly, Lister's first patient did not survive the treatment, but Lister rationalized his failure by noting that the patient was too fragile to be an appropriate test subject. Lister had more success with his second patient, a young girl, who had recently undergone surgery on her leg. After four days, Lister and his associate gingerly unwrapped the child's acid soaked dressings. To their great relief the wound was free from infection. Lister's jubilation over the success of his experiment was only slightly tempered by the tearful discomfort of the child whose already sore leg

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[32] De Kruif, *Microbe Hunters*: 334.

had been severely burned by Lister's highly acidic experimental treatment. "Perhaps we used too much [carbolic acid]," suggested Lister's research associate. "Yes, but that's easily fixed," rejoiced Lister dismissively, "The important thing is the experiment worked! We've killed off the...[word unclear]...germs that cause suppuration."[33]

The Consummate Professional

Lister, like the other scientists portrayed in these radio dramas was a self-stylized man. He was an independent thinker who defied traditional practices in an attempt to improve them. He was a tireless worker who sacrificed his private interests to serve a more noble social cause. The accolades he received, including the conferment of a Lordship by Queen Victoria, were well deserved but were by no means the object of his ambitions. As the narrator of the radio drama explained, "such honours are as nothing in comparison with the gratitude of countless human hearts restored from suffering by the miracles of modern medicine which his discoveries made possible." In other words, Lister did not serve his own self-interest; he served humanity.

In each of these radio dramas, the scientist's heroism is premised on the abrogation of personal self-interest. Pasteur, Ehrlich and Lister risked professional ridicule by defying the scientific establishment. Reed and Damien risked personal safety. Virtually all of them had to forego some form of social pleasure. Pasteur skipped dinner and worked all night, Lister seemed to work constantly, Ehrlich refused dinner

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[33] *The Work of Lord Lister*, (Health League of Canada. 1942). [NAC. R-4000]

invitations, Trudeau felt compelled to leave his wife and later risked her disapproval to pursue his work. This portrait of the self-sacrificing, truth-seeking scientist conveniently corresponded with turn-of-the-century efforts to re-conceptualize middle class masculinity.

Older models of Victorian masculinity tended to emphasize the rugged individualism of the self-made man. By the end of the nineteenth century, however, men were defined as much by the colour of their collars as by the success of their specific accomplishments. Working men, for instance, placed a premium on strength and skill, whereas middle class men were more likely to emphasize education, emotional self-restraint, and the acquisition of personal property. Gail Bedermen has argued that because of their relatively sedentary lives, middle class men found it especially difficult to reconcile the older notions of masculinity with the reality of their daily experiences. Moreover, the increasingly visible presence of women and non-whites in politics and the professions also seemed to undermine men's authority over what had hitherto been their exclusive domain. Consequently, middle class men set out to refashion the image of manhood according to their own likeness. Bederman suggests that in the early twentieth century, middle class white men reconfigured the manly balance between rough and respectable to include a greater emphasis on the masculine virtues. The power of masculine strength and virility was expressed in part through the growing number of

leisure activities available to middle class men, especially sports and wilderness adventures such as camping, hunting and trips to the cottage.[34]

Evidence of this new masculinity can also be found within the discourse of middle class professionalism. Christian theologians, for example, began to promote the idea of a muscular Christianity in which the image of Christ was transformed from that of a wispy tearful man in robes, to that of a hardworking craftsman and fisherman who converted men to Christianity through the strength of his convictions and the logic of his arguments.[35] Michael Grossberg's study of the legal profession demonstrates that lawyers also liked to play up the masculine nature of their profession by emphasizing their power to subdue hardened criminals and effect justice for the victims of crime.[36] The Health League's radio dramas, along with Paul de Kruif 's *Microbe Hunters*, the Metropolitan Life's *Health Heroes* series and the many fictional films and novels that were produced in this era, were engaged in a similar effort to engender the medical sciences with a rugged

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[34] Gail Bederman, *Manliness and Civilization: A Cultural History of Gender and Race in the United States, 1880-1917*, (Chicago: University of Chicago Press, 1995): esp. 10-23; Other sources which discuss this 'crisis of masculinity' and the relationship between class and masculinity include. Michael Kimmel, *Manhood in America: A Cultural History*, (New York: The Free Press, 1996): 81-117; Anthony Rotundo, *American Manhood: Transformations in Masculinity from the Revolution to the Modern Era*. (New York: Basic Books, 1993): 222-246; Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War*, (Chicago: University of Chicago Press, 1996): 192-205; Ava Baron. "On Looking at Men: Masculinity and the Making of Working Class History," *Feminists Revision History*, ed. Ann-Louise Shapiro, (New Brunswick, NJ: Rutgers University Press, 1994): 146-171.

[35] Susan Curtis, "The Son of Man and God the Father: The Social Gospel and Victorian Masculinity," *Meanings for Manhood: Constructions of Masculinity in Victorian America*, eds. Mark C. Carnes and Clyde Griffen (Chicago: University of Chicago Press, 1990): 67-78; Jonathan Vance, *Death So Noble: Memory, Meaning and The First World War*, (Vancouver: UBC Press, 1997): 73-110; Cecilia Morgan. *Public Men and Virtuous Women: The Gendered Landscape of Religion and Politics in Upper Canada, 1791-1850*, (Toronto: University of Toronto Press, 1996): 141-182; Ann Douglas, *The Feminization of American Culture*, (New York: Avon Books, 1978).

[36] Michael Grossberg, "Institutionalizing Masculinity: The Law as a Masculine Profession," *Meanings for Manhood*: 133-151; Tracy L. Adams makes a somewhat similar argument regarding the professional identity of dentists as both skilled workers and learned men, see. *A Dentist and a Gentleman: Gender and the Rise of Dentistry in Ontario*, (Toronto: University of Toronto Press, 2000).

masculinity. While the "men of science" may have lacked the robust physical attributes characteristic of earlier heroes, their fearless confrontations with dangerous microbes, as well as their compassion for human suffering and their uncompromising work ethic rendered them brave and noble men.

The characterization of science as a manly art had the added attraction of being a quintessentially modern profession. Science, after all, was responsible for the feats of engineering which manufactured the industrial revolution. It had invented the motor cars, aeroplanes, radios, telephones, phonographs, movie theatres, and sky-scrapers which came to symbolize the modern era. In its biological form, science alleviated human suffering and extended the lives of everyone who participated in the new and improved industrial economy. Even those pessimists who resented the faster pace of life and feared the loss of traditional family and moral values believed that the efficient application of science could help restore order to the chaos. In short, science served as a modern version of the last frontier. As the leaders of their field, the men of science became the heroes for a modern age and a new model for modern manhood.

Of course, few scientists or medical practitioners ever reached the level of professional or popular success achieved by Pasteur, Lister, Ehrlich or Reed. The vast majority of doctors and scientists enjoyed moderate but generally uncelebrated success in their private practices, hospital clinics and university laboratories. For these men, and an increasing number of women, power and authority was conferred through their professional credentials and not purely from their own specific accomplishments. Their heroic qualities were conveyed through their ability to work for long hours, to solve

puzzling medical problems and to ignore social temptations. Their sense of compassion for the misery of the sick was tempered by a professional detachment which ensured that they were always in command of any situation, no matter how gruesome or chaotic. For ordinary doctors and scientists, the assertion of this professional authority was achieved by promoting the practitioner's public identity as a skilled professional over his (or her) private identity as a unique individual.

The factors which define professionalism are complex. Sociologist, Talcott Parsons, has argued that professionals are distinguished by their highly specialized institutional training, their technical skills and by their collective authority to regulate the quality and quantity of professional members.[37] The importance of these factors in establishing the professional authority of Canadian doctors has been well documented by the historians of Canadian medicine.[38] Even non-academic histories, including the books written by Paul de Kruif, Grace Hallock of the Metropolitan Life Insurance Company, and the Health League of Canada, as well as the fictional stories created by Sinclair Lewis, George Bernard Shaw and Hollywood filmmakers, emphasize these features of professionalism. The centrality of skill, training and self-regulation is clearly important in

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[37] Gerald Geison attributes this codification of professional criterion to Talcott Parson, "Professions," *International Encyclopedia of the Social Sciences*, ed. David L. Sills. (New York, 1968): 536. see also Gerald L. Geison, "Introduction," *Professions and Professional Ideologies in America*, ed. Gerald L. Geison, (Chapel Hill: University of North Carolina Press, 1983): 4

[38] See for instance, Terrie M. Romano, "Professional Identity and the Nineteenth-Century Ontario Medical Profession," *Histoire Sociale/Social History*, Vol. 8, no. 55, (May 1995): 77-98; S.E.D. Shortt, "Physicians, Science and Status: Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century," *Medical History*, Vol. 27 (1983): 51-68; Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*, (Toronto: University of Toronto Press, 1991); S.E.D. Shortt, ed., *Medicine in Canadian Society: Historical Perspectives*, (Montreal: McGill-Queen's University Press, 1981); Ronald Harnowy, *Canadian Medicine: A Study in Restricted Entry*, (Canada: The Fraser Institute, 1984); H.E. MacDermot, *One Hundred Years of Medicine in Canada, 1867-1967*,

defining the professional identity, but these factors alone are not enough. Part of what distinguishes professionals from other skilled workers, such as artists, plumbers or carpenters, is the authority and privilege they command within society at large. In other words, professional authority is not only determined by the professional's skills, it is also contingent on the willingness of society to accept the profession's claims of social necessity.

Paul Starr has suggested that professionals garner community respect through an ongoing process of self-promotion which encourages the community to value the professional's skills above all other similar services. Starr describes this relationship between the professional and the broader community as one of dependency and legitimacy. He argues that professional regulation helps create a monopoly of services and, in the absence of other 'legitimate' service providers, the public necessarily becomes dependent upon the profession.[39] The challenge for professionals is to encourage the public to accept their services as the only legitimate services of its kind. Professionals must therefore advertise their skills, as both crucial and exclusive. They must encourage potential clients to seek out only certified professionals and to reject all others as dangerous impostors.

The problem, however, is that by popularizing the virtues of professional knowledge, there is always the risk that clients will no longer feel dependent on it. Afterall, if professional knowledge becomes common knowledge, then there is no need to

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(Toronto: McClelland and Stewart, 1967); R.D. Gidney and W.P.J. Miller, *Professional Gentlemen: The Professions in Nineteenth Century Ontario*, (Toronto: University of Toronto Press, 1994): 85-105.

[39] Paul Starr, *The Social Transformation of American Medicine*, (New York: Basic Books, 1982): 9-17.

seek out the professional. For public health advocates, this challenge was particularly acute. On the one hand, they wanted to reduce the rate of infectious illnesses by familiarizing Canadians with the rudiments of preventive medicine. On the other hand, many general practitioners worried that self-diagnosis and self-medication could endanger the health of the patient and undermine the physician's medical monopoly over health care. Some of this anxiety was abated by the literature's emphasis on prevention rather than treatment. Consumers of health information were told how to recognize the signs of illness, but, as they were repeatedly reminded, only a qualified medical professional could determine the presence of disease and the necessary course of treatment.[40]

JoAnne Brown has argued that this tension between the need to both popularize and monopolize professional knowledge is resolved through the creation of "special forms of argument that explain the profession to its clients without revealing its secrets." Brown adds that "the most common and effective way professionals do this... is through the use of metaphor."[41] In her own research, Brown describes the efforts of psychiatrists to promote intelligence testing as an objective measurement of mental potential. Through the application of this allegedly scientific tool, psychiatrists hoped to align themselves more closely with other scientific disciplines. Other historians have noted how the images of scientific technology as well as the profession's unique style of dress, language, and ceremony can simultaneously illuminate and obfuscate the scientific process. The images

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[40] Minutes of the Dominion Council of Health [DCH], Dec. 4-6, 1928; June 23-25, 1931; Dec. 15-17, 1931; Oct. 15-16, 1937; May 13-15, 1940; Nov. 29 to Dec. 1, 1945; May 26-28, 1954. [NAC. Reels C-9814-6]; See also Cynthia R. Comacchio, *Nations are Built of Babies: Saving Ontario's Mothers and Children, 1900-1940*, (Montreal: McGill-Queen's University Press, 1993): 150-156.

[41] JoAnne Brown, *The Definition of a Profession: The Authority of Metaphor in the History of Intelligence Testing, 1890-1930*, (Princeton, N.J.: Princeton University Press, 1992): 22.

help to identify the profession, but they can also make the actual practice of the profession seem more mysterious.[42] Moreover, while these metaphors of medical professionalism become increasingly familiar, the identity of the individual practitioner becomes ever more obscure. The qualities which rendered practitioners unique individuals are eclipsed by the signs, symbols and rituals of their professional identity. As a result, doctors, nurses and scientists appear as objective as the science they practice.

Tools of the Trade

This process is certainly apparent in Canadian public health literature. With the exception of the various biographies described above, health literature rarely portrayed health professionals as unique individuals. Few of them were even given the luxury of their own name. Most were simply referred to by their professional designation: "Doctor," "Professor," "Nurse". In their appearance, individual practitioners were equally nondescript. Probably the most common visual image associated with the medical sciences was that of the white lab coat. The lab coat serves both a practical and symbolic function. Its primary purpose is to protect the clothing of doctors and scientists from whatever noxious material might come their way. The coat has traditionally been bleached white so as to highlight the dirt. The style of the coat has varied through time and

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[42] Marcel C. LaFollette, *Making Science Our Own: Public Images of Science, 1910-1955*, (Chicago: University of Chicago Press, 1990): 112; Stanley Joel Reiser, *Medicine and the Reign of Technology*, (Cambridge: Cambridge University Press, 1978); Burton Bledstein, *The Culture of Professionalism*, (New York: Norton, 1976): esp. 80-128; Ian R. Dowbiggin, *Inheriting Madness: Professionalization and Psychiatric Knowledge in Nineteenth Century France*, (Berkeley, Ca: University of California Press, 1991): 144-161.

according to the specific needs of the different branches of medical science. In the health education literature, scientists and lab technicians wear lab coats which extend down to the thigh, button up the front, have a collar, side pockets and occasionally a breast pocket. In the 1920s, it was common for general practitioners to be pictured without the white lab coat, especially if they were performing house-calls. By the 1940s doctors were rarely portrayed without their lab coats. Surgeons, of course, also wore white, but instead of coats they wore collarless smocks which tied at the back. In some of the literature surgeons appear in white aprons, similar to the aprons historically worn by skilled artisans, especially, cobblers, blacksmiths and butchers.

As a uniform, the lab coat is readily identified with the scientific professions. It distinguished doctors and scientists from the lay population. The whiteness of the coat indicated cleanliness as well as purity. The simplicity of the uniform privileged a pragmatic aesthetic over the frivolities of fashion. Moreover, because it was a type of uniform, the lab coat helped to sublimate the distinguishing features of the individual by emphasizing the profession's commonalities. It encouraged the notion that doctors *qua doctors* were equal and therefore, at least professionally, were interchangeable. They were not individuals, they were doctors, or scientists, or surgeons. The identity of the individual is subsumed within the identity of the profession. Images which showed doctors wearing the caps, gloves and masks typical of surgeons, further accentuated the

sublimation of the individual into the uniform identity of the medical professional (figures 4.2 and 4.3).[43]

In addition to clothing, images of medical technology also contributed to the visual perception of the medical professional. Scientists were always portrayed in their laboratories, standing or seated before a long, neatly ordered work bench. Carefully arranged on the countertop was the inevitable microscope and usually some combination of test-tubes, Petri dishes, measuring jugs, weighing-scale, notebooks and Bunsen burner. One cannot help but be impressed by the appearance of order and cleanliness. The methodical nature in which the scientist bends to his task is reflected in the systematic arrangement of the tools of his trade (figure 4.4).

Physicians, like scientists, were also portrayed with various forms of technology. The stethoscope was the most common instrument. When it was not in use it could usually be found slung around the physician's neck or peeking over the pocket of the doctor's lab coat. Other common medical instruments included the sphygmomanometer, (used for measuring blood pressure), the otoscope (used for examining the inner ear), the ophthalmoscope (used for inspecting the eye), the syringe and the X-ray machine. Each of these instruments enhanced the physician's ability to see into the body. They quite literally provided the physician with *in*-sight. With the help of these tools, doctors could detect signs of physical abnormality which might not be readily apparent to the patient.

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[43] For a review of the history and meaning of the white lab coat see, Dan W. Blumhagen, "The Doctor's White Coat," *Annals of Internal Medicine*, Vol. 91, No. 1, (July 1979): 111-116; For a more general discussion regarding the symbolic importance of the white coat for physicians see, David G. De Marco, "Contemplating the White Coat," *Annals of Internal Medicine*, Vol. 131, No. 2, (July 6, 1999): 73-4; William T. Branch, "Deconstructing the White Coat," *Annals of Internal Medicine*, Vol. 129, No. 9, (Nov. 1998): 740-1.

For instance, the sphygmomanometer might indicate that the patient had high blood pressure which suggests the onset of arteriosclerosis or kidney disease. The patient, however, might only experience these ominous problems in the form of fatigue, dizziness and headaches. Similarly, an X-ray might reveal a tumour which was otherwise undetectable. In both examples, the doctor's insight is superior to that of the patient. To the patient, the superiority of the physician's sensory skills is both mysterious and absolute. The tools might be familiar, but without proper instruction patients were ill-equipped to interpret the information derived from the instruments. Thus the tools which were most commonly identified with the medical profession were also symbols of the profession's superior claim to power (figure 4.5).[44]

The power associated with medical tools and technology is typically asserted through visual metaphors. Some of the most overt examples of this can be found in the wartime health literature. In the 1939 film, *With These Weapons*, audiences were introduced to the tools for detecting and treating syphilis. Several scenes show doctors and nurses checking eyes, drawing blood, and examining blood cells under a microscope. At the conclusion of the film, doctors and scientists are shown working to defeat syphilis. The image shifts from the scientific expert who is concentrating over a microscope to a close-up of a blood sample riddled with the dreaded spirochaete. Slowly, and triumphantly, the germs which are trapped within the circular frame of the microscope are replaced by a syringe and test tubes. The destructive power of the instruments is

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[44] Reiser, *Medicine in the Reign of Technology*, 23-90; Jacalyn Duffin, *To See With a Better Eye: A Life of R.T.H. Laennec*, (Princeton, N.J.: Princeton University Press, 1998): esp. 302-303; Jacalyn Duffin, *History of Medicine: A Scandalously Short Introduction*, (Toronto: University of Toronto Press, 1999):

emphasized through the arrangement of the tools. The spotlight which shines on the tools suggests the purity often associated with light, while the shadow cast by the tools enhances their menacing potential.[45] The overall effect suggests that syringes and test tubes are like daggers which skilled doctors and scientists use to murder the germs of syphilis.

Similar images are re-enacted in *Let's Open Our Eyes* (1938), *Let's Keep the Killer Down* (1941), *Behind the Shadows* (c1950), *Are You Positive?* (1958), *Fight Syphilis* (1943) and *That They May Live* (1942).[46] In each of these films, the instruments of detection and treatment are regarded as weapons in the war against disease. Once again the repetition of the image re-enforces the association between medicine, science and technology. Audiences are reminded that in the hands of trained experts, these instruments augment the sensory power of physicians, thus enabling them to observe symptoms which the patient might not consciously experience. Films, pamphlets and radio plays concerning venereal disease were particularly careful to dissuade audiences of their assumption that they are qualified to determine the state of their health. In films such as *Fight Syphilis* (1943), *Let's Open Our Eyes* (1938), *Plain Facts about Syphilis and Gonorrhoea* (1941), *Syphilis - Its Nature, Prevention and Care* (c1945), *Very Dangerous* (1945), and *Sixteen to Twenty-six* (1945) audiences are warned that syphilis can remain in the body for many years without presenting significant symptoms, however,

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191-212; Aubrey B. Davis, *Medicine and Its Technology: An Introduction to the History of Medical Instrumentation*, (Westport, Conn.: Greenwood Press, 1981): 211-231.

[45] *With These Weapons*, (US, 1939), [NAC, V1 8208-096].

[46] *Let's Open Our Eyes*, (US, 1938), [NAC, V1 8208-097]; *Let's Keep the Killer Down*, (US, 1941), [NAC, V1 8208-097]; *Behind the Shadows*, (US, c.1950), [NAC, V1 8506-0123]; *Are You Positive?*,

doctors and scientists can detect the disease by conducting a Wassermann blood test.[47] The same warning is offered in *With These Weapons*: "Only a physician can interpret the results of the test" declares the narrator.[48] In this instance, however, the narrator's pronouncement is inadvertently belied by the image of a lowly female lab technician who is examining and therefore interpreting Wassermann blood tests.[49]

Public health authorities were particularly wary of non-medical diagnoses of venereal disease, because both syphilis and gonorrhoea could present with initial symptoms of discomfort which are easily ignored. Since these symptoms tend to disappear on their own, patients would understandably believe the problem had gone away. In the case of gonorrhoea, many women do not experience any symptoms whatsoever, but the gonococcal bacteria are still present. The germs of syphilis will also persist if untreated; however, even the second stage of symptoms, which may appear several weeks or even months after the initial infection, are easily mistaken for fairly ordinary skin diseases. Once again the symptoms may disappear without treatment, only to lie dormant for several years. The eventual onset of tertiary symptoms may reveal permanent damage resulting in possible heart disease, blindness, dementia or paralysis (locomotor ataxia). Without a proper diagnosis, patients were likely to remain ignorant of

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(US, 1958), [NAC, V1 8506-0123]; *Fight Syphilis*, (US, 1943), [NAC, V1 8208-009]; and *That They May Live*, (Can., 1942), [NAC, 13-0581].

[47] *Fight Syphilis*, (US, 1943); *Let's Open Our Eyes*, (US, 1938); *Plain Facts about Syphilis and Gonorrhoea*, (US, 1941), [NAC, V1 8208-009]; *Syphilis - Its Nature, Prevention and Care*, (US, c.1945), [NAC, V1 8208-009]; *Very Dangerous*, (NFB, 1945), [NAC, V1 9208-0028]; *Sixteen to Twenty-six*, (Can, 1945), [NAC, V1 9208-0027].

[48] *With These Weapons*, (US, 1939), [NAC, V1 8208-096].

[49] A similar scene is played out in the film *Subject for Discussion*, (UK, 1942), [NAC, V1 8208-096]. When a young man asks a doctor how you can tell if you have syphilis, the doctor replies that the testing

the spirochaetes harboured within their bodies and would continue to spread the disease. Because of the difficulties in detecting the disease, audiences were encouraged to recognize the early, if minor, signs of infection and to contact a physician should any of the symptoms manifest themselves. The inability of patients to diagnose the ailment themselves was re-enforced through the detailed descriptions of the procedure for detecting the spirochaete within the blood system. The use of a syringe, the preparation of the blood sample, the microscope and the eventual identification of the cork-screw shaped spirochaete or rounded gonococcus left little doubt as to the superiority of medical knowledge and technology in the identification of disease.

While public health officials may have been particularly dogmatic when it came to the self-diagnosis of VD, the use of medical technology in the diagnosis of other diseases was similarly apparent. In the 1941 film, *Let's Keep the Killer Down*, parents were cautioned to contact their doctor at the first sign of diphtheria, whereupon the physician would conduct the necessary tests to confirm the diagnosis.[50] The film presents a detailed description of the process of examination, identification and eventual treatment. Audiences are shown how physicians obtain cultures from the throat and nose which are later sent to a laboratory to be examined by qualified technicians. The film also praises the benefits of anti-toxin and toxoid, and provides a complete demonstration of how these drugs are produced and administered. The film's close attention to scientific detail was no doubt intended to allay any fears the audience might hold regarding the safety of

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process is quite complicated and "wouldn't mean much except to a medical man." Meanwhile, the audience is shown an image of a female lab technician checking blood samples.

[50] *Let's Keep the Killer Down*, (US, 1941), [NAC, VI 8208-097].

immunization. The authority of science was conveyed through the impressive, if confusing, images of the scientific process. Parents who rejected this authority and refused to immunize their children were deemed negligent and irresponsible. "It should never be forgotten that if diphtheria gains sufficient headway not even anti-toxin can win the struggle for life. But most important to remember is that all the suffering, doctor's bills, cost of lab maintenance, the loss of earning power due to quarantine and the agony of waiting while life trembles in the balance as a leaf that is shaken by the wind is absolutely unnecessary -- the tragic and wasteful result of neglect -- the fearful price for failing to immunize."[51]

Are You Positive? (1957), an animated film about tuberculosis was specifically intended to unsettle audiences by demonstrating that subjective experiences are often inaccurate and must always be tested against objective measurements. "What do you believe?" asks the narrator, "What you see? What you Hear? Seeing is believing -- but is it for sure?... Are you positive?" The film then proceeds to present a series of optical illusions which challenge the viewer's sensory perception and popular beliefs which are dismissed as "old wives' tales." Finally, the film turns to the problem of tuberculosis which is its primary focus. "If I had tuberculosis I'd know by the symptoms," reasons one of the characters in the film. Like the previous myths, the narrator quickly dispels the man's assumption. "How do you know if you have tuberculosis?" responds the narrator. "You may work at your job, feel fit as a fiddle, and have tuberculosis -- no symptoms.

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[51] Ibid; A similar tale is told in *Defeat Diphtheria* (UK, 1941). [NAC. VI 9712-0029]. *Defeat Diptheria* also includes a brief history of Dr. Von Berring's research into toxoid. Typically, the dramatic re-

They only show up at the later stages. You've got to get beneath the surface and the X-ray is the machine to do it." The narrator also insists that an annual chest X-ray and skin test are the only reliable methods of detecting tuberculosis.[52]

The frequent references to diagnostic technology served several useful purposes. First, it introduced audiences to the methods and procedures used by modern physicians to identify germs and treat disease. Second, the images of disease which were illuminated by the diagnostic technology helped audiences to become more familiar with the science behind contemporary medical practices. This in turn enabled health educators to promote preventive measures from a biological as well as a social rationale. Third, the physician's reliance on medical technology confirmed the specialized nature of medical knowledge. Only trained professionals possessed the ability to interpret the significance of information gleaned from microscopes, x-rays, stethoscopes and otoscopes. Thus, even as the process of collecting diagnostic information was de-mystified, the meaning of it remained solely within the domain of the medical expert. Finally, the identification of scientific technology with therapeutic medicine helped audiences to distinguish between 'real' medicine and mere quackery. The tools of modern science and medicine became visual markers of scientific legitimacy. The absence of such tools necessarily called into question the authenticity of the practitioner.

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enactment of Von Berring's discovery portrays the scientist as an elderly man who night and day worked alone in his laboratory.

[52] *Are You Positive?* (US, 1957), [NAC, V1 8506-0123]

Quacks

By the mid-twentieth century, Western allopathic medicine was firmly established as the only 'legitimate' form of medicine; however, the denizens of the North American medical establishment were still anxious to distance themselves from the so-called 'quackery' practiced by homeopaths, herbalists, naturopaths, chiropractors, and physiotherapists. The problem was specifically addressed in a 1958 film entitled *Quacks and Nostrums*.[53] The story opens in the comfortable living room a middle class home. Larry, a high school senior, and his girlfriend, Helen, are doing their homework. When Larry's mother arrives home, Helen jokingly complains that Larry has rejected all of her ideas for Larry's research project. "Well what'd you expect?" begs Larry, "I've got to write a term paper on health education and the only thing this brain over here can come up with is 'the natural superiority of women!'" The truth behind Larry's snide rejection of Helen's essay idea is revealed when Larry's mother confesses that she has just returned from the Hotel Rhinelander where she attended a public lecture delivered by 'Dr. Aluka Ka Humana'.[54] The mother enthusiastically explains that Dr. Ka Humana hails from a small island in the south seas where the people "maintain perfect health through the use of one basic medicine... it's a kind of tea... it's made up of special herbs." Larry denounces Ka Humana as a fraud and begs his mother to visit a registered physician if she is feeling unwell. Helen sides with Larry's mother suggesting that Larry is merely being reactionary. "Perhaps Dr. Who-ha can help," suggests Helen. Larry dismisses such quackery and

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[53] *Quacks and Nostrums*, (US: Crawley Films, 1958), [NAC. V1 9508-0027].

decides to make "quacks and nostrums" the subject of his term paper. Over the course of his investigations Larry visits "a real doctor" as well as an official at the Food and Drug Administration. Larry learns that the Food and Drug Administration have "had their eye on 'Ka Humana' for some time." Laboratory tests demonstrated that the tea Ka Humana gave to Larry's mother "isn't harmful but is worthless in terms of treatment." Moreover, an American Medical Association investigation into the testimonials written by Dr. Ka Humana's supposedly satisfied customers revealed that "some writers died, before their testimonials appeared in print, of the disease they thought they were cured of." During a tour of the Food and Drug Administration Larry is taught to mistrust bizarre-looking therapeutic devices, and to be skeptical of the exaggerated advertising of patent medicines. Larry is told that all 'official' drugs are listed in pharmaceutical books and only legally registered doctors and pharmacists have the knowledge, training and skills to handle drugs. As Larry leaves the offices of the Food and Drug Administration the official warns him "to tell your mother the wisest thing is to see her family doctor and not rely on something sold by a high powered lecturer." Sadly, neither his mother nor his girlfriend were willing to listen to the wisdom of Larry's argument. Eventually and inevitably, Larry's mother becomes seriously ill and is taken to hospital. Later, after Larry's mother is back at home convalescing, Larry triumphantly points out a newspaper article which states that Mr. Ka Humana was indicted by a grand jury for fraud. At last the mother admits, "Oh when I think of all the men and women who could be seriously ill going to a

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[54] I have attempted to spell the name phonetically.

man like that -- a man who's only interested in their money. I can't be sorry that he's going to jail.... Oh, but he seemed so honest and sincere."

Although the film never actually shows an image of the infamous Dr. Aluka Ka Humana, there are several clues which suggest he is a charlatan. Ka Humana's name is foreign and presumably Asian. This immediately sets him apart from most western allopathic physicians. His homeland is never named but is located somewhere in the exotic obscurity of the South Seas. His medicine is "a kind of tea" which is made up of unknown "special herbs." Even the Hotel Rhinelander, where Larry's mother first heard Ka Humana lecture, suggests an air of foreigness which is vaguely ominous given Germany's prewar occupation of several Pacific islands and its wartime alliance with Japan. In contrast to the foreigness and inexactitude of Ka Humana's false medicine, the 'legitimate' medicine practiced by Western doctors appears precise and familiar. The Western doctors, scientists and nurses who appear in the film are unmistakably white Anglo-European. Their familiar lab coats and uniforms are starched and spotlessly white. The doctor's offices are filled with impressive looking medical textbooks, diagnostic instruments and framed diplomas. The science labs are crowded with Bunsen burners, microscopes and test tubes. Unlike Ka Humana's herbal tea which was distributed indiscriminately as a cure-all for a variety of ills, Western medicine was thoroughly tested by trained scientists to treat the specific ailments identified by physicians. The authority of Western medicine was given added weight by the endorsements of groups such as the Food and Drug Administration, the American Medical Association, the Better Business Bureau, and the Federal Trade Commission. When compared with these prestigious

organizations the simple testimonials supplied by Ka Humana seem both trite and insignificant. Most damning of all was the assertion that Ka Humana's objectives were purely self-serving and materialistic. Ka Humana's attempt to make money from his wondrous elixir was a sure sign that he was a fraud who cared little for the suffering of his clients. In contrast to the self-serving Ka Humana, 'real' doctors and scientists appeared entirely altruistic. The concept of profiting from the woes of their patients was anathema to the principle of disinterested self-sacrifice which was so carefully cultivated by professional practitioners. The fact that both doctors and scientists were fully compensated for the services they rendered was largely ignored by the public health literature. In fact, the only time money was ever mentioned was to remind the patients that free medical services were provided to anyone who could not afford to consult a private physician. Thus even here, the altruism of the medical community remained in tact.

The assumption that 'quacks' were not only bad doctors but were also dishonorable men was repeated throughout the health literature. Information relating to venereal disease was particularly vitriolic in its condemnation of medical quackery. In dramatic film and radio productions, patients often sought the advice of disreputable doctors rather than face the embarrassment of confessing their indiscretion to their personal physician. For instance, in the HLC's production of *Damaged Lives* (1933) young Don Bradley was so ashamed of his pre-marital tryst with a woman who later confessed to having "it" (presumably syphilis) that he sought the advice of a Dr. Horton who advertised his services in the local newspaper. The 'doctor' is shown wearing a dark

suit but no lab coat. His office looked authentic with several framed diplomas on the wall. After performing a few cursory tests, Horton declared Don's infection a "false alarm," nonetheless he charged Don an exorbitant $100. Later, after Don and his fiancée, Joan, are married and expecting their first child, Joan is diagnosed with "an infection". Tests reveal that Don too "has a blood disorder... a venereal disease." Don confides to his own physician, Dr. Vincent, a clean-cut expert in a white lab coat, that an earlier doctor had told him he was cured. Dr. Vincent dismisses the earlier doctor was a mere quack, "an advertising doctor" and a "faker".[55] A similar fate befalls Marge, who contracted syphilis from her suicidal husband, in the 1949 radio play, *The Story of Our Town*. Rather than risk being exposed as a syphilitic (and therefore stigmatized as a woman of loose morals), Marge consults the shady Dr. Garfield who promises to treat her quickly and quietly for a mere $10 per day. Dr. Garfield is eventually exposed as a fraud when he is arrested for practicing without a license.[56]

In each of these stories the fraudulent doctor is exposed as a self-serving materialist. Instructional films offered a similar portrayal. *Nine Cents Per Capita* (1942) followed the efforts of "John Doe" to cure himself of syphilis. Initially, John sought the help of "Dr. Quack" whose prolonged treatment process left John virtually penniless. Eventually, John went to a 'real' doctor who conducted a thorough physical exam and a blood test before beginning the treatment therapy. Dr. Quack's lack of scruples is demonstrated by his exorbitant fees. Conversely, the treatment provided by the legitimate

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[55] *Damaged Lives*, (Can./US, 1933), [NAC, V1 9206-0023]; *Damaged Lives* was a joint production of the Health League of Canada and Columbia Pictures in the United States. The production of the film is

doctor was not only more scientific, but was also cheaper because the costs were offset by provincial taxes which totaled a mere nine cents per capita.[57] *Very Dangerous* (1945) warned against drug-store cures and self-treatment of on the spurious grounds that "nothing that you can buy will ever cure you."[58] Similar images were shown in *Syphilis: Its Nature, Prevention and Cure* (c. 1945) while audiences were explicitly told: "Do not buy advertised 'cures.' Do not trust the advertising 'specialist.' He wants your money but does not care for your health."[59] The link between quacks and commerce was graphically depicted in the instructional film, *Fight Syphilis* (1943) which cautioned audiences not to be drawn in by advertisements that promised a quick cure. The advertisements were graphically portrayed amid the bright lights and loud jazz music typical of urban street scenes, thus metaphorically linking quacks to the rampant commercialism of modern consumer culture.[60]

If quacks were identified by their commercialism, then legitimate doctors were identified by their association to all things scientific. In contrast to the quack, doctors and scientists appeared honest, relentless, efficient, methodical, precise, altruistic, and they were always successful. "The intelligent prevention of any disease," declared the narrator of *Syphilis: Its Nature, Prevention and Cure* (c. 1945), "must rest on research and experiment."[61] In *A Test for Love* (c. 1935) a serious doctor explained to his hapless

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discussed by Cassell, but he mistakenly reported that there were no remaining copies of the film in Canada. See Cassell, 240-3.

[56] *The Story of Our Town*, (US, 1949), [NAC, R-2999].

[57] *Nine Cents Per Capita*, (Can., 1942), [NAC, V1 9712-0025].

[58] *Very Dangerous*, (Can.: NFB, 1945).

[59] *Syphilis - Its Nature, Prevention and Care* (US, c.1945).

[60] *Fight Syphilis*, (US, 1943), [NAC, V18208-009].

[61] *Syphilis - Its Nature, Prevention and Care* (US, c.1945).

patient that "There is no magical cure for this disease... It can only be cured by skill, patience and regular treatment."[62] Similarly, in *Health is a Victory* (1942), the narrator urged the audience to remember that "a physician is needed to cure and prevent the spread of gonorrhoea... Avoid quacks. Don't attempt self-treatment. Only a physician can be trusted."[63] Such statements were invariably accompanied by detailed scenes depicting the methodical process through which doctors examined patients, assessed the meaning of their symptoms, identified the germs causing the disease and then set about to evict the offending germ from the body of the patient.

Scenes showing the treatment process usually demonstrated how syringes were filled and injected, but they rarely mentioned the actual drugs involved. *Fight Syphilis* (1943) described the use of Bismuth, mercury and arsenic. Most films simply made oblique references to "painless weekly injections." Even after the discovery of penicillin in 1941, it was unusual to see explicit references to the new drug. According to Allen Brandt, health advocates worried that audiences might disregard prophylactic measures if they thought penicillin was an easy cure. It is also possible that the association between the quick fix and the quack doctor made health promoters reluctant to advertise the new cure.[64]

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[62] *A Test for Love*, (UK, c.1935).

[63] *Health is Victory*, (US: ASHC, 1942), [NAC, V1 9602-0115].

[64] I have yet to see any reference to penicillin in a VD film that was shown in Canada prior to 1960. Of course, this does not mean that such films do not exist. The use of antibiotics in the treatment of VD. meant that the disease was no longer among the DNHW's promotional priorities. The NFB had created several new VD films during the war, and although they were not up-to-date on treatment, the DNHW continued to use them in their educational campaigns. Among radio dramas the first known mention of penicillin in the treatment of syphilis was made in 1948 with the broadcast of *One Million People*. Other dramas from the same series emphasized that modern medical treatment could cure syphilis within two weeks, but only *One Million People* actually attributed the new rapid treatment to penicillin. Finally,

Since the allure of quacks was often attributed to the patient's reluctance to confess their indiscretion to their own physician, health literature attempted to reassure patients that confidentiality was always guaranteed. In *It's Up to You* (1943), volunteers in the armed forces were urged to contact their medical officer as soon as the first symptoms of syphilis or gonorrhoea appeared. The narrator promised that all "cases will be treated with sympathy and confidentiality."[65] In other words, the medical officer would not dismiss, lecture or report on soldiers who contracted venereal disease. In *Sixteen to Twenty-six* (1945), a film intended for young women, viewers were assured that all medical doctors take an oath of confidentiality and free clinics respect an individual's privacy. Audiences were shown how patient records were kept carefully filed in locked cabinets. In fact, mused the narrator, "If you keep yourself as safely put away as these medical papers, the dangers of contracting the disease will be slight."[66]

The concern over confidentiality adds yet another dimension to the personality of the medical expert. The repeated assurances of confidentiality do not necessarily mean that no one will find out about the patient's condition. Several films promised patients that "no one need ever know you have syphilis" while simultaneously showing pictures of

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references to penicillin appear in several American pamphlets by the late 1940s, but I am unable to determine when the first Canadian equivalents were produced. See *One Million People*, (USA: 1948), [NAC, R-2999]. Samples of American pamphlets can be found amid the correspondence between D.V. Liberti (Federal Security Agency of the Public Health Service, Washington, DC) to Dr. B.D.B. Layton, (Chief, Div. of VD Control, DNHW), Aug. 17, 1948, [NAC, RG. 29, Vol. 109, file 180-13-1]. For a discussion of the impact of penicillin on anti-VD promotional material, see Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880*, (New York: Oxford University Press, 1985): 170-178; David P. Adams, "The Penicillin Mystique and the Popular Press. (1935-1950)," *Pharmacy in History*, Vol. 26, no. 3, (1984): 134-142; Peter Neary, "Venereal Disease and Public Health Administration in Newfoundland in the 1930s and 1940s," *Canadian Bulletin of Medical History*, Vol. 15, no. 1, (1998): 129-151.

[65] *It's Up to You*, (Can., 1943), [NAC, 13-0054]

[66] *Sixteen to Twenty-Six*, (Can., 1945), [NAC, V1 9208-0027].

nurses, clerks, other doctors and even other patients within the immediate vicinity.[67] In the film, *Know for Sure* (1942), an experienced older physician is seen discussing the personal and medical history of several syphilitic patients with another doctor.[68] *A Test for Love* went to great pains to demonstrate how the anonymity of VD patients at a rapid treatment centre is preserved by giving everyone a number. Viewers who paid close attention to the film would wonder at the success of this system as the clinic's nurse frequently referred to the film's hapless heroine by her real name.[69] Assurances of confidentiality were also belied by the insistence that patients give the names of all their recent sexual contacts. While this information may have been necessary to stem the spread of the disease, it also meant that an ever larger number of health care and social workers possessed information that patients believed to be confidential.[70] Several films boasted of the extensive networks of information that enabled doctors, nurses, clerks, lab technicians, social workers, public health authorities, ministers and even employers to participate in the discovery and eventual treatment of the syphilis and gonorrhoea.[71] When

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[67] *Know for Sure*, (US, 1942), [NAC, V1 9712-0029].

[68] Ibid.

[69] *A Test for Love*, (UK, nd., c. 1935), [NAC, HLC Coll., V1 9709-0025]; The Canadian instructional film, *For Your Information* also shows how patients were assigned numbers instead of names, ostensibly to preserve the patient's privacy. *For Your Information*, (Can., nd., c. 1940s), [NAC, 13-0061]

[70] In 1949, members of the Health League of Canada debated the problem of keeping patient records confidential. It was noted the results of workplace health exams were often made available to employers and to office staff. Committee Chairman, Dr. D.R.S. Howell reported that "The disclosure of this information frequently resulted in embarrassing situations and possible loss of jobs where such certificates are handled by unauthorized persons (clerks, personnel directors etc.) in the routine distribution and filing of reports." The Health League recommended that industrial physicians be urged to "educate top management that confidential handling of records is essential." Minutes of National Health Committe, Health League of Canada, January 15, 1949. [NAC, MG 28-I-332, Vol. 101, file Industrial Health Committee Minutes Division, 1944-1950].

[71] See for example, *Fight Syphilis*, (US, 1943); *Let's Open Our Eyes*, (US, 1938); *Plain Facts about Syphilis and Gonorrhoea*, (US, 1941); *Syphilis - Its Nature, Prevention and Care*, (US, c.1945); *Very Dangerous*, (NFB, 1945); *Sixteen to Twenty-six* (Can, 1945); *Nine Cents Per Capita*, (Can., 1942).

the narrator of the film *Very Dangerous* proudly declared "Today, employers and employees are co-operating with health authorities in discovering those who have been infected," members of the audience must have wondered just how private their private medical files actually were.[72] Implicit in all of these discussions regarding confidentiality was the assumption that anyone who works within or for the health care community is above the petty gossip or sanctimonious moralizing which supposedly plagued the lay population. Doctors, scientists and nurses simply were not interested in the personal lives of their patients; they were solely concerned with the health or sickness of the patient's body. As one wise doctor stated in the VD film, *Subject for Discussion*, "to a doctor all disease is an evil -- something to be fought and overcome."[73]

Statistics

Statistics offers the final metaphor through which science conveyed its professional authority. As JoAnne Brown has commented, the progressive era "was characterized by a fondness for large numbers."[74] Public health literature is certainly no exception. It was riddled with large and impressive figures which were presented as definitive and objective proof that disease was prevalent, costly and preventable. At first glance, the numbers were generally persuasive; however, a closer reading of the material reveals strange inconsistencies. For instance, the 1945 film *Very Dangerous*, estimated that one in every

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[72] *Very Dangerous*, (Can.: NFB, 1945).
[73] *Subject for Discussion*, (UK, 1942).

20 Canadians suffered from venereal disease and that a new case was contracted every 30 minutes.[75] In 1945 the Canadian population was approximately 12 million.[76] Five per cent of 12 million is 600,000. Conversely, if a new case is contracted every 30 minutes, there would be 17,520 new cases a year. Even if one considers that some people neglected to seek treatment for the disease, the difference between 17,520 and 600,000 is an unreasonably large discrepancy. These figures are further complicated by another statistic taken from the film *Sixteen to Twenty-six* (1945) which states that 40,000 Canadians are infected with venereal disease.[77]

Similar incongruities appear in the American context when a 1939 film declared 6,500,000 Americans suffer from syphilis.[78] This figure is contradicted by a 1938 film which argues that "every five minutes, five new cases of syphilis are contracted in the United States."[79] At one new case per minute, there would be 525,600 new cases a year in the United States, which is a far cry from the 6,500,000 cases reported in the previous film. The high rate of syphilis might suggest that syphilis is more prevalent than gonorrhoea, however, in 1942 the film *Health is Victory* claimed that gonorrhoea was over three times more prevalent than syphilis.[80] An earlier report from the Canadian Social Hygiene Council agreed, stating that "gonorrhoea is the more prevalent of all

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[74] JoAnne Brown, *The Definition of a Profession: The Authority of Metaphor in the History of Intelligence Testing, 1890-1930*, (Princeton, NJ: Princeton University Press, 1992): 130.
[75] *Very Dangerous*, (NFB, 1945).
[76] M.C. Urquhart and K.A.H. Buckley, eds., *Historical Statistics of Canada*, (Toronto: MacMillan, 1965): 14.
[77] *Sixteen to Twenty-six*, (NFB, 1945).
[78] *With Theses Weapons*, (1939).
[79] *Let's Open Our Eyes*, (HLC 1938).
[80] *Health is Victory* (1942). This statistic was originally presented as a bar graph rather than an actual number.

diseases except measles."[81] Presumably this assertion does not take into account the number of people suffering from the common cold, which one 1948 radio play suggests amounts to 300,000,000 cases per year in the United States.[82]

Not to be out done by these impressive statistics, the American Tuberculosis Association's film *Are You Positive?* (1957) claimed that "50 to 60 million Americans have tuberculosis."[83] Conversely, the 1961 film, *Merry-Go-Round* suggested that one in five Americans had tuberculosis.[84] The overwhelming prevalence of tuberculosis suggested by these statistics was challenged by a 1946 Canadian report which found that between 1940 and 1944, the morbidity of tuberculosis was outranked by both scarlet fever and whooping cough. This ranking is reversed when one considers mortality rates. Whereas tuberculosis accounts for only 16 per cent of the diseases listed, it represents a staggering 53.3 per cent of the deaths.[85] Another pamphlet downplayed the severity of tuberculosis by pointing out that deaths from cancer and heart disease were considerably higher than

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[81] Canadian Social Hygiene: untitled Report. (c. 1929-36) [NAC, MG 28-I-332, Vol. 146. file 'VD Statistics, 1929-1936']

[82] radio play: *The Common Cold* (Jan. 1948). The announcer states that "the average person... suffers from at least two colds in the course of a year. On a national basis that adds up to about 300,000,000 colds annually." [NAC, RG 29, Vol. 120, file 190-1-1 pt 1]

[83] *Are You Positive*, (1957).

[84] *Merry-Go-Round*, (1961).

[85] The statistics in this pamphlet were reportedly taken from a "National Selective Service" survey, June 30, 1945. The report states that in Canada between 1940-1944, there were 90,910 cases of scarlet fever and 585 deaths. There were 87,373 cases of whooping cough and 2,374 deaths. There were 45,077 cases of tuberculosis and 24,009 deaths. The other diseases listed are diphtheria with 14,171 cases and 1,307 deaths, and influenza with 43,596 cases and 8,840 deaths. Thus scarlet fever has the highest morbidity rate, but the lowest mortality rate. See pamphlet, "Labour and Learning" Feb. 1946. [NAC. RG 29. Vol. 180, file 300-1-6].

deaths due to TB.[86] Yet another report showed that infant mortality surpassed all three of these diseases put together.[87]

Statistics demonstrating the high rates of disease were often accompanied by figures showing the number of working days lost to illness or the total cost of lost wages and production. Once again, the numbers are impressive but contradictory. One Canadian source stated that "the average wage earner in Canada loses 9.5 days' work and wages per year... this yearly loss in wages is estimated at $135,000,000."[88] Another pamphlet determined that 21,000,000 working days were lost per year and "the annual cost of illness is estimated to be approximately $300,000,000."[89] A third source, estimated that illness cost Canadian workers $50,000,000 in lost wages and cost employers $75,000,000 in lost profit.[90]

Officials within the government, the Health League and other organizations were not entirely oblivious to these statistical inconsistencies, but their criticisms were generally confined to their private correspondence and were not normally voiced until after the figures had already been published. For instance, in 1935, Dr. Charles Fenwick of the

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[86] This pamphlet estimates that 7,500 Canadians die from tuberculosis, 10,646 die from cancer, and 13,734 die from heart disease. See pamphlet: "Health Conservation: A National and Economic Necessity" (HLC, 1937). [NAC, MG 28-I-332, Vol. 1946].

[87] The pamphlet approximates that 30 million children die in infancy, 12 million die from heart disease, 7.7 million die from cancer, 8 million die from tuberculosis. See pamphlet: "Adventures in Health, 1909 to 1930" (MLI, 1930).

[88] *Labour and Learning*, Feb. 1946.

[89] *Health Conservation: A National and Economic Necessity*, (HLC, 1937). Ten years later, Gordon Bates quoted the Hon. Ian MacKenzie, Minister of Pensions and National Health, who reportedly stated that "the direct cost of illness in Canada has been calculated to be about $300,000,000 a year." Other figures allegedly announced by MacKenzie are so similar to those cited in the "Health Conservation" pamphlet that one wonders whether the minister was finding his information in the Health League's pamphlet. see "National Aspects of Health in War and Peace" by Gordon Bates, (1946). [NAC, MG 28-I-332, vol. 146.]

Health League of Canada disputed the accuracy of many of the statistics presented in a recently published government pamphlet on venereal disease. Fenwick argued that the pamphlet's claim that "syphilis affects about 8 per cent of the total population... is a pretty high figure" given that "the actual cases under treatment for syphilis at any one time vary from 4.9 to 6.6 per thousand of population" [emphasis original]. Elsewhere Fenwick objected to statements which claimed that "one-half of the one child and childless marriages are due to gonorrhoea." According to Fenwick, "the most probable cause of the lack of family [was] due to the active practice of birth control" and not the presence of gonorrhoea. As for the pamphlet's assertion that "between 25 to 50 per cent of the operations on the female pelvic organs are necessary because of gonorrhoea," Fenwick argued that hospital records demonstrate that only 2.7 per cent to 7.28 per cent of gynaecological operations are related to gonococcal infection.[91]

Fenwick's concerns over the veracity of statistical evidence was echoed by the Dominion Council of Health [DCH]. Despite repeated efforts to collect accurate morbidity records from the nation's physicians, Canadian doctors remained obstinate in their refusal to comply. Statistics on venereal disease appeared to be particularly difficult to ascertain. "The compilation of reliable VD statistics is an old reef upon which has been wrecked many a ship of good intention and honest effort" stated J.A. Amyot (Chair of

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[90] Report: "Prevention of Sickness: Among Industrial Workers" Sept. 1942. [NAC, MG 28-I-332, Vol. 102, file 'Industrial Health, 1941-45']

[91] C.P. Fenwick (Associate Director, HLC) to J.J. Heagerty, (Chief Executive, Dept. of National Health), July 16, 1935. [NAC, MG 28-I-332, Vol. 146, file 'VD Statistics, 1935-1936']. Fenwick is responding to the pamphlet: "Information for Parents: Teaching of Sex Hygiene to Children," (Ottawa: Dept. of Pensions and National Health, 1935).

DCH and Deputy Min. of Health, 1919-1932).[92] Dr. J.J. Heagerty (Asst. Dir. of Dept. of Health, 1929-1945) agreed. "I tried it for nine years," explained Heagerty, "... and I knew as little in the end as I did when I sent out the questionnaire. My attitude is that the effort to obtain venereal disease statistics is more or less of a hopeless one...."[93] One year later, Prof. Fitzgerald of the University of Toronto admitted that none of the Canadian statistics regarding the prevalence of any disease could be considered accurate.

> What is the situation in Canada... what is the volume of sickness and invalidity in this country, either attended or unattended? We have no exact or definite knowledge or information with which to answer this question. It is true that certain estimates have been made, based upon the experience in England and Wales and in the United States, as to the volume of sickness and invalidity, and its costs. But I should like to reiterate that we have no precise and definite information, because no provision is made for the collection of morbidity figures. The volume and kind of sickness occurring in the community at all times in large part goes unreported. Secondly, what provision have we in this country for dealing with sickness and invalidity? It is impossible to completely answer that... The third question is what is the cost of medical care, including hospitalization, dental treatment, nursing and so on? Here again we can only resort to speculation, to arrive at any idea at all as to its amount.[94]

Given the admitted inaccuracies of government statistics, one wonders why the figures continued to appear with such frequency within the literature. One possible explanation is that the general information conveyed by the numbers was accurate even if

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[92] Minutes of the DCH 20th Annual meeting, June 3-5 1930. [NAC, DCH, Vol. 255, reel C-9814].
[93] Ibid.
[94] Minutes of the DCH 22nd Annual meeting, June 23-25, 1931. [NAC, DCH, Vol. 255, reel C-9814]. By 1937, the situation remained unchanged. In the *Report of the Committee of the Dominion Council of Health on Federal Grants to the Provinces on Behalf of Venereal Disease Control: Appendix D* (1937) stated that "There is an apparent lack of accurate information as to the extent of syphilis and gonorrhoea throughout the country as a whole. While the figures are available as to the extent to which advantage is taken of clinic facilities set up in urban centres, it is not known to what degree such figures might be considered as an index of the amount of venereal disease in any area. Further, there appears to be little or no information available as to the prevalence of this condition in areas not served by such clinics... One is

the actual figures were not. In other words, so long as the audience went away with the knowledge that venereal disease was a serious problem or that tuberculosis affected thousands of people, then perhaps it didn't matter if the precise number was wrong. Nevertheless, if the object was to impress audiences with generalities, then why use statistics at all? The most obvious answer would seen to be that statistics appear accurate even when they are not. The persuasiveness of statistics rests on the presumption that numbers represent a value-free interpretation of a quantifiable phenomenon. Because they are produced through a mathematical process, statistics appear to be unfettered by the ideological whims of popular prose. Numbers are, or at least appear to be, logical, rational, unbiased, impersonal, accurate, and absolute. Put simply, numbers don't lie. This is a highly desirable quality for a profession which seeks public authority through the dispassionate logic of its certifiable proofs. Obviously, scientists, like other researchers, were well aware that statistics can be manipulated to give the appearance of favorable results. The assurance of authenticity, then, resides not in the numbers alone, but in the integrity of the individual. However, for the average lay person who is unfamiliar with the origins of the statistics, the presentation of impressive numbers bolsters the authority of the group that publishes them. People trust that the numbers are accurate and because they trust the numbers, *ipso facto* they trust the people who compiled them. Thus the qualities attributed to statistics are transferred to the scientists who use them and vice versa. In this respect, statistics join microscopes, and lab coats as part of the

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compelled to resort to pure speculation in attempting to estimate the extent of syphilis and gonorrhoea...." Minutes of the DCH 34th Annual meeting. June 21-22. 1937. [NAC, DCH, Vol. 255. Reel C-9815].

metaphorical language through which the values attributed to science and its practitioners are conceptualized.

Conclusion

At first glance, Canada's public health literature seems to present a contradictory image of doctors and scientists. In popular biographies medical scientists appear as brilliant heroes whose passion, determination, self-discipline and mental accuity enable them to challenge the scientific status quo, and forego the luxuries of success, so that they may eventually uncover the mysteries of the microbiotic universe. In this portrait, doctors and scientists appear as manly men, who have the courage to venture into the scientifically unknown and the strength of character to withstand the physical dangers and mental trials which challenge their progress. They can be compassionate, but they never let their sympathy for the suffering of others cloud their scientific judgment. Like other good middle class men, they have learned to harness their passionate nature and turn it toward a socially useful end.

In contrast to this heroic portrait, there is the more common image of the nameless professional, whose anonymity masks his individuality and intensifies his professional identity. In this image, doctors and scientists are methodical, self-disciplined, highly skilled, highly trained, exacting and accurate. They appear without personal lives and without distinguishing personality traits. The uniformity of their appearance and the standardization of their skills suggests that, as professionals, they are essentially

interchangeable. This is wonderfully illustrated in the many graphic drawings which depict doctors and scientists, along with nurses and social workers, as a white army of health care providers; their well-coordinated efforts serving as a Maginot Line against invading germs.

The contrast between these two conflicting images is reconciled in the notion of modernity. Caught between the highly structured chaos of disease, and the infinite complexity of human behaviour, medical scientists are compelled to straddle both worlds. They are passionate about their work, but disciplined in their methods. They have the physical frailties of the lay population and yet, they have the power to see beyond the visible world, into the microbiological one. They are subjectively independent and objectively professional. It is because of these many admirable qualities, that the physician remains aloof from the ordinary men and women who succumb to disease. Ultimately, the physician is not a model to be emulated but a knowledgeable guide who escorts the more fallible lay population through the dangers and pleasures of modern society.

Figure 4.1 - The fearless doctor protects a family against the Grim Reaper, in this CSHC pamphlet advocating periodic health exams. *Periodic Health Examinations*, (CSHC pamphlet, c.1936).

Figure 4.2 - A doctor and nurse weigh a newborn following a home delivery, while the grandmother looks on. The healthcare workers are distinguished by their surgical aprons, caps and masks. In contrast, the grandmother retains her visual personality. *Fight for Life*, (US, 1940).

Figure 4.3 - In this clinical scene of a hospital birth, the doctor, anaesthetist and nurse are almost completely hidden by the uniform of their profession. *Mother and Child*, (NFB, 1947).

Figure 4.4 - Scientist shown in his laboratory. *Fight for Life*, (US, 1940).

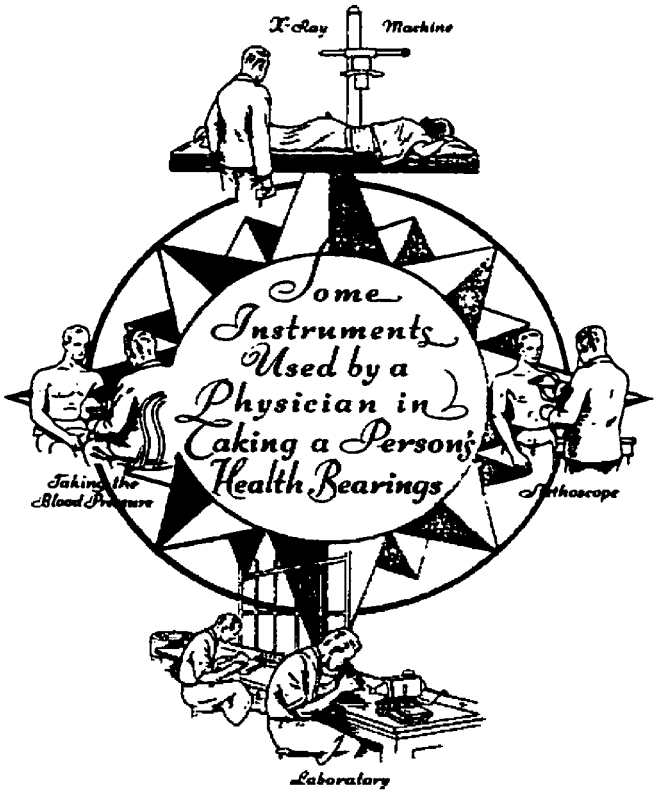

Figure 4.5 - Instruments of science and medicine. *Taking Your Bearings*, (MLI pamphlet, 1920).

Chapter 5: Patients, in Sickness and in Health

The final actor in the drama of health was of course the patient. The patient was the central protagonist in the almost mythic struggle between the evils of disease and the virtues of health. Unlike the 'men of science' whose quest for insight set them apart from ordinary citizens, patients lived in the world. Patients were anti-heroes who enjoyed the pleasures of modern living but were often seduced by the perils of self-indulgence. Disease was the inevitable result. But even as they were tormented by microbes, science held out the promise of resurrection. The challenge was to find a balance between the pleasures which led to future happiness and the self-indulgence which led to disease. The key, according to public health literature, was found in the acquisition of knowledge and the acceptance of personal responsibility. The choice, however, remained with the individual. They could choose to be healthy or they could take the risks that led to disease and debility.

The image of the patient, as presented in public health literature, varied according to the subject and style of the presentation. Some material viewed patients with compassion, portraying them as tragic figures, whose ignorance and/or foolishness resulted in their pitiable condition of ill-health. Other material cast them in a more critical role, treating them with a derision bordering on contempt. Regardless of whether patients were treated with sympathy or cynicism, virtually all of the health literature considered patients to be active agents in the preservation of their health and the treatment of their illness. Only those patients deemed 'innocent victims' were excused from culpability, and

even then blame was usually assigned to someone close to the patient (typically a parent, spouse or co-worker) who had thoughtlessly exposed them to the disease.

The notion of responsibility was central to the public health agenda. It was the objective of public health education to encourage individuals to accept personal responsibility in preserving the integrity of their health. Towards this end, health literature first had to persuade audiences that good health was personally and socially desirable. Second, the literature had to make certain that audiences understood the causal relationship between their actions and their health. That is, audiences had to realize that they had the power to control their health. Finally, and perhaps most importantly, the literature had to convince audiences that they not only could control their health, but that they also had a social and ethical obligation to do so.

The first objective was met by contrasting the apparent benefits of good health, such as beauty, strength and success, with the unpleasant effects of illness, namely pain, weakness and diminished personal potential. To clarify the causal links between personal health and personal behaviour, public health literature presented dramatic parables which defined certain lifestyles as healthy and others as unhealthy. Lastly, the assertion that individuals have an obligation to be healthy was premised on the assumption that health is a mediating factor in all social relations, especially those concerning the family, the community and the nation.

This chapter will explore how these three objectives were transcribed into the public health material. Starting with the metaphors that made health seem desirable, the chapter will describe the influence of gender in delineating notions of health and illness.

The chapter will then discuss how these gendered images were projected onto the broader social stage, thereby linking personal desires to broader social responsibilities.

The Sick Role

That health is a desirable condition would seem to be intuitively obvious. Few individuals would willingly want to endure the hardships brought on by disease. There are, however, some benefits to being ill. As early as 1929, Henry Sigerist observed that sickness placed individuals in a unique and often privileged social position. According to Sigerist, many ancient cultures believed illness was a form of demonic possession or divine retribution for some past wrong-doing. In these cultures, suffering was the means through which sick individuals atoned for their sins. Thus, the restoration of health was a sign of physical and spiritual redemption. Moreover, suggests Sigerist, illness presented healthy individuals with an opportunity to demonstrate their capacity for selfless charity. Consequently, sick people were not only freed from the usual burdens of work and self-maintenance, but they usually attracted greater consideration from their friends and family.[1] Talcott Parsons' oft cited investigation into the doctor-patient relationship presented similar conclusions. Like Sigerist, Parsons argued that illness is not simply a medical state, but is an institutionalized 'social role' which is defined in part by the

[1] Sigerist's examples may be historically and/or anthropologically based, but his anecdotal writing style renders some of his observations academically suspicious. For instance, Sigerist's characterization of Semitic culture as 'higher' than some 'primitive cultures' but lower than Greek or Christian culture appears to be a personal opinion rather than an academic observation. Notwithstanding, his spurious ranking of ancient cultures, Sigerist's central conclusions concerning the cultural specificity of sickness is

individual's "excemption from 'normal' social responsibilities," such as the need to go to work, to earn a living, or to take care of one's self. The corollary to this unique social privilege was the less attractive prospect of personal helplessness, the admission that illness is undesirable, and the necessity of submitting to the indignity of outside intervention (presumably medical) in order to get well.[2]

The notion of 'secondary gain' is evident in the work of several medical historians who note that some illnesses confer a form of privilege on individuals whose wealth enables them to indulge their illness, and whose lives were not unduly threatened by the imminent prospect of death.[3] For instance, Edward Shorter's study of late nineteenth century neurasthenia concluded that the ailment was a psychosomatic manifestation of the leisured lady's social ennui. Karl Figlio has suggested that the listlessness associated with chlorosis, (a condition which was common in the 14th to 20th centuries and is now thought to have been anaemia), was interpreted by physicians as either a manifestation of working-class laziness or a manifestation of middle-class fragility. In both cases, the disease appeared to exempt patients from the tedium of their work and domestic

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compelling. Henry E. Sigerist, "The Special Position of the Sick" (1929), *Culture, Disease and Healing: Studies in Medical Anthropology*, ed. David Landy, (New York: MacMillan Pub., Co., 1977): 388-394.

[2] Talcott Parsons, *The Social System*, (New York: The Free Press, 1951): 436-437; A more concise rendition of Parson's argument can be found in, Talcott Parsons, "The Sick Role and the Role of the Physician Reconsidered," *The Milbank Memorial Fund Quarterly: Health and Society*, Vol. 53, no. 3 (Summer 1975): 257-78.

[3] The notion of 'secondary gain' originates with Freud. It is described as "acceptable or legitimate interpersonal advantages that result when one has the symptoms of a physical disease." Quoted in D.A. Fishbain, et al., "Secondary Gain Concept: A Review of the Scientific Evidence," *Clinical Journal of Pain*, Vol. 11, no. 1, (March 1995): 6-21; G.J. Kaptain, et al., "Secondary Gain Influences the Outcome of Lumbar But Not Cervical Disc Surgery," *Surgical Neurology*, Vol. 52, no. 3, (Sept. 1999): 217-223, discussion 223-5.

responsibilities.[4] Tuberculosis sanatoria not only relieved patients from the stress of their home and work place, but in some instances offered patients an idyllic environment and leisurely atmosphere in which to recover.[5] Susan Sontag noted that the disease was further romanticized by fiction writers and fashion models who celebrated the pale, emaciated bodies of tubercular patients as a symbol of the tragic beauty of doomed youth.[6] Perhaps the most notable example of perceived patient privilege is found amongst the mentally ill. In both the nineteenth and twentieth centuries, mental illness has been understood as an escape from some unpleasant reality. Soldiers in the First and Second World Wars who were diagnosed with 'battle exhaustion' were temporarily exempt from war service, although many contemporary physicians believed that the disorder was indicative of cowardice or malingering. 'Shell-shock' or Post Traumatic Stress Disorder (as it is now more commonly diagnosed) is no longer dismissed as 'malingering', but, like other forms of neurotic behaviour, it is perceived to be a reasonable psychological response to an unreasonable physical circumstance. In other words, psychiatrists regard the disorder as a patient's unconscious attempt to avoid a confrontation with a traumatic experience.[7]

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[4] Edward Shorter, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era*. (Toronto: Maxwell MacMillan, 1992); Karl Figlio, "Chlorosis and Chronic Disease in Nineteenth-Century Britain: The Social Constitution of Somatic Illness in a Capitalist Society," *Social History*. 3.2. (May 1978): 167-197.

[5] Sheila Rothman, *Living in the Shadow of Death Tuberculosis and the Social Experience of Illness in American History*, (Baltimore: Johns Hopkins University Press. 1995): 211-225, 226-245; Barbara Bates. *Bargaining for Life: A Social History of Tuberculosis, 1876-1938*, (Philadelphia: University of Pennsylvania Press, 1992): 59-74; Katherine McCuaig, *The Weariness, the Fever and the Fret: The Campaign Against Tuberculosis in Canada, 1900-1950*. (Montreal and Kingston: McGill-Queen's University Press, 1999): 254-257.

[6] Susan Sontag, *Illness as Metaphor*, (New York: Farrar, Strauss and Giroux, 1978).

[7] Tom Brown, "Shell Shock in the Canadian Expeditionary Force. 1914-1918: Canadian Psychiatry in the Great War," *Health, Disease and Medicine: Essays in Canadian History*. ed. Charles Roland. (Toronto:

Clearly, the privileges of being sick pale in comparison with the pain, anxiety and humiliation associated with a debilitating or disfiguring illness. Public health literature made certain that Canadians never underestimated the benefits of health or the disadvantages of disease. To highlight the desirability of health, public health literature drew a simple association between good health and other socially valued physical qualities, such as beauty, strength, efficiency and sexual vitality. Not surprisingly, many of these qualities were refracted through the prism of gender, race and class.

Health and Femininity

For women, health was most often associated with physical beauty. Both qualities were linked to a woman's personal success and popularity. For instance, young readers of the popular social hygiene pamphlet, *Healthy, Happy Womanhood* (c. 1926), were told; "Good Health gives such beauty, a beauty that will wear. Its foundation is health of mind and body; its expression is a sparkling eye, a clear complexion, a graceful body, an active brain. Today the popular girl is the girls [sic.] who glows with life, who can swim and dance and play outdoor games, who has plenty of energy for fun when she has finished her

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The Hannah Institute for the History of Medicine, 1984): 308-332; Terry Copp and Bill McAndrew, *Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army, 1939-1945*, (Montreal and Kingston: McGill-Queen's University Press, 1990); Several historians have described the tendency of nineteenth century physicians to equate mental disorders in women as a rejection of femininity. See for instance, Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980*, (New York: Pantheon Books, 1985); Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*, (Toronto: University of Toronto Press, 1991): 278-355; Helen B. Lewis, "Madness in Women," *Women and Mental Health*, eds. Elizabeth Howell and Marjorie Bayes, (New York: Basic Books, 1981): 207-227; Ann Douglas Wood, "'The Fashionable Diseases': Women's Complaints and

daily tasks. Good health, since it produces high spirits, vitality, cheerfulness, and leadership will help to make you popular."[8] The American hygiene film, *The Life of a Healthy Child* (1932) offered similar advice. The film follows a day in the life of an attractive blonde girl who is about twelve years old. The film presented general information regarding nutrition, bed rest, posture and physical check-ups. Punctuating each scene was a visual or verbal reminder that good health habits made girls pretty and popular. Audiences were informed that "cleanliness is nature's best beauty treatment... by sitting up straight you will develop a good form and a pleasing personality which goes with it... lawn dancing is a mild form of exercise... [which] develops a graceful body, poise of mind and a co-operative spirit."[9] Few general hygiene films featured boys. Those that did, never suggested that the goal of health was "beauty," "a pleasing personality" or "a graceful body." For boys, the more common refrain was that health led to greater strength, agility, athletic prowess and leadership potential.

In 1940, the DNHW released *Posture for Poise*, an American film specifically dedicated to improving women's deportment. The film instructed women in the proper method of such simple manoeuvres as sitting, standing, and walking, as well as more complicated procedures such as holding a phone, carrying luggage, writing notes and

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Their Treatment in Nineteenth-Century America," *Women and Health in America*, ed. Judith Walzer Leavitt, (Madison, Wisconsin: University of Wisconsin Press, 1984): 222-238.

[8] pamplet: *Healthy, Happy Womanhood* (USA: ASHC, reprinted by CSHC, c. 1926) The pamphlet was orginally produced by the American Social Hygiene Council, but was reprinted by the CSHC for distribution in Canada, [NAC, MG 28-I-332, Vol. 18, file 18-4]. Similar social hygiene advice literature is discussed Mariana Valverde, *The Age of Light, Soap and Water: Moral Reform in English Canada, 1885-1925*, (Toronto: McClelland and Stewart, 1991): 67-76; Michael Bliss, "Pure Books on Avoided Subjects: Pre-Freudian Sexual Ideas in Canada," *Historical Papers*, (Canadian Historical Association, 1979): 89-108; Carolyn Strange, *Toronto's Girl Problem: The Perils and Pleasures of the City, 1880-1930*, (Toronto: University of Toronto Press, 1995): 120-129.

serving tea. "Good posture and good manners are pleasing partners" assured the narrator.[10] The inclusion of this film amongst the DNHW's hygiene and fitness series demonstrates the extent to which women's health was aligned with feminine manners and affectations.

Perhaps the most blatant assertion of the 'health as beauty' metaphor is found in the RCAF instructional film, *Hygiene for Health* (1945). The film begins with a review of the many ways in which women have participated in the Canadian war effort as members of the RCAF. The booming voice of a male narrator explains that "a woman who has good health has the best foundation for performing any job life can offer her." More importantly, he explains, "The woman who is healthy is attractive. Because you are a woman, health and attractiveness are important to you."[11] Although the narrator seemed to admire the war work of RCAF women, there was little doubt that women would return to more feminine roles once the war ended. As the narrator asked "What part are you going to play in the world of peace for which you are now fighting?" At this point the images of marching women quickly gave way to bathing-suited women lounging in canoes steered by handsome shirtless men. In anticipation of this romantic future, RCAF women were advised to devote extra attention to the techniques of personal grooming, posture, make-up and shoe shopping. Viewers were also instructed in the physiology of their bodies with respect to menstruation, reproduction, pregnancy and childbirth. Clearly, the female viewers of this RCAF hygiene film were expected to forego their non-traditional

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[9] *The Life of a Healthy Child*, (Dr. A.F. Hill, 1932). [NAC, VI 8111-032]
[10] *Posture for Poise*, (produced by the State University of Iowa, c. 1940. Distributed in Canada by the DNHW: Fitness and Amateur Sport Directorate, c. 1940). [NAC, VI 8905-0024]

public careers and return to more domestic endeavours upon the war's conclusion (figures 5.1, 5.2, 5.3 & 5.4).

A 1951 remake of *Hygiene for Health*, entitled *One Girl to Another*, did little to challenge this assumption. The updated film cut out the introductory military references and replaced them with more modern images of contemporary school girls. The bombastic male narrator was similarly replaced by the more intimate voice of a female narrator. Notwithstanding these changes, the essential message remained the same; women can be anything they want to be, provided they remain healthy and attractive. As the narrator explains; "Modern woman knows where she is going... ahead of her lies the future bright with the attainment of desires, holding the promise of romance, warm with love... The young girl dreams of becoming a business executive, perhaps a famous actress, a successful wife and mother." Once again health and physical appeal are tied to the attainment of these goals. "Health means attractiveness," exclaims the narrator. "All women in their secret heart want to be attractive. Personal hygiene, careful grooming do more to make a woman charming and attractive than the possession of regular features. A woman's body is beautiful, but its beauty must be tended."[12] Aside from the slightly altered introduction and the use of a female narrator, *One Girl to Another* is a direct replica of *Hygiene for Health*. Even the scene with the thinly clad canoeing couples remained intact.

The association between hygiene, personal grooming and reproduction was curious but not at all uncommon. Physicians have typically regarded menstruation as the

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[11] *Hygiene for Health*, (RCAF, 1945) [NAC, VI 8912-0073]

messy endstage of a regenerative biological cycle. The menstrual process might be 'natural' but it was certainly not attractive. Menstruation tied women to a natural bodily process, which like other bodily functions such as urination, defecation, and sex, were evidence of a primitive link to lower animal species. Unlike men, who were thought to be largely indifferent to their bodily cycles, menstruation tied even the most refined women to the natural rhythms of their bodies. Personal grooming encouraged women to reassert control over their bodies and returned women from the natural state of their reproductive cycle to the civilized state of feminine refinement. Of course, the preferred state of feminine deportment was not without its physical appeal. When the narrator of the *Hygiene for Health* asserted that "because you are a woman, some parts of your body require more care and understanding than others" he was acknowledging both the aversion and appeal of women's sexuality. On the one hand, the film's advice regarding hygiene and grooming encouraged women to wash away all physical evidence associated with the hormonal changes that accompany menstruation. On the other hand, women's devotion to physical appearance made them more physically desirable. Thus, the literature simultaneously encouraged women to subvert their reproductive potential and highlight their sexual appeal.[13]

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[12] *One Girl to Another*, (Associated Screen News. Dir. Harold Peabody, 1951). [NAC. 13-0041]

[13] On sex education in Canada, see Christabel L. Sethna, "The Facts of Life: The Sex Instruction of Ontario Public School Children, 1900-1950," Ph.D. Dissertation, University of Toronto, 1995; Mary Louise Adams, *The Trouble with Normal: Postwar Youth and the Making of Heterosexuality*, (Toronto: University of Toronto Press, 1997): 107-135; On medical views of menstruation see, Emily Martin, *The Woman in the Body: A Cultural Analysis of Reproduction*, (London: Open University Press, 1987): 27-53; Wendy Mitchinson, *The Nature of the Their Bodies: Women and Their Doctors in Victorian Canada*, (Toronto: University of Toronto Press, 1991): 77-98; Vern Bullough and Marth Voght, "Women, Menstruation and Nineteenth-Century Medicine," *Women and Health in America*, ed. Judith Walzer Leavitt, (Madison, Wisonsin: Wisconsin University Press, 1984): 28-37; On associations between health

Since good health fostered beauty (at least in women), ill-health was usually accompanied by a loss of attractiveness. For instance, in the 1947 NFB film, *The Feeling of Rejection*, a shy young office worker named Margaret "is troubled by headaches, stomach aches and dizzy spells." In addition to these physical problems, evidence of Margaret's illness is apparent in her personal appearance. Margaret's clothes are dowdy, her hairstyle is neat but unflattering and even her deportment seems diminutive (figure 5.5). Margaret's ailments prove to be a physiological manifestation of a psychological disorder. With psychotherapy, Margaret's psychosomatic ailments disappear and her appearance improves. Margaret becomes a more confident shopper; choosing to buy fashionable footwear over the sensible shoes advocated by the salesman. She begins to wear more attractive clothing. She styles her hair and starts to apply make-up. In the film's final scene, Margaret is shown interacting with women and men her own age, indicating an expansion of her social circle and the possibility of a romantic attachment (presumably heterosexual) sometime in the near future (figure 5.6).[14]

Personal grooming was also a factor in determining the mental stability of Helen Ferguson, a fictitious mental patient in the radio docu-drama, *In Search of Mental Health: Case History of a Woman* (1950). Helen is described as a 31-year old homemaker, whose feelings of depression and fatigue were precipitating the breakdown of her marriage. Helen's abusive husband complained that she was a poor housekeeper, a

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and beauty see, Kathy Peiss, "Making Faces: The Cosmetics Industry and the Cultural Construction of Gender, 1890-1930," *Unequal Sisters in U.S. Women's History*, eds. Vicki Ruiz and Ellen Carol Dubois. 2nd ed., (New York: Routledge, 1994) 372-394; also Kathy Peiss. *Hope in a Jar: The Making of America's Beauty Culture*, (New York: Metropolitan Books, 1998); Jennifer Susan Marotta, "Constructing the Norm: Medical Advice Literature to Canadian Adolescents, c. 1873-1922." M.A. Thesis, Queen's University, 1998: 46-58.

disinterested mother and that she was always 'nagging' him about imaginary problems. After five weeks of intensive psychoanalysis, chemical sedation and electro-shock therapy, (which she received at the prestigious Allen Memorial Institute in Montreal),[15] Helen's attitude changed. She accepted that her youthful interest in academics and her preference for a career over marriage were merely childish attempts to compensate for her deeply repressed feelings of abandonment. Once Helen accepted this insight, she ceased to resist her femininity. She adopted a maternal interest in her infant daughter. She shouldered complete responsibility for her husband's anger and frustration. Finally, Helen also began to take an active interest in her physical appearance. "You look good," Helen's husband comments during one his visits. "Oh, I just put on some lipstick," demurs Helen. "I noticed!" exclaims her enthusiastic husband. The improvement of Helen's physical appearance and her willingness to resume the traditional responsibilities of her gender was evidence that her mental disorder had passed and her health had been restored.[16]

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[14] *The Feeling of Rejection*, (NFB, 1947).

[15] The Allen Memorial Institute opened its doors in July 1944 and quickly became one of Canada's foremost centres for Psychiatric research. Unlike most institutions which were run either as day clinics or chronic care asylums, the Allen attempted to recreate a less institutional setting in whihc the doors were never locked and patients were free to check out at any time. In the 1950s, the Institute was often singled out as a model for the most modern, progressive and humane approach to treating mental disorders. Ironically, the Institute's emphasis on freedom and individuality belied its more sinister experiemnts with brainwashing which were conducted by Dr. Ewan Cameron with funding from the CIA and the Canadian government. Investigations into Dr. Cameron's research in the late 1970s and early 1980s, also revealed his excessive use of electroschock treatments, insulin-coma therapy and psychotropic drugs such as LSD. Although greeted with contempt today, in the late 1940s and 1950s these forms of psychotherapy were praised as important breakthroughs in the treatment of mental illness. Conequently, DNHW educational material frequently hailed such treatments as examples of modern medicine's success at restoring order to the disordered mind. See Anne Collins, *In the Sleep Room: The Story of the CIA Brainwashing Experiments in Canada*, (Toronto: Key Porter Books, 1988); also, Harvey Wienstein, *A Father, A Son and the CIA*, (Toronto: James Lorimer & Co., 1988).

[16] *In Search of Mental Health: Case History of a Woman*, (CBC radio: 1950).

For some public health advocates, physical beauty was not only the symbol of female health, it was also the means of obtaining it. This phenomenon is beautifully illustrated in Dr. John J. Slaven's speech before the Planning Committee of the Proposed Canadian Conference on Children on December 3rd, 1951. Slaven's speech calls for the adoption of a more holistic approach to child care which would include the acquisition of "good food, decent housing, understanding informed parents, a rounded education, spiritual and religious guidance, proper medical and dental care and wholesome recreation." Despite his recognition that health is determined by the physical, mental and material conditions of the child, Slaven's choice of case study simply re-asserts the contemporary 'beauty myth'. Slavens describes the case of "Mary X," a 14 year-old girl who sought help from (or more likely was sent to) her school's guidance department "because of poor achievement and withdrawal from class and group activities." Slavens explains that "An examination revealed a girl, untidy in appearance, 35% overweight, with acne and poor posture." Although further counselling revealed that Mary "came from a broken home" and suffered from "sibling rivalry," the recommendations proposed by Mary's team of counsellors concentrated exclusively on the improvement of her physical appearance. The counsellors recommended, "1) reduction in weight, 2) advice regarding personal hygiene and clothing, 3) skin care, 4) stimulation and encouragement to participate in group activities, and, 5) choral work (she has a good voice)." "Within six months," reported Slavens proudly, "Mary had achieved better social adjustment. There was a marked improvement in her scholastic standing and her personal appearance,

and, as a result of some loss of weight, better personal hygiene and advice in dressing, she had improved to the extent that she now looked attractive, especially to boys."[17]

Health and Masculinity

Physical appearance was also an important factor in men's health, but there were some important differences. Whereas women's health was most often associated with beauty, men's health tended to be associated with strength. Interestingly, the metaphors which linked health to strength usually drew upon other contemporary images of masculine power. In the 1920s and 1930s, when progress was almost exclusively measured by productivity, metaphors of masculine power were often drawn from the machines that men created and ran.[18]

This celebration of the human machine was invoked by both Taylorite enthusiasts, who saw the machine as a symbol of man's progressive ingenuity, and leftist politicos who saw it as the indifferent agent of labour's oppression. The love-hate relationship between man and machine was also a common theme among artists and writers. Poets such as Ezra Pound and T.S. Eliot contemplated the disaffection of men from the world they had created. Cubist artists like Pablo Picasso transformed people into geometry while futurists, like Marcel Duchamp, discovered grace and movement in the machine-like

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[17] Dr. John J. Slavens, "The Needs of Children in Canada Today," conference paper presented at the Planning Committee of the Proposed Canadian Conference on Children, Ottawa, Dec. 3, 1951. [NAC, MG 28-I-332, Vol. 76, file 76-13]

[18] Anson Rabinbach, *The Human Motor: Energy, Fatigue, and the Origins of Modernity*, (New York: Basic Books, 1990): esp. chapters 4 & 5; JoAnne Brown, *The Definition of a Profession: The Authority*

repetition of cubist images.[19] In the interwar era, the growing uneasiness with the modern machine was increasingly evident. Portraits of urban life and industrial landscapes by artists such as Edward Hopper and Charles Sheeler, seemed strangely disassociated from the people who lived and worked among them.[20] The massive murals painted by social realists like T.H. Benton, Diego Rivera, Ben Shahn, and Canada's Charles Comfort re-invigorated the images of technological progress with a human component. Nevertheless, the juxtaposition between awesome machines and powerful men seemed to question whether men were the masters or the victims of machine-age modernity.[21]

Interwar, health literature offered a similar though somewhat less ambivalent contrast between man and machine. On the one hand, the mechanized images of dangerous microbes described in Chapter 3 and the emergent biological dangers posed by modern cities, factories and leisure activities, suggested that the machine age was not good for human health. On the other hand, the coordinated perfection of power and efficiency which the machine seemed to represent offered a compelling metaphor for modern masculinity. For instance, the Canadian Social Hygiene Council (CSHC) pamphlet, *Canada is at War* (1933), presented an enthusiastic tribute to the human machine: "We are accustomed to being told that this is the machine age. If people would only learn that their bodies are marvelous flesh-and-blood machines, and would give those

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of Metaphor in the History of Intelligence Testing, 1890-1930, (Princeton, NJ: Princeton University Press, 1992): 103-106.

[19] see for example, Pablo Picasso's *Portrait of Ambroise Vollard*, (1910); Marcel Duchamp's, *Nude Descending a Staircase*, (1912).

[20] see for example, Edward Hopper's *House by the Railroad* (1925) & *Nighthawks* (1942); Charles Sheeler's *American Landscape* (1920).

[21] see for example, T.H. Benton's *The Changing West I*; Diego Rivera's *Workers in the Revolution* (1929); Ben Shahn, *The Riveter* (1938), Charles Comfort's *Romance of Nickel* (1937).

machines the same care and attention that expensive machinery receives in an up-to-date factory, there would be less sickness and lower death-rates." [22] In this metaphor, the machine is exalted as a model of efficiency which humans would do well to emulate.

A similar metaphor is reproduced in *Working for Dear Life* (c. 1925), a silent film produced by the Metropolitan Life Insurance Company. In this film, the male body is likened to a automobile. "Mr. Jones," an apparently healthy young man in denim work clothes, is shown inspecting the engine of his shiny new motor car. When the postman delivers a health pamphlet advertising the virtues of a regular health examination, Jones protests that the recommendation is "nonsense" as he is "as fit as a dollar." "So is your motor," responds the postman, "because you inspect it regularly and forestall possible trouble -- is not your heart the human motor?" The postman's comments are accompanied by simple animation which contrasts the beating of Jones's heart with the working pistons of his automobile's engine. Jones reviews the health pamphlet he has just received. It states, "...a health inspection... will indicate what repairs and overhauling, if any, are due your human machine." Jones's contemplation of this advice is suddenly interrupted when he notices that his car's pressure gauge is dangerously high. After quickly releasing the steam, Jones finally understands the value of a medical check-up. Once at the doctor's office, the physical examination is quick but thorough and reveals that Jones', like his car, suffers from high (blood) pressure. The doctor reassures Jones that the problem has been caught in time and a simple change of diet will restore him to

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[22] pamphlet: "Canada is at War," (CSHC, 1933). In this instance, the war referred to in the title is waged against germs, not Germans. [NAC, MG 28-I-332, Vol. 18, file 18-4]

perfect health. After one year, Jones returns to the doctor's office, his blood pressure is normal, and he is now a committed disciple of the regular health examination.[23]

One of the reasons the machine metaphor worked so well for men's bodies was that it reflected both the physical mechanics of the human body, as well as the cultural function ascribed to it. Men's bodies, according to popular convention and medical presumption, were uniquely designed for work. Women's bodies, on the other hand, were designed to attract men and nurture children. Thus metaphors which associated women's health with women's beauty suited what society had deemed to be a women's proper social and biological function. The machine, however, offered a more appropriate symbol for the male body, because it reflected the power, efficiency and endurance of male productivity. The objective of the periodic health exam was to improve the level of productivity by ensuring the smooth functioning of the body. In *Working for Dear Life*, the association between health and work was conveyed by the images of modern machinery, by the work clothes worn by Mr. Jones, and by the implicit assertion of the film's title that a healthy body should be physically functional and socially productive.

While the machine metaphor may have stressed function over form, the muscular male body was certainly celebrated as an aesthetic ideal. Evidence of the popularity of this new aesthetic is readily apparent in the rugged individualism of America's adventure-seeking former president, Theodore Roosevelt, and in the hard-living, hard-drinking life and work of writer Ernest Hemingway. On film, it could be found in the aggressive sensuality of Rudolf Valentino and the athletic physicality of Douglas Fairbanks.

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[23] *Working for Dear Life*, (MLI, US, c. 1925] [V1 9307-0031]

Serialized novels, comic strips, radio dramas and commercial films introduced young audiences to a variety of virile heroes, (such as Edgar R. Burrough's Tarzan and the men of Zane Grey's western adventures), all of whom disdained the effete conventions of civilized society even as they protected its fundamental principles of social and moral justice. Canada's home grown fictional heroes such as Jim Halliday's *Dale of the Mounted*, William Lacey Amy's *Blue Pete* and the many characters created by Ralph Connor may have shown a greater interest in preserving law and order, but their commitment to upholding federal laws did not undermine their independent authority as virile manly man.[24]

The masculine heroes created by fiction writers and movie stars were joined by an expanding circle of professional and amateur athletes such as baseball legend, Babe Ruth, boxers Jack Dempsey and Gene Tunney, as well as athletic curiousities like body builder Charles Atlas, who promised to transform the puny body of any 98 pound weakling into a muscle-bound Adonis. Popular interest in athletic competition certainly predates the

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[24] Between 1918-1926, Rudolf Valintino appeared in 21 films. Probably his most famous film was *The Sheik*, (1922). Douglas Fairbanks was twelve years older than Valintino, but both actors rose to stardom in the early 1920s. Fairbanks, who performed all his own stunts, starred in such early blockbusters as *The Mark of Zorro* (1920), *The Three Musketeers* (1921), and *Robin Hood* (1922); Tarzan first appeared in Edgar Rice Burroughs' novel, *Tarzan of the Apes*, (1914). Several other Tarzan books followed. The character also appeared in comic books and movies; Zane Grey wrote several westerns in the 1910s, '20s and 30s, including *Riders of the Purple Sage*, (1912), *Lone Star Ranger* (1914) and *Mysterious Rider*, (1921); Gail Bederman discusses the masculine meanings of Theodore Roosevelt, Tarzan and Rudolf Valentino in *Manliness and Civilization: A Cultural History of Gender and Race in the United States, 1880-1917*, (Chicago and London: Chicago University Press, 1995): 170-239; For a discussion on the self-stylized masculinity of Ernest Hemingway see Lynne Segal, *Slow Motion: Changing Masculinities, Changing Men*, (New Brunswick, NJ: Rutgers University Press, 1990): 111-115; On masculinity in the movies see, Miriam Hansen, *Babel and Babylon: Spectatorship in American Silent Film*, (Cambridge, Mass.: Harvard University Press, 1991): 243-294; For a review of Canada's fictional RCMP heroes see Keith Walden, *Visions of Order: The Canadian Mounties in Symbol and Myth*, (Toronto: Butterworth & Co., 1982); and Michael Dawson, *The Mountie from Dime Novel to Disney*, (Toronto: Between the

1920s, but with the expansion of commercialized sport, the availability of mass media to advertise events, the reduction in work hours and the increase in disposable income, both middle and working class men were able to participate in sports activities. Growing numbers of women also found pleasure in athletic past-times, but commercialized events tended to focus exclusively on the athletic achievements of men, thereby relegating women to the role of adoring fan, cheerleader and in some cases the sexual spoils of manly competition. The penultimate symbol of athleticism was the Olympic Games. Throughout the 1920s and 1930s, the Olympic games increased the number of events, athletes and participating countries. More importantly, the emergence of mass communication media enabled an international audience to participate vicariously in the sporting event. Olympic enthusiasm spawned a revival in classical motifs which paid homage to the masculine form. Representations of these images are particularly prevalent in the art and architecture of Europe's fascist governments. In Spain, Italy, Germany and Russia the sleek athleticism of male youth offered a compelling metaphor for what each government believed was the power and purity of their ideological platforms.[25]

Lines, 1998); For a general overview of popular culture in the 1920s see Lynn Dumenil, *The Modern Temper: American Culture and Society in the 1920s*, (New York: Hill and Wang, 1995).

[25] On masculinity in sports and leisure see Roy Rosenzweig, *Eight Hours for What We Will: Workers and Leisure in an Industrial City, 1870-1920*, (Cambridge, N.Y.: Cambridge University Press, 1983); Varda Burstyn, *Rites of Men: Manhood, Politics and the Culture of Sport*, (Toronto: University of Toronto Press, 1999): 76-102; Derek Birley, *Playing the Game: Sport and British Society, 1910-1945*, (Manchester: Manchester University Press, 1995): 194-222; Steven A. Riess, *City Games: The Evolution of American Urban Society and the Rise of Sports*, (Urbana and Chicago: University of Illinois Press, 1989) 93-126: Lynn Dumenil, *The Modern Temper*, 77-84; Note also, Elliott J. Gorn, "The Manassa Mauler and the Fighting Marine: An Interpretation of the Dempsey-Tunney Fights," *Journal of American Studies*, 19 (April 1985): 27-47; Elizabeth Toon and Janet Golden, "Rethinking Charles Atlas," *Rethinking History*, Vol. 4, no. 1, (2000): 80-84; On male athletics and national identity see, Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain, and the Great War*, (Chicago: University of Chicago Press, 1996); Michael Kimmel, *Manhood in America: A Cultural History*, (New York: The Free Press, 1996): 191-222; On race and masculinity see George L. Mosse, *Nationalism and Sexuality: Middle Class Morality and*

In addition to gender, this masculine aesthetic was also packaged in a racialized form. Contemporary fascination with the male body was imbued with the racial presumptions of the era. Whereas masculine images suggested strength and authority, whiteness represented the civilizing qualities of purity, rationality and self-restraint. Having been excluded from the white male rubric by virtue of their skin tone, non-white men found themselves caricatured as either strong but primitive, or cultured but weak and/or devious. Fiction writers perpetuated these derogatory images by molding Africans, Asians, Indians, Jews, Italians, Socialists and Russians into all manner of delinquents, scoundrels, traitors, gangsters, bootleggers, racketeers and sexual deviants. Even in Canada, as white society embraced the material culture of Africa, India and the Orient, social politics remained stalwartly xenophobic. The violent actions and rhetoric of groups like the Ku Klux Klan, Swastika Clubs and Adrien Arcand's Brownshirts, may have represented the extremist views of a minority of whites, but the more general acceptance of policies which endorsed anti-Semitism, native assimilation, black segregation, socialist deportation, Asian head taxes and the eugenic theories of race suicide, demonstrates the nation's intolerance of social, ethnic and political diversity.[26]

The images conjured up in public health literature did not escape this cultural climate, but readily drew upon the same assumptions regarding masculine power and

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Sexual Norms in Modern Europe, (Madison, Wi.: University of Wisconsin, Presss 1985): 133-180; George L. Mosse, *The Nationalization of the Masses: Political Symbolism and Mass Movements in Germany from the Napoleonic Wars Through the Third Reich*, (New York: Howard Fertig, 1975): 100-126; Albert Speer, *Inside the Third Reich*, translated from the German by Richard and Clara Winston, (New York: MacMillan co., 1970): 96-97, note illustrations of classical architecture and motifs.

[26] Bederman, *Manliness and Civilization*; See also Alan M. Kraut, *Silent Travelers: Germs, Genes, and the "Immigrant Menace,"* (Baltimore and London: Johns Hopkins University, 1994); On the Ku Klux

racial integrity. Sickness perverted male bodies and rendered them repugnant and ineffectual. For instance, in a short radio play about the benefits of smallpox vaccinations, Jim Cowan is transformed from a popular successful insurance agent to a pathetic object of pity. Jim and his wife, Marie, refused to get vaccinated, even after they learned that there was a local outbreak of smallpox. Predictably both Jim and Marie are infected. Marie dies. Jim lives, but he is "disfigured so badly that people who meet him stare in sympathy -- or shudder with horror and look away." The disease also broke his spirit and even after ten years he was still "lonely and heartbroken, filled with remorse, without heart or courage for his work."[27]

The clinical photographs and warnings which accompanied venereal disease films added to the gruesomeness of the disease. Various films showed patients with sores on their penis, lips and tongue. Some films showed men who had massively enlarged testicles, severe skin rashes, joints damaged by locomotor ataxia and the expressionless stare of insanity. In attacking the sexual organs of the body, venereal disease struck at the heart of men's virility. The symptoms of the disease served as public evidence of their physical corruption. The emasculating nature of the disease was compounded by the dire warnings that untreated syphilis and gonorrhoea could cause sterility and that children born of syphilitic parents were likely to be born weak, blind, diseased or dead.[28]

Klan and other right-wing extremists in Canada see, Martin Robin. *Shades of Right: Nativist and Fascist Politics in Canada, 1920-1940*, (Toronto: University of Toronto Press, 1992);

[27] radio script: Let's Talk About Health! series: program #3, *Smallpox*, (HLC, 1941). [NAC. MG 28-I-332, Vol. 129, file 129-2].

[28] Virtually all venereal disease prevention films offered verbal warnings and visual evidence describing the gruesome consequences of untreated syphilis or gonorrhoea. It is interesting to note that few other films presented such disturbingly graphic clinical images. No doubt, the producer hoped that audiences would be sufficiently horrified by the images that they would seek medical help at the first sign of

In health literature, manly men only retained their claim to authority so long as they remained healthy. With the onset of disease, men lost the defining features of their masculinity. They became weak, feeble, irrational, dependent and self-absorbed. Probably the most exaggerated illustration of this is found in the 1951 animated Walt Disney film, *How to Catch a Cold.* The story traces the misadventures of the "Common Man" from health to illness. The Common Man initially appears as a father figure who wears a suit, hat, bow tie and smokes a pipe. As the "Common Man with a Common Cold" the same figure is shown languishing in bed. He wears pajamas instead of a suit, a cold compress instead of a hat, and in place of a pipe, the man now has a thermometer in his mouth. Determined to ignore his illness, the man thoughtlessly spreads the disease and makes himself vulnerable to more serious complications. One scene shows the sick man's immune system attempting to defend itself from the onslaught of aggressive cold complications. The scene is presented as a football match; however, the thin, pale, stooped and cowardly figures who represent the man's immune system are clearly no match for the large muscular figures who represent the germs of pneumonia, influenza, laryngitis, and bronchitis. When at last the Common Man succumbs to his cold, he is shown comfortably propped up in bed reading a good book and listening to the radio. He is no longer a worker or breadwinner, but an enfeebled dependent who whiles away his

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infection. The following films offered some of the most visually graphic images of the illness. *Very Dangerous,* (1945), [NAC, V1 9208-0028]; *Plain Facts about Syphilis and Gonorrhoea,* (1941) [NAC, V1 8208-009]; *It's Up to You,* (1943), [NAC, 13-0054]; *Trial for Marriage,* (c. 1935); *End of the Road,* (c. 1932); The following films represent rare examples of clinical footage feature female patients. *Syphilis: Its Nature, Prevention and Cure,* (c.1945), [V1 8208-009]; *Sixteen to Twenty-Six,* (1945), [NAC V1 9208-0027].

time with pleasant leisure activities. The bouquet of flowers on his nightstand offers a final feminine touch to symbolize the sick man's emasculated status.[29]

Earlier films presented a similar transformation. In *The Priceless Gift of Health* (c. 1920), young Bobby is a healthy athletic boy who is socially popular and good at school. Conversely, Bobby's cousin Richard is small and weak. Richard has no interest in games or sports and he is a poor student. After graduation, Bobby's future held a promising career in business, but for Richard "there was nothing but a future of 'jobs' -- just jobs, any old jobs." It was at one of these dead-end jobs that Richard's problem finally came to the attention of a medical doctor. Following a routine pre-employment physical examination it was discovered that Richard "had developed adenoids which retarded his growth and made him dull and listless." Because the problem had gone undetected for so long, the treatment would take several years, but audiences were reassured that Richard would one day be cured. The implications of this ten minute morality play were fairly clear. Richard's unimpressive physical stature and his uncertain economic future rendered him an unsuccessful man.[30]

No Football for Philip, a 1940s radio play, also draws an association between health and masculinity. In this story, Jim and Edna receive a visit from Jim's Aunt Harriet, who is the widowed wife of a western country doctor and a current member of the Health League of Canada. Soon after her arrival, Aunt Harriet expresses concern over the peculiar behaviour of the couple's youngest son, Philip. In contrast to his older

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[29] *How to Catch a Cold*, (Walt Disney Prod., 1951) [NAC, V19712-0029].
[30] *The Priceless Gift of Health: From Infancy to Maturity*, (National Motion Picture Co., Indianapolis, c. 1920) [NAC, V19709-0025].

brother Eric who is "a growing concern," four-year-old Philip is "quiet, thoughtful... listless." Philip's father finds this wimpy behaviour tedious and tends to "sneer at him because he isn't a rough neck like Eric." "I just want him to be more of a little man," Jim exclaims with exasperation. "I know," commiserates Aunt Harriet. "Boys can't all be football players," Aunt Harriet reminds Jim but she insists that Philip be examined by a doctor. Sure enough, blood tests reveal that Philip is suffering from anaemia, but with the help of iron rich nutritional supplements he should eventually return to normal.[31]

The assertion that male patients were somehow less manly was especially common in the postwar mental health literature. For instance, in the 1949 NFB film, *Over-Dependency*, Jimmy Howard appears as the emotionally immature husband of a maternalistic older wife. Jimmy was a delicate child who was ignored by his father, teased by his brothers and mollycoddled by his mother and older sister. As a boy, Jimmy preferred playing 'shopping' games with the girls rather than football with the boys.[32] He was frequently called a sissy. When he grew up, Jimmy found it difficult to master the responsibilities of adulthood. He had touble holding onto a job. He perpetually deferred to his mother's wishes. He depended on his wife to be the primary breadwinner. Perhaps most damning of all, Jimmy's fear of fatherhood called into question his heterosexual virility. Through psychoanalysis Jimmy discovers that his life-long dependency on women prevented him from achieving the emotional maturity typical of a grown man. Therapy helped Jimmy to develop greater self-confidence and enabled him to take command of his

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[31] Your Health - Your Welfare radio series: *No Football for Philip*, (DNHW, c. 1946), [NAC. R-4098]

life. He learns to say "no" to his mother. He transforms his artistic interests into a career in graphic arts. He also becomes a more attentive husband. In the film's final scene Jimmy and his wife are seen strolling down a residential street, laughing and chatting with the neighbourhood children. The implication seems to be that Jimmy's mental helath as well as his masculinity is fully restored and he is at last ready for fatherhood.[33]

For Jimmy, mental instability was a form of impotence which robbed him of his traditional gender role and identity. Thus Jimmy was unable to fulfill his normal duties as breadwinner and husband, nor was he able to meet society's expectations of masculine strength and integrity. However, once Jimmy overcame his neurotic dependency on older women, he shed his feminine affectations and asserted his masculine identity. Other productions presented a similar image of mental illness in men. For instance, in the radio drama, *A Terrible Secret* (1950), Fred McCrea was portrayed as a shiftless auto mechanic whose fear of injury caused him to avoid the hospital's carpentry workshop in preference for weaving and dance.[34] Another radio drama, with the peculiar title, *Violence is a Virtue* (1954), described young Carl MacMullan who was an inmate at the Rollins Reformatory. Despite Carl's streetwise vernacular and his violent temper, the superintendent (who in this scenario also served as the local psychologist) determined that Carl was in fact as "sensitive as a girl." His tough exterior masked an inner softness which was fostered in childhood when he played with his sisters and the boys called him a sissy.[35]

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[32] In the original script, this scene has Jimmy playing "kissing" games with girls. I could find no explanation for the change. Perhaps the kissing scene was considered too sexually deviant. Conversely, it might have been considered too normal.

[33] *Over-Dependency.* (Canada: NFB, 1949).

[34] *In Search of Mental Health: A Terrible Secret,* (Canada: CBC radio, 1950).

[35] *In Search of Ourselves: Violence is a Virtue,* (Canada: CBC radio, 1954).

Finally, in *In Search of Mental Health: Case History of a Man* (1950), a fictitious patient named Meadows suffers from paranoid delusions, amnesia and acute anxiety. Psychoanalysis, group therapy and twice daily shots of insulin reveal that Meadows' troubles stemmed from his crippled foot which made him unpopular with girls and prevented him from getting into the army. Meadow's feelings of inferiority made it difficult for him to hold down a job. Unable to support his family himself, Meadows relied on his wife's income and his brother-in-law's charity. Meadow's shrewish wife never failed to point out her husband's inadequacies. At various times throughout the drama Meadows's wife nags, "Be a man... try to be a man... I thought I'd married a man!" To the social workers she complains, "soon as things get a little tough he goes to pieces... he's got no character... he wasn't any good as a husband and he can't earn a living!"[36]

In each of the above mentioned films and radio dramas, illness is not only painful and unpleasant, it is also emasculating. The male patient's feeble body, dull or irrational mind, and listless dependency on others stands in stark contrast to the robust bodies and keen minds of healthy virile men. The male patient's deviation from the traditional masculine aesthetic places him within the uncertain category of disaffected 'Others' which include women, the labouring poor and non-white men.

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[36] *In Search of Mental Health: Case History of a Man*. (Canada: CBC radio. 1950).

Health and Ethnicity

In public health literature, the association between illness and race was often ambiguous. On the one hand, metaphorical images of disease were often constructed out of existing fears of dangerous foreigners and an aggressive uncouth working class. On the other hand, the foreignness of some patients suggested that the primary danger posed by foreigners was physical enfeeblement rather than physiological violence. Although films and radio dramas rarely drew direct verbal connections between disease and race or ethnicity, the names, accents and visual cues enabled audiences to make the connection. For instance, the 1942 American social hygiene film, *Know for Sure* (1942), traces the causes and consequences of syphilis in three men. The first syphilitic victim is Toni Madroni (note the feminized spelling of 'Toni'), who is a friendly but excitable Italian man who runs a small dry goods story. In the opening scene, Toni is proudly re-painting the sign of his dry goods store in the happy anticipation of the birth of his first child. "Toni Madroni and Sun" he writes. A passer-by points out the misspelling, but neither Toni nor his friends appear to know what the letter "O" looks like, (which is a bit surprising given that the letter appears in his own name). The happiness of this scene is ultimately shattered by the tragic news that Toni's "bambino" was stillborn. The doctor explains to Toni that the baby died of congenital syphilis which was passed from Toni to the baby via his wife. Toni is devastated by the news and even makes a brief attempt at suicide before bursting into tears. Toni's emotional outbursts, illiteracy and ignorance stand in stark contrast to the two white Anglo-American men who offered Toni assistance.

Both the passerby, who helped Toni with his spelling, and the doctor, who delivered the baby, are tall, neat, rational and intelligent. Their compassion towards Toni is expressed as paternalism and Toni's effusive gratitude, especially towards the doctor (at one point he even kisses the doctor's hand) consolidates his status as their subordinate.

The film's second syphilitic victim is a contrite labourer who claims to have caught the disease from a girl he picked up at a dance hall. Like Toni, this unnamed second man is shorter than the doctor, his denim work clothes belie his subordinate class status and his slow deferential speech patterns suggest that he is not too bright. As with Toni, the doctor treats the patient with paternalistic compassion and even praises him as a "good boy" when he explains his decision to seek treatment. The final victim is a young white college student named Jerry Anderson. Jerry believes he caught syphilis after his team won the big football game and he and the rest of the team celebrated their victory by going to a brothel. Although the audience doesn't get to see "Miss Peg", Jerry's usual escort, the door to the brothel is opened by a black woman who may or may not be the house madam. Clearly audiences are encouraged to associate Jerry's disease with the eroticised sexuality of African Americans.[37]

Animated films were, if anything, more forthright in linking patients to a foreign 'other'. For instance, in *The Road to Health* (c. 1936), which was mentioned in a previous chapter, venereal disease transforms healthy white men and women into torpid black shadows, whose vigor and whiteness is only restored by treatment.[38] The 1950

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[37] *Know for Sure*, (The Research Council of the Academy of Motion Pictures, Arts and Sciences. 1942) [NAC, V1 9712-0029].
[38] *The Road to Health*, (British Social Hygiene Council, c. 1936) [NAC, V1 9712-0025].

tuberculosis film, *Rodney*, employed a similar visual metaphor. Rodney is described as an 'average' man from an "average town". He is friendly, popular, athletic, law-abiding and helpful. He also has tuberculosis. When Rodney asks his doctor, "Who spread it to me?" The doctor explains that the disease is spread by "spitting, sneezing and coughing". In the accompanying graphics, Rodney's white body is suddenly transformed into a black silhouette and he is joined by other black bodies, all of whom are shown releasing the deadly germs into the air.[39]

Finally, in the animated Walt Disney film, *How Disease Travels* (1944), Joe Burns appears as a brown-skinned peasant farmer. Joe is a nice fellow, but his simple ignorance ultimately endangers the entire village. Because Joe's farm lacks a latrine, he tends to relieve himself in his own corn field. Joe's "filth" pollutes the drinking water and attracts flies causing Joe and his neighbours to get sick. Many of Joe's neighbours turn out to be equally foolish. John Smith, the shop-keeper, has a lung disease which he spreads to his family and customers. Bill Jones' son, Johnny, has 'spots', but because he is not quarantined his illness spreads to his classmates and their families. Notwithstanding their Anglo-Saxon names, all of the characters in *How Disease Travels*, are brown-skinned and live in simple adobe buildings. The film was part of the "Health for the Americas" series sponsored by the Institute of Inter-American Affairs of the U.S. Government. The objective of the series was to introduce the principles of hygiene and prevention to third world nations. The series also received widespread distribution in Canada and the United States. The DNHW considered *How Disease Travels*, "an

[39] *Rodney*, (National Tuberculosis Association, 1950). [NAC. VI 9712-0033].

excellent film for Indians, and interesting and instructive... for children anywhere."[40] The characters in this film were certainly sympathetic, but they were also responsible for the diseases that threatened to devastate their village. For native audiences, who were expected to see themselves in the characters of Joe Burns, John Smith and Bill Jones, the representation relegated them to the status of witless victim. For white audiences, the narrator's insistence that these characters threaten the health of "your wife" and "your family" and "our village" takes on a the familiar ring of xenophobia.[41]

Health and Social Responsibility

This notion that the diseases of a single individual undermined the vitality of the entire village offered audiences yet another incentive to remain healthy. As the literature repeated time and again, sickness was not only a tragedy which befell a single individual it was a social event which hindered progress by disrupting the normal social order and diverting scarce resources towards largely unproductive ends. Thus the factors which set patients outside the bounds of normality were not just physical, they were also social. In failing to protect their health, sick individuals failed to meet their social obligations as workers, parents and citizens. They became a burden to the community of family, friends and health care providers who nursed them back to health. Moreover, sick individuals

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[40] *National Health and Welfare Film Library Catelogue*. (Ottawa: Information Services Division. DNHW, 1960): 74.
[41] *How Disease Travels*, (Walt Disney, Dept. of Inter-American Affairs, 1944) [NAC, DNHW VLT 7907-0459].

threatened to perpetuate the disorder caused by disease by spreading their germs to anyone who came into contact with them.

social costs

The social costs of illness were most often, though not exclusively, measured in economic terms. "Sickness costs Canada about $311,000,000 a year," announced Henry Spenser, (MP for Battle River, Saskatchewan) to a meeting of the CSHC in 1930.[42] In 1937, the Health League of Canada issued a pamphlet entitled, *Health Conservation: A National and Economic Necessity*, which suggested that the institutional cost of maintaining Canada's 87,645 hospital beds was $169,803,177. The pamphlet also suggested that this figure did not take into account the other hidden expenses such as the millions of dollars spent on Mother's Allowances which, according this pamphlet, were largely paid out to "widows and orphans whose husbands and fathers... were killed by preventable diseases."[43] Another pamphlet suggested that when one calculates in the loss of earnings through the premature death of the breadwinner, the overall cost of sickness rises to "$1,311,000,000 annually."[44]

Health advocates further argued that most of these figures represented a very small fraction of the many social problems which followed in the wake of ill-health. "Criminality

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[42] Henry E. Spencer (MP, for Battle River), "The Health Problem in Canada," speech before Canadian Social Hygiene Council, April 30 1930. [NAC, MG 28-I-332, Vol. 80, file 80-4].
[43] HLC pamphlet: *Health Conservation: A National and Economic Necessity*, (Toronto: HLC, 1937) [NAC, HLC, MG 28-I-332, Vol. 146, file. VD Survey Toronto, 1937.].
[44] CSHC pamphlet: *He Stoppeth One in Three*. (Toronto: CSHC, c.1930) [NAC, HLC, Mg 28-I-332, Vol. 18, file 18-4].

is closely related to the health factor," stated Henry Spenser, as are "such subjects as education, unemployment, insanity... immigration, increased taxation, poverty and numerous other things."[45] Particularly problematic was the impact of an ineffectual or absentee male breadwinner. "Many children are left in want at an early age owing to the premature death of the breadwinner. The life of poverty that follows is often the mother of crime."[46] An identical argument was made in 1946, when the Institute of Maritime Labour surmised that;

> The workers incapacitated by preventable disease -- for example, the victims of locomotor ataxia or chronic heart disease, unable to work or support his family is not only a prospect for relief or charity himself, but his dependent children are too frequently the problem of the Juvenile Courts. Where death steps in, the problem is even more serious. Death is as potent a factor in creating the broken home as is divorce or desertion. Mothers' Allowances and relief cannot supply the complete remedy.[47]

patriotism

With the advent of war, the social utility of good health shifted from production to combat. Whether Canadians built planes, or flew them, patriotic self-sacrifice was now the true measure of citizenship. Health advocates drew upon patriotic sentiments in their effort to promote good health. "This is total war" declared Dr. Gordon Bates, "Civilians and sailors and soldiers and airmen are all fighters alike... an adequate defense program

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[45] Spencer, "The Health Problem in Canada." April 30 1930.
[46] Ibid.
[47] cited in *Labour and Learning: Bulletin of the Maritime Labour Institute*, Feb. 1946. [RG 29. Vol. 180. file 300-1-6].

calls for the maintenance to the highest degree possible of the health of every man, woman and child in the Dominion... For health is a precious asset...Strength of heart, strength of mind... strength of body... all these will be required of us before Victory is finally ours."[48] Bates re-iterated this argument in another radio broadcast, "Courage, endurance, strength, are born of healthy minds and healthy bodies. Before this war is over, everyone of us will be called upon to demonstrate our powers of endurance."[49]

Citizens who failed to protect their health were chastised for diverting precious resources away from the war effort. "Half of the sickness today is silly, stupid, [and] unnecessary," declared Gordon Bates, "Bad enough in peace time, but positively criminal in time of war."[50] J.S. McLean of the Health League of Canada denounced "sickness" as "a form of sabotage."[51] American Social Hygiene posters charged that "a soldier who gets a dose [of syphilis] is a traitor"[52] and the industrial health film, *We're on the Spot* (c. 1940) declared that "a careless worker in industry is as bad as a deserter in the army."[53] The Metropolitan Life Insurance Company similarly warned that "nothing could more seriously sabotage our war effort than a widespread epidemic of Flu. Even without an epidemic, Flu... may cause the loss of many hours of essential war production... Remember... your health, your usefulness to your country, perhaps even your life may

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[48] radio talk, Dr. Gordon Bates, CKCL, 10pm Nov. 20, c.1941. [NAC, HLC, MG 28-I-332, Vol. 18, file 18-11].
[49] radio talk by Gordon Bates, c.1941, [NAC, HLC, MG 28-I-332, Vol. 18, file 18-12].
[50] Ibid.
[51] J.S. McLean (Hon. Chairman of the Industrial Division of the Health League of Canada, and exe. officer of Canada Packers Ltd.), June 21, 1943. [NAC, HLC, Mg 28-I-332, Vol. 102, file "Industrial Health, 1941-45"].
[52] slogan on poster produced by the American Social Hygiene Council/Association. HLC collection. [NAC, HLC, MG-I-332, Vol. 145, file: "Social Hygiene Publications - American"].
[53] *We're On the Spot*, (US film, c. 1940). [NAC, HLC col., V1 8208-097].

depend upon prompt, wise action on your part."[54] The importance of wartime health especially amongst industrial workers was usually punctuated by impressive sounding statistics which measured the number of days lost due to illness or accident by the amount of military equipment which might have been produced. For instance, *We're on the Spot* (c. 1940), presented animated graphics to assert that "250,000,000 man days are lost through plant accidents." While each sick day represented a loss of income to an individual worker, to the nation as a whole it meant the loss of "20,000 large bombers, 100,000 fighter planes, 260,000 light tanks, 500 destroyers, 60 battleships"[55]

When the war in Europe and Japan ended in 1945, national policy once again focused on domestic concerns. Canada's reconstruction policies attempted to ease the transition from wartime to peacetime by stimulating economic development, encouraging foreign investment, and underwriting the cost of various social programmes designed to help veterans improve their skills, find employment, and buy or renovate a house. For women and men alike, domesticity became their mantra. Women were to forego economic independence and concentrate on child care and housekeeping, and men were expected to resume their role as provider and patriarch. Public health educational initiatives also targeted the private sphere with renewed vigor. Advice literature instructed housewives in proper nutrition, basic child care, and how to most effectively spend the monthly family allowance cheque.[56]

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[54] MLI pamphlet: *Influenza*, (1942). [MLI archives, 4-HW-11 #3].
[55] *We're On the Spot*, (US film, c. 1940). [NAC, HLC col., V1 8208-097].
[56] Postwar government childcare advice literature included, the ever popular *Canadian Mother and Child*, (regularly updated since 1920s), and *Up the Years from One to Six*, (1948). Films include, *Mother and Child*, (1947), *Peppo and the Family Allowance Cheque*, (c. 1946), *Know Your Baby*, (1947), *Mystery in the Kitchen*, (1959), and the NFB's *Ages and Stages* series (1949-1957). For a review of postwar childcare

At first glance, much of the maternal advice literature appears to be a more modern rendition of the prewar material, but, the focus and tenor of the advice had changed. In the interwar years, most maternal advice literature concentrated on meeting the physical needs of children. Parents who failed to meet these needs were ridiculed for undermining the racial integrity of the nation. During the war, when healthy bodies were at a premium, the sick and infirm were admonished for wasting precious health care resources and failing to perform their patriotic duty. By the end of the war, many of the debilitating diseases of childhood had been reduced through vaccinations, medical wonder drugs like penicillin and improved municipal sanitation and housing standards. The rising standard of living also ensured that more families could afford the food, housing and medical care necessary to raise healthy children.

With the dramatic decline of infant, child and maternal mortality, postwar health experts turned their attention towards children's psychological development. Anxious audiences were warned that mothers, and to a lesser extent fathers, could profoundly influence their child's emotional health, which in turn would determine whether they had the mental vigor to confront the adult challenges of the modern world. Instructional films such as *What's On Your Mind?* (1947) explained that the postwar world was fraught with problems and adults who lacked the mental strength to handle them jeopardized their own chances at success and happiness: "In a world changing over night, men long to escape the fears of atomic destruction, the anxieties of everyday living... [the] search for a place

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advice literature in Canada, see Mona Gleason, "Disciplining Children, Disciplining Parents: The Nature and Meaning of Advice to Canadian Parents, 1945-1955," *Histoire Sociale/Social History*, Vol. 29, no. 57, (May 1996): 187-209.

to live... the uncertainties of the job, the worries of the family. For some, the urge to escape grows so extreme they make the final exit in suicide."[57] Like other forms of debility, the problems associated with mental illness were not just personal, they were also social. Health advocates warned of the social and economic costs of divorce, alcoholism, juvenile delinquency, poor job performance, absenteeism, and unwed motherhood, not to mention of the institutional costs of building hospitals and maintaining more hospitals and treatment programmes.[58]

Some experts even went so far as to suggest that national security hinged on the mental fortitude of Canada's citizens. "It is clear that we must learn to live peacefully together, or perish together." Dr. Ewan Cameron, Director of the Allen Memorial Institute of Psychiatry and one of Canada's most respected (and later notorious) psychiatrists, argued that individuals who failed to develop the mental resources to master everyday stresses were far more likely to seek out radical political alternatives, such as communism. "Communism," he argued, "[arose] out of a basic human desire to find security."[59]

The assertion that disease was bad for both the individual and the nation was backed up by constant reminders that individuals were themselves responsible for all of these health related problems. "Sickness does not happen - it is caused," explained the announcer of a 1936 radio programme. "Sometimes it is the result of ignorance,

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[57] *What's On Your Mind?* (NFB, 1947). [NAC, VI 8603-0095].

[58] list of topics from radio series, *What's On Your Mind?* (Spring 1946). [NAC, DNHW, RG 29, Vol. 121, File 190-3-8]; advertisement for CBC radio broadcast *In Search of Ourselves*, (Jan. 9, 1948) [NAC, DNHW, RG 29, Vol. 121, file 190-3-8]; HLC News Release: "Mental Illness undermines the Economy of Canada" (Jan. 20, 1954) [NAC, HLC, MG 28-I-332, Vol. 19, file 19-11].

sometimes carelessness, at times lack of opportunity or deliberate folly and dissipation. But, ever and always, when sickness comes one can, if he delves deep enough, find the cause for it."[60] Dr. Grant Fleming, from the Department of Public Health and Preventive Medicine at McGill University was equally adamant that health was largely a matter of personal responsibility. In a speech presented before the CSHC in 1929, Fleming declared: "The public themselves, because of their ignorance, superstition, carelessness or indifference, are directly responsible for this appalling state of affairs which results in the taking of a tremendous toll in human lives...."[61]

parenting

Parents especially were held accountable for the diseases that endangered children's lives or rendered them enfeebled adults. "Why should children suffer for the ignorance or other faults of their parents?" asked Grant Fleming in his speech before the CSHC in 1929, "Why should the child of today lose his life, why should he suffer pain or lose his adult health just because his parents neglected to protect him?"[62] The literature was particularly vitriolic towards parents who failed to immunize their children against diphtheria. "DIPHTHERIA IS A PREVENTABLE DISEASE" shouted the bold letters of one HLC pamphlet, "SOMEONE MUST BE HELD ACCOUNTABLE FOR EVERY

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[59] Montreal *Gazette*: "Attitude to Behaviour Help to Reds, says Psychiatrist" (April 25, 1951). [NAC, HLC, MG 28-I-332, Vol. 106, file "Mental Health, 1950-51"].
[60] radio talk: CRCT, March 31, 1936. [NAC, HLC, MG 28-I-332, Vol. 90, file 90-7].
[61] article/speech by Dr. A Grant Fleming (Dept. of Public Health and Preventive Medicine, McGill University), CSHC, Montreal, June 1929. [NAC, HLC, MG 28-I-332, Vol. 10, file 10-29].
[62] Ibid.

DEATH FROM DIPHTHERIA."[63] "Every time a little child dies of diphtheria, someone is to blame...." concluded one radio drama.[64] Another radio announcer put the situation even more bluntly, "if your children die of diphtheria, it is your fault because you preferred not to take the trouble to protect them against it." [65] "Parents who really love their children," insisted yet another radio talk, "will never permit this disease to come into their homes."[66]

Few forms of child care advice literature were as harsh as the condemnations against diphtheria. More common were the not-so-subtle health dramas which described what happened when parents failed to put their children's needs ahead of their own. For instance, in the booklet, *Your Baby's Teeth* (c. 1944), a first time mother-to-be, named Bess, refused to give up her busy social life when she became pregnant. She also failed to solicit the advice of a doctor or dentist. Conversely, Bess' neighbour, Helen, gave up all outside interests and religiously followed the prenatal advice of her physician. As expected, the choices made by Bess and Helen had a direct impact on their offspring. Helen's baby was a healthy, well-behaved child who had straight white teeth and a sunny disposition. Bess's daughter, Carol, was an ill-tempered undernourished baby who cried all the time, was bow-legged and had crooked yellow teeth. The tragedy of Carol's sickly disposition was of course compounded by the fact that she was a girl. As Bess repeatedly

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[63] "Diphtheria, Its Prevention and Cure" (CSHC, nd). [NAC, HLC, MG 28-I-332, Vol. 18, file 18-4].
[64] Radio talk: *The Fairy Wand in Diphtheria*, 1938-39 season. [NAC, DNHW, RG 29, Vol. 121, file 190-1-2].
[65] radio talk: no title, no date, re. Diphtheria, c. 1932-36. [NAC, HLC, MG 28-I-332, Vol. 90, file 90-7].
[66] Radio talk No. 7 (c. 1935). [NAC, MG 28-I-332, Vol. 90, file 90-7].

wailed, "a little girl who isn't pretty has a miserable time... if a little girl isn't pretty it's just terrible."[67]

The contrast between Bess and Helen's approach to parenting demonstrated that good health was not determined by fate or biology but by the conscious decisions of individuals. In this story, the sins of the mother were visited upon the child in the form of an unattractive appearance and ill-tempered disposition. The long term consequences resulting from Helen's good decisions and Bess's bad ones appeared as definitive evidence of the causal links between a parent's conscious choices and a child's physical and emotional disposition.

Other tales offered a similar warning to parents who failed to take necessary precautions to safeguard their child's health. In *Tonsils*, a Department of National Health and Welfare (DNHW) radio play circa 1934, Billy Barton was an irritable young boy who suffered from ear aches and loss of appetite. Despite the advice of their friends and Billy's own doctor, Mr. and Mrs. Barton were reluctant to pay for a tonsillectomy. Predictably, Billy's situation eventually turned critical and he was forced to undergo emergency surgery.[68] In another, untitled radio drama produced by the HLC (circa 1934), young Helen Spencer pleaded with her parents to be given the toxoid shot against diphtheria; Helen's friends were all given pennies or nickels for "taking their toxoid without squawking." Unfortunately, Helen's parents delayed getting the procedure done with

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[67] booklet: "Your Baby's Teeth" prepared by the Canadian Dental Association and the the Federal Division of Child and Maternal Hygiene (c. 1944). [NAC, HLC, MG 28-I-332, Vol. 76, file 76-11].
[68] radio drama: "Tonsils" (HLC, c. 1934) [NAC, HLC, MG 28-I-332, Vol. 128, file 128-17].

predictable consequences. Helen developed diphtheria and had to be sent away to an isolation hospital. In frustration the doctor chastises Helen's parents:

> That child's life is in your hands, and... you aren't capable of trust when you neglect to protect your child against a disease of this sort... Instead of mild and pleasant toxoid, which is absolutely harmless, you face the child now with Isolation Hospital, huge doses of anti-toxin injected into the blood stream with long needles. The youngster will be sick a long time with diphtheria, and one never knows what after-effects it will leave... It sometimes impairs the sufferer for life... Those are the things that you have brought on by negligence....[69]

In each of the stories described above children were portrayed as the innocent victims of their self-serving or irresponsible parents. Since children lacked both the knowledge and the means to protect their own health, they could not be held accountable for the diseases they contracted. Adults, on the other hand, were supposed to know better. Unlike children, adults were expected to have the background knowledge necessary to make sensible choices concerning their health. Moreover, their obligation to fulfill certain socially prescribed roles meant that they had a corresponding obligation to seek health and avoid disease. In an effort to convince audiences to take this obligation seriously, the writers of health literature tended to exaggerate the culpability of individuals and the consequences of their actions.

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[69] Radio Talk: "Health Drama No. 2" 1934/35 season. [NAC, HLC, MG 28-I-332, Vol. 128, file 128-7].

Accidents

Accident prevention material offers a particularly good example of this. For instance, in the animated short film, *Three Blind Mice* (NFB, 1945),[70] the foibles of three anthropomorphized mice are used to demonstrate the dangers of ignoring industrial safety regulations. During the course of the five minute film, the mice forget to put the guard on the machinery and are sucked in. They hurt their backs while lifting heavy boxes. They break their bones when they trip over carelessly misplaced equipment. They also fell off a telephone pole because they forget to use a harness. Eventually the mice are blinded by an explosion which they started when they thoughtlessly threw their cigarette butts into a pile of oily rags. Although the cartoon is clearly intended as an educational comedy, it nevertheless offers a number of derogatory linkages between class, ethnicity and intelligence. Class is conveyed through the mice's clothing and work-place. Ethnicity is suggested when the mice spontaneously, and inexplicably, break into Russian folk dancing. Intelligence, or the lack thereof, is demonstrated by the childlike foolishness of the mice. To add insult to injury, the decision to choreograph a film about occupational safety to the tune of a children's nursery rhyme belittles the severity of industrial accidents and suggests that victims of accidents are no smarter than children (figure 5.7).

Some live action films also employed humour to convey ideas about prevention. Like the characters in animated graphics, the actors in these films portrayed characters who were excessively foolish or unlucky. *Accidentally Yours* (1950), describes the

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[70] *Three Blind Mice*, (NFB, 1945), [NAC, 13-1211].

misadventures of "Mr. Dorian Dope", who is left alone in the house when his wife leaves town for a few days. During his wife's absence, Dorian happily takes over his wife's domestic chores. In the process, Dorian manages to step on broken glass, swallow poison, slip in the bath-tub, electrocute himself, cut himself, set the kitchen on fire, trip over furniture, fall off a ladder and cause the hall ceiling to cave in. Dorian also antagonizes a burly milkman and a ferocious dog, both of whom eventually get the best of the hapless Dorian. Similar to *Three Blind Mice* which playfully mocked working-class immigrants, *Accidentally Yours* found humour in the antics of a domestically challenged man. Dorian's lack of traditional manly qualities is asserted through his diminutive demeanor, his effeminate-sounding name, his glasses, his bow tie, his willingness to undertake domestic chores (Dorian even wears an apron while doing housework), his fear of strong men and loud dogs, and his complete inability to perform even the simplest of tasks without hurting himself. Obviously Dorian is completely lost without his wife. Dorian's humorous ineptitude in the domestic sphere bolsters the notion that housework is a uniquely feminine skill, and yet the inanity of Dorian's accidents simultaneously makes light of the actual skill and usefulness of women's domestic labours (figure 5.8).

The characters portrayed in *Three Blind Mice* and *Accidentally Yours* may have been premised on derogatory notions of workers and housekeepers, but the films were intended to be humorous, not offensive. The films exaggerated the artlessness of the characters in order to teach audiences how to avoid certain types of common accidents. Interestingly, film-makers found that humour was particular effective in teaching accident prevention. Viewer surveys conducted at the NFB in the early 1940s found that audiences

were generally unmoved by accident prevention literature. The reason for the lack of interest, explained NFB producer, Stanley Hawes, was simple; "Most accident prevention films... are dull." Hawes suggested that "there is... a kind of resistance among industrial audiences to films on safety, based on every workman's belief that he has nothing to learn about safety, even if the other fellow has." Hawes concluded that if accident prevention films are to be effective they "must employ a technique which will capture the interest of the audiences, even against their wishes. This must be done by the films on their own merit as entertainment, apart from the lessons they contain. Humour... is the obvious means to this end."[71] The advantage of humour was that it invited audiences to laugh at the foibles of the central characters. Audiences were not expected to identify with the victims but to feel superior to them. Their sense of superiority, however, lasted only as long as they remained accident-free. Since accident victims were clearly to be derided as careless fools, it was hoped that audiences would try to avoid accidents and therefore deflect ridicule.

The problem with this approach was the tendency to assume that all accidents were due to carelessness on the part of the victim (or perhaps co-worker). The possibility that the job itself was dangerous, or that machinery has a tendency to malfunction, or that employers have a responsibility to ensure the safety of their employees, was largely ignored. In making accident victims culpable in their own misfortune, personal responsibility replaced the element of chance. For at least two members of the NFB film crew, the injustice of this premise was obvious. During the filming of an episode of

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[71] Report: "Films on Accident Prevention" by Stanley Hawes. 23 August, 1944. [NFB archives, NFB

Accidents Don't Happen (a live action series which was shot on location at the Canadian General Electric plant in Peterborough, Ontario), a three pound, 3.5 inch wood drill broke off its shank and hurled through the air, hitting cameraman Kenneth Pealow in the face, and fracturing the skull of sound-recordist, Clifford Griffin. Pealow suffered several lacerations which probably left scars but were otherwise superficial. Griffin was not so fortunate. He had to have a metal plate surgically inserted into his head and recurring infections required additional operations. Griffin spent several months in hospital before returning home. It is unclear whether he was ever able to return work. Filming of *Accidents Don't Happen* resumed shortly after the incident, apparently without alteration to the script. [72]

Humour may have been a popular method of livening up a mundane topic, but it was not employed very often. Instead, most public health education literature adopted a more serious tone. Even material that was presented under the partial guise of entertainment (notably radio dramas and feature films) was generally construed as melodramas rather than comedies. There are several possible explanations for the preference for serious presentations. The most obvious is that the seriousness of the material was intended to reflect the seriousness of the problem. Unlike accidents which are the traditional fodder of slapstick comedies, it is more difficult to find humour in disease, especially the degenerative diseases. As noted earlier, the style of the literature also influenced the way the audience are positioned vis-à-vis the characters in the

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#1, 02-040],

[72] No one was deemed responsible for the accident and it is not clear whether Griffin or Pealow received financial compensation. Mulholland merely admits that "Griffin has suffered considerably, both

presentation. Whereas comedies invited the audience to feel superior to the 'patient,' dramatic presentations and fact-based documentaries encouraged the audience to empathize with the patient. By making the patient appear as a sympathetic character rather than a ridiculous one, it was hoped that audiences would more readily recognize the patient's flaws and experiences as similar to their own. To foster this form of self-identification, educational literature strove to make patients appear as average and as ordinary as possible.

lifestyle

Having established that responsibility for illness rested with the individual, public health experts offered information on how individuals might best avoid disease and preserve their health through lifestyle choices. Typically, this information concentrated on the lifestyle choices made by the individual. Some sources plainly spelled out the types of activities which lead to particular diseases. For instance, the inter-titles of the silent film, *Confessions of a Cold* (1924), explicitly warned viewers to "avoid warm dancing... avoid inappropriate/inadequate clothes... avoid large crowds during epidemics and poorly ventilated buildings... sleep enough and eat sensibly."[73] Similarly, many of the venereal disease films offered overt warnings not to indulge in illicit sexual contact and to avoid situations which might facilitate a casual encounter. For instance, the RCAF film, *It's Up*

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physically and financially." Donald C. Mulholland (NFB producer) to V.C. Phelen (Dept. of Labour). October 30, 1946. [NFB archives, NFB#1, 02-040].

[73] *Confessions of a Cold*, (US, 1924). [NAC, V1 8208-096].

to You! (1943) warned men to "Avoid exposure. Beware of pick-ups. Be suspicious of any girl you can pick up in the street, dance halls, restaurants, hotels or beer parlours. These pick-ups usually have venereal disease... Beware of Prostitutes. These women are always infected. There is no such thing as a safe prostitute... Watch liquor. Liquor excites sexual desires. But what's worse, liquor causes carelessness. Proper precautions are often neglected because of too much alcohol."[74] The equivalent film for women, *Sixteen to Twenty-six* (1945) offered similar advice:

> There are times when you feel lonely and tend to play along with a casual pick-up. Don't do it! These men are often infected. Fits of depression or disappointment sometimes make you take too much drink, hoping that the loss of inhibitions will make you a gayer or more popular person. Seeking escape this way is dangerous. Alcohol not only makes you look like a fool, it makes you foolishly careless. With your normal sexual emotions greatly heightened by liquor it's very easy to expose yourself to infection.[75] (figures 5.9 and 5.10).

Similar to other instructional films, the examples cited above relied on an authoritative narrator to detail the factors which contributed to the contraction and spread of disease. The narrator's forceful warning to avoid certain foods, drinks, people and activities left little room for equivocation. Other sources presented a somewhat more nuanced approach. Dramatic films, such as *The End of the Road*, *Damaged Lives*, and *Her Own Fault*, employed a variety of cinematic tropes which visually linked lifestyle choices to good or bad health choices.

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[74] *It's Up to You*, (RCAF, 1943). [NAC, 13-0054].
[75] *Sixteen to Twenty-six*, (NFB, 1945). [NAC, VI 9208-0027].

In *The End of the Road* (1918), Mary, the young heroine, is portrayed as a wholesome, attractive, level-headed young woman. As a child, Mary's mother answered her questions regarding reproduction without embarrassment or fabrication. Consequently, Mary grew up to be a responsible young woman who was able to avoid dallying with unsuitable men. Mary's friend Vera was not so fortunate. Vera's mother failed to inform Vera of the 'Facts of Life' and instead encouraged her to use men as a way to get the things she wanted, namely money, presents and a wedding ring. Ultimately, Vera's 'fast' life of men and alcohol led to her ruin. Mistaking sex for love, Vera's abusive millionaire boyfriend left her with an unnamed sexually transmitted disease (presumably syphilis) before abandoning her entirely. Mary did not make such an error in judgment. Mary rejected her first marriage proposal on the grounds that she was too young. Instead, she became a nurse and joined an overseas field hospital, where she met and eventually married a dashing young medical officer. While the differences between Mary and Vera may have been rooted in their upbringing, their differing moral codes were evident in their physical appearance and demeanor. Mary was attractive and wholesome. She wore simple tailored clothing. She wore little make-up and her long brunette hair was neatly fashioned in a loose bun. Mary's home was modest yet comfortable and adorned with family photographs. In contrast to Mary, Vera was a self-indulgent, sexually alluring gold-digger who wore excessive make-up, revealing clothing, and expensive jewelry. Vera drank alcohol, smoked cigarettes and bleached her 'naturally' blond hair. Unlike Mary, whose devotion to the care of others was both selfless and patriotic, Vera's

interests were entirely mercenary. Her sole objectivea were to have fun, and to marry a rich husband.[76]

For audiences accustomed to reading, watching and listening to dramatic tales featuring virtuous heroes, rapacious villains and false or fallen women, the characters in the *End of the Road* were eminently familiar, as were the visual clues that defined the essential qualities of their personality and ultimately sealed their fate. Other educational dramas employed a similar set of personality types. *Damaged Lives*, a joint Canadian/American production released in 1933, describes the trials of Donald Bradley, a handsome but impatient young man who is making his way up through the ranks of his father's shipping company. Donald is engaged to Joan. Although Joan loves Donald, her insistence on a prolonged engagement frustrates Donald, and he eventually seeks solace in the arms of Elise, a glamorous blond beauty whom he meets in a nightclub. Donald's brief affair with Elise ends with predictable results. Elise discovers that she has contracted a disease from one of her previous lovers (the exact nature of the disease is implied rather than stated), and she warns Donald that he may have caught the disease from her. Convinced that "nothing like *that* could happen to me" Donald storms out of Elise's apartment whereupon the hapless Elise shoots herself. Donald hides his condition from Joan, whom he eventually marries, and seeks treatment from a disreputable doctor. The doctor's promise of a cure turns out to be false and Donald unwittingly passes the disease onto Joan and his unborn child. When the "blood disorder" is finally revealed, both Joan

[76] *The End of the Road*, (US, 1918), [NAC, ISN 20097, 13-0234].

and Donald are devastated. Joan attempts suicide, but Donald's last minute rescue suggests that their marriage and their family may yet survive.[77]

In their own ways, each of the three central characters in *Damaged Lives* are sympathetic, yet no less culpable in the fate that befalls them. Donald is a self-confident young man, whose ambition, impatience and self-centredness made him vulnerable to the drunken cajoling of his peers, the flirtations of Elise and the false promises of a quack doctor. Donald's night on the town offers viewers a glimpse of urban nightlife that is both exciting and chaotic. The venues he visits are hazy with smoke, crushed with people, deafened by the exhilarating tones of ragtime and jazz, and fraught with the possibility of casual encounters with exotic strangers such as Elise. Elise is a thoroughly modern woman who has given herself over to the exotic culture of nightclubs, speakeasies and house parties. Elise smokes, drinks, wears expensive 'showy' clothes and jewelry. Her make-up is attractive but obvious and her hair is professionally dyed and curled. Elise's elegant penthouse apartment is equally modern and betrays nothing of her family roots or her daytime occupation. Elise is not what contemporary reformers referred to as a professional prostitute, but neither was she a sexual innocent. She was comfortable with men and knew how to manipulate them. In the end, however, her self-indulgent lifestyle led to syphilis and suicide. Joan is probably the most grounded of the three characters, but her lifestyle also puts her at risk for disease. Like Elise, Joan is also a modern woman who is (apparently) self-sufficient, has her own apartment and enjoys contemporary leisure activities, but in comparison with Elise, Joan's tastes are considerably more

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[77] *Damaged Lives*, (Canada/US: 1933). [NAC, ISN 195693, V1 9206-0023].

moderate. Joan's apartment is 'homey', her couture is fashionable but not glamorous, and her social interests tend toward light music, casual dinner parties and bridge games rather than raucous nights on the town. While Joan seems headed toward a fairly traditional domestic future, it is her desire for prolonged independence that initially sets off the chain of events which ultimately threatens the security of her marriage, children and even her life.

Although venereal disease readily leant itself to melodramatic interpretation, other diseases employed similar techniques to link the lifestyle choices of the individual with the diseases of the patient. In 1921, the Industrial branch of the Ontario Department of Health released the silent film, *Her Own Fault*. The film was dramatic in style, but its content was explicitly educational. The story compares the lives of two women. Both women work on the same assembly line of a busy shoe factory, but they lead otherwise separate lives in a large urban community. Mamie, described as "the girl who fails in life's struggle," sleeps with the window closed and wakes up too late to have a proper bath or a decent breakfast (figure 5.11). She prefers to wear pretty dresses rather than appropriate work clothes. Interestingly, Mamie shares her boarding-house bed with another woman. As Mamie's sleeping arrangement passes without remark, it is unclear what conclusions audiences were expected to draw. It is unlikely that audiences were expected to infer that Mamie was a lesbian; however, since virtually everything Mamie did was condemned as inappropriate, her sleeping arrangements were no doubt similarly suspect. Once at work, Mamie is seen chatting and complaining. Her work station is messy and it is clear that she is not an efficient worker (figure 5.12). During her breaks

and over lunch, Mamie gossips and squanders her income on fine clothes. Conversely, Eileen, who is described as "the girl who succeeds", sleeps alone in a bright tidy room. She wakes up early so as to have enough time for a bath. She eats a full breakfast with the other boarders at her rooming house. She dresses appropriately for work. She is punctual, neat and efficient. During her breaks, she does calisthenics, reads the newspaper and knits (figure 5.13). In the evening, Eileen "gets fresh air and exercise" by going canoeing with the factory foreman. Since Mamie, is "too tired for real exercise, [and] too nervous to rest," she "seeks excitement" by going dancing. After several months, the audience is informed that "both girls get what was coming to them." The factory foreman (whom Eileen has been dating) offers Eileen a promotion. Mamie ends up in a sanatorium with tuberculosis (figure 5.14).[78]

Like the characters who contracted venereal disease in the dramas described above, Mamie's tubercular fate was the result of a self-indulgent lifestyle which privileged personal pleasure over healthy moderation. Although Mamie's illness was not the result of sexual misconduct, her affinity with the more chaotic aspects of contemporary culture left her equally vulnerable to moral and physical deterioration. Virtually all of the scenes featuring Mamie highlighted the disorder associated with modern living. She gets pushed in line-ups, crushed at sale racks and jostled on the dance floor. She is always rushing around and yet is always behind schedule. The street scenes show a confusion of motorcars, carriages and people moving at the accelerated pace typical of early silent

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[78] *Her Own Fault*, (Canada: 1921). [NAC, V1 8903-0005]. References to the film also appear in Carolyn Strange, *Toronto's Girl Problem: The Pleasures and Perils of the City, 1880-1930*. (Toronto: Univeresity of Toronto Press, 1995): 189-193.

films. By contrast, Eileen's life is pictured against a backdrop of residential neighbourhoods, family dinners and natural settings. Eileen's more wholesome lifestyle could be construed as a wistful longing for a simpler bygone era; however, Eileen is not old fashioned. She, like Mamie, is an independent woman, who lives on her own, is economically self-sufficient and enjoys an unchaperoned romantic relationship with a man. Unlike Mamie who is so seduced by modern consumer culture that she ends up dying of consumption, Eileen understands the value of moderation. Eileen balances the strain of urban factory work with the simple pleasures found from fresh air and sunshine. Eileen is not driven by time; she manages it. Her life is organized, efficient and ultimately successful. Good health, career advancement and romantic prospects are her final reward.

Over time, the lifestyle choices and cultural cues which were associated with social and physical disorder changed, but the links between the two remained strong. The mental health literature created in the 1940s and 1950s offers a particularly good illustration of the continuing association. By the end of the second world war, much of the prewar ambivalence concerning the self-indulgent excesses of modern consumer culture had dissipated. Years of economic self-restraint gave way to an unabashed celebration of conspicuous consumption. Though most Canadians still exercised fiscal moderation, the booming advertising industry offered the illusion that progress could be purchased in the form of new and improved consumer products. Health promoters incorporated this new consumer optimism into their literature by showcasing the most

recent developments in science, medicine and technology at improving the availability of healthcare services.

With the introduction of antibiotic drugs and vaccines, many of the most virulent pre-war infections, including syphilis, gonorrhoea, tuberculosis, diphtheria, influenza and typhoid, became treatable. By contrast, the dangers of cancer and mental illness seemed to loom larger. In keeping with the notion that mental illness was a form of anti-social behaviour, mental health instructional dramas tended to highlight the patient's neurosis against the backdrop of contemporary consumer culture.

For instance, in 1948 the NFB, in cooperation with the DNHW, released *Feelings of Hostility*, the second installment of its award-winning *Mental Mechanisms* series. The film explores the suppressed neurosis of an ambitious young woman named Clare. Clare is an unmarried, middle-class white woman, who holds a senior position in the editorial department of a successful publishing company. Despite her professional success, it is apparent that Clare is a social failure. Through a series of flashbacks, audiences learn that Clare's childhood was scarred by a series of emotional disappointments, including the accidental death of her adventuresome father, her mother's second marriage to a lackluster banker, the birth of her spoilt step-brother, and her mother's pre-occupation with various other personal troubles. Unable to find the love she needed at home, Clare sought praise in the form of scholastic achievement. Academic competition also served as a conduit for Clare's repressed feelings of hostility. The narrator explained that "Clare works hard at her successes but they give her little real satisfaction because they are gained at the expense of others. She has to excel -- to beat everyone. Success is

necessary to her, but it does not make her happy. It bars her from warm friendly relations." Aside from the narrator's insistence that Clare "has succeeded only in her work and not in the fullness of living," the only clues to Clare's unhappiness are environmental. The isolation which Clare felt as a child was symbolically represented by the overcast skies and frosty landscapes that accompanied virtually all of the outdoor scenes. Clare's childhood home was also oppressive. Its high ceilings, dark wood trimmings and outmoded furniture reflected Clare's emotional isolation from the rest of her family. As an adult, Clare's isolation is most strikingly revealed during her solitary walk home from work in which she steadfastly ignores the allure of brightly lit shop windows, tantalizing cinema billboards and happy chatter of young couples. Once alone in her drab little apartment, Clare puts a record on the phonograph, absentmindedly leafs through a magazine and then dejectedly smokes a cigarette in the semi-darkness of her lonely room (figure 5.15).[79]

Like the women in the prewar health films described above, Clare is a modern independent woman, who is both self-sufficient and self-confident. Unlike the other women, Clare derives no pleasure from her situation. Her material possessions serve as a poor substitute for the emotional vacuum of her non-existent personal life. Whereas the earlier films expressed an ambivalence towards the banality of modern culture, *Feelings of Hostility* suggests that an individual's cultural accommodation is one of the few definitive signs of social stability. In both scenarios, appropriate lifestyle choices surface as the benchmark of health.

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[79] *The Feeling of Hostility*, (Can.: NFB, 1948), [NAC, VI 8702-0002].

Conclusion

The presumption that individuals were accountable for the emergence and transference of disease transformed individuals from hapless victims of aggressive microbes into active agents in the aetiology of disease. This left individuals with an onerous responsibility. Not only were they accountable for the state of their own health, but, more importantly, they were held accountable for the social consequences of their illness. It was the social consequences that most concerned the public health experts. In linking the health choices of individuals to broader social issues such as the overall cost of healthcare, the pace of economic progress, the success of the war effort and the security of the family, public health advocates deflected responsibility for social welfare away from the state and back onto the citizen. The state, working through the various public health agencies, provided individuals with the tools and information necessary to maintain their health, but it was the responsibility of the citizen to act upon it.

The problem then became one of motivation. To encourage prevention, the literature appealed to the vanity of the individual as well as to their sense of social responsibility. Sick patients were castigated for their unattractiveness, weakness and dependency, which in turn made them poor workers, ineffectual breadwinners, bad parents, and disloyal citizens. Only the 'innocent victims' of disease, those who contracted their illness entirely through the negligence of others, escaped culpability. However, their innocence only remained intact if they agreed to submit fully to their

patient status and actively helped to prevent the further spread of infection. Finally, because the images of health and disease were defined, in part, by the notion of personal interest and social obligation, the prescribed means of prevention were also socially defined. Prevention became linked to lifestyle. Life choices that served an acceptable social end led to health, whereas lifestyle choices that challenged conventional social mores of moderation and decorum, or compromised conventional social goals regarding work, family and citizenship, invariably led to disease.

Figure 5.1 - Women in the RCAF shown working at administrative jobs. *Hygiene for Health*, (NFB, 1945).

Figure 5.2 - "What part are you going to play in the world of peace for which you are now fighting?" *Hygiene for Health*, (NFB, 1945).

Figure 5.3 - "The woman who is healthy is attractive." *Hygiene for Health*, (NFB, 1945).

Figure 5.4 - "Because you are woman, health and attractiveness are important to you." *Hygiene for Health*, (NFB, 1945).

Figure 5.5 - Margaret is "a quite competent girl." This picture shows a dowdy Margaret during her first visit to a psychiatrist. *The Feeling of Rejection*, (NFB, 1947).

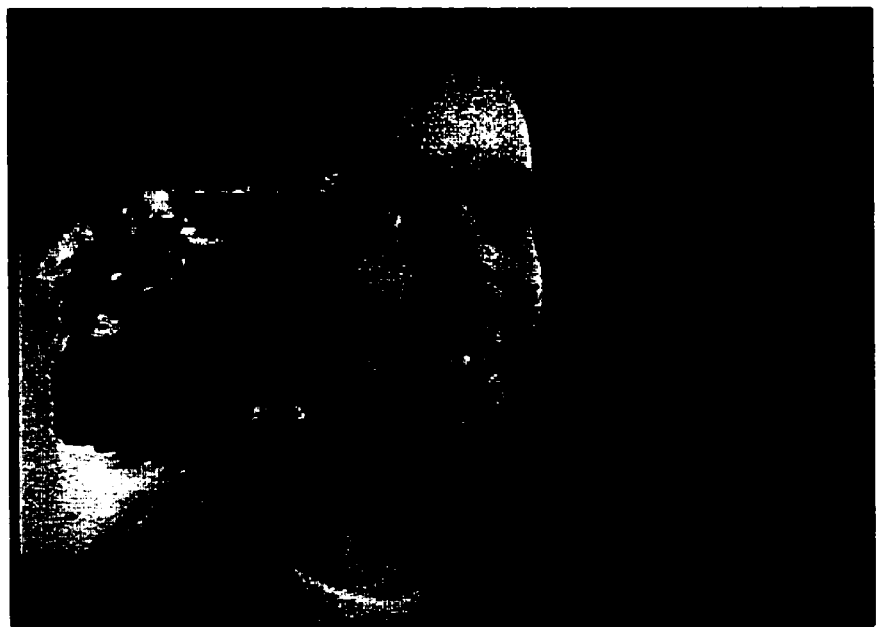

Figure 5.6 - Margaret, cured of her neuroses, appears more attractive and vivacious. In this picture, Margaret has just asserted her independence by asking the shoe salesman to show her something more stylish. *The Feeling of Rejection*, (NFB, 1947).

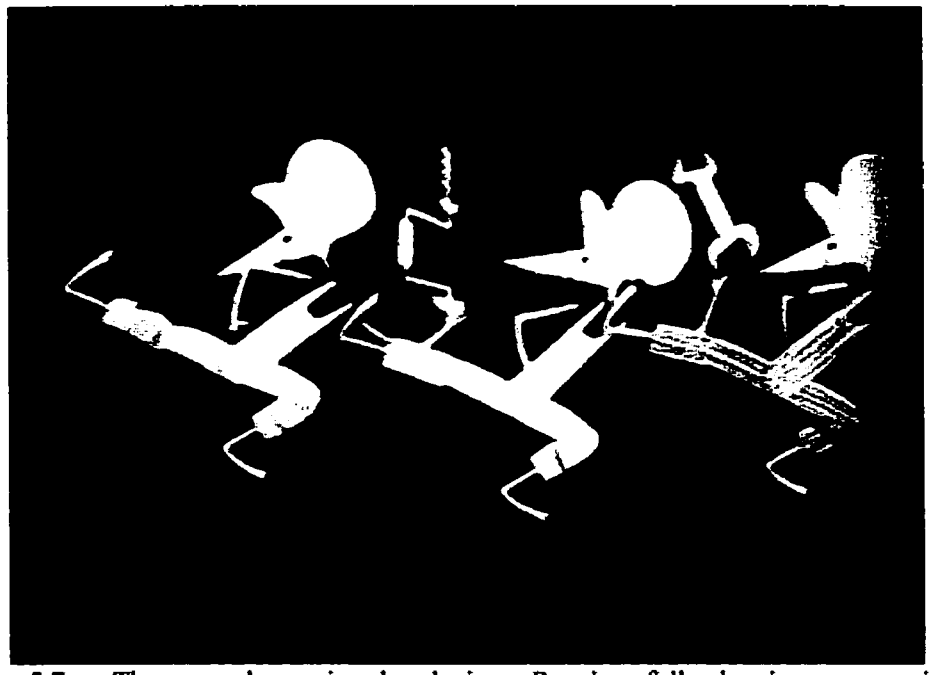

Figure 5.7 - Three worker mice break into Russian folk dancing, suggesting an association between careless workers and communist sabotage. *Three Blind Mice*, (NFB, 1945).

Figure 5.8 - Dorian Dope dons his wife's apron before cooking himself breakfast. *Accidentally Yours*, (NFB, 1950).

Figure 5.9 - In this prelude to seduction, an exotic woman plies a young man with liquor while at a house party. Notice the nude statue in the background. *Trial for Marriage*, (UK, 1936).

Figure 5.10 - Shortly after finishing their drinks, the couple retire to the bedroom where they embrace... and the man contracts syphilis. *Trial for Marriage*, (UK, 1936).

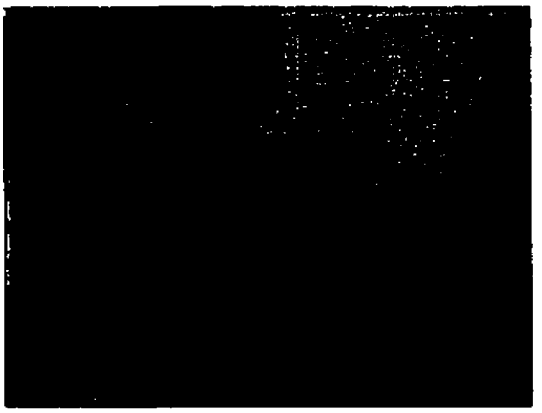

Figure 5.11 - Mamie wolfs down a quick (and presumably inadequate) breakfast at a downtown diner. Notice the busy street scene outside the window. *Her Own Fault*, (Can., 1921).

Figure 5.12 - Mamie and Eileen make heels at a busy shoe factory. Mamie is shown slouched over her machine in foreground. Eileen sits beside Mamie in the background. Eileen sits up straight, and her workstation shows a much larger pile of heels. *Her Own Fault*, (Can., 1921).

Figure 5.13 - Eileen does calisthenics during her mid-morning break. *Her Own Fault*, (Can., 1921).

Figure 5.14 - As a result of her 'fast living' Mamie ends up dying young of tuberculosis. *Her Own Fault*, (Can., 1921).

Figure 5.15 - Successful at work but not at life, Clare smokes a cigarette in her bachelorette apartment. The shadow across her face is symbolic of her incomplete personality. Notice also the unlit candle in the foreground. Candles are typically symbols of hope, but in this instance it could also be interpreted as phallic. The fact that Clare chose to light a cigarette (often a symbol of degeneracy) instead of the candle, suggests that Clare's romantic future will remain desolate. *The Feeling of Hostility*, (NFB, 1948).

Conclusion

When the Canadian government undertook to teach Canadians how to lead healthier lives, its objectives were both pragmatic and ideological. On the one hand it was concerned with reducing the social and economic costs of sickness. On the another hand, it was interested in preserving and promoting national ideals.

In the early twentieth century, Canadians suffered from a variety of debilitating, but largely preventable ailments. Their suffering, moreover, was not just physical, it was also economic. In the absence of a social safety net to subsidize the costs of sick leaves, doctor's bills, hospitalization and the premature death of the family breadwinner, disease could tip the balance between simple poverty and outright destitution. For middle class Canadians, who worried about the apparent links between poverty, crime and urban decay, sickness was both a medical and a social problem. With the increasingly radical and well-organized protests of workers, it became apparent that these social problems would need to be met with concrete solutions. Public health education offered one such solution.

The government's public health education programme was intended to supplement legislative measures which aimed at cleaning up the urban environment and ensuring minimum standards of work, food, housing and sanitation. While these regulatory measures concentrated on the public sphere, education focused on the private sphere. Education was designed to teach individuals how to regulate their own physical and physiological environment so as to maximize their own health and longevity. The information was also was premised on the assumption that preventable diseases were

acquired through ignorance and neglect, rather than as a result of systemic inequalities. With public health education, individuals were encouraged to assume greater responsibility for their health. Recipients of health information were taught the rudiments of biology, the benefits and techniques of preventive hygiene, and the necessity of medical consultation if and when the symptoms of a disease appeared.

Had public health educators merely wished to teach people how to be healthy, such information would have been sufficient. The objective, however, was not just to impart knowledge, but to stimulate a desire to be healthy. It was not enough for citizens to know how to be healthy, they also had to want to be healthy, and they had to be willing to make the necessary personal sacrifices to achieve it. In an effort to make these otherwise pedantic lessons in disease prevention more provocative, health educators wrapped up the information in a variety of attractive packages. Using the tools of mass communication, health educators attempted to tailor their information towards different target audiences. Some material was strictly educational, providing specific information and advice on a diversity of medical problems. Other material was intended to reach a broader cross-section of Canadians by merging health education with popular entertainment, such as film and radio. Health promoters believed that information conveyed via entertainment would not only be more memorable, it would also be more attractive to audiences who would not otherwise be interested in public health information. In this way, health advocates hoped to capture the interest of workers and housewives, immigrants and natives, school children and young adults.

When packaged as a form of entertainment, health information necessarily had to conform to the dictates of contemporary cultural values. By conforming to the popular culture, health information inevitably became a reflection of it. In the 1920s, when the federal government first launched its educational programme, culture was modern. It was new, youthful, and technological. It was characterized by motor cars, aeroplanes, movie theatres, and jazz clubs. 'Self-made men' and 'new women' challenged traditional mores, embraced consumption, and flirted with the era's exotic fashions, past-times and politics. Counter-balancing this fascination with progress was a certain nostalgia for the traditions of the past. The pervasive banality of contemporary culture left many searching for a renewed sense of order. For some, the restoration of order meant a return to the fundamental values of religion, and entailed the censorship of all morally suspect activities, including the regulation of dance halls, movie theatres and public parks. Others attempted to reassert order through the harassment, incarceration, and deportation of radicals, activists and immigrants. Even birth and reproduction became the subject of regulatory measures.

Public health literature reflected both sides of this modernist equation. On the one hand, health advocates deplored the self-indulgent excesses of modern culture and stressed the health-giving virtues of moderation. On the other hand, health promoters were quick to embrace the tools and technology of modern culture in order to disseminate their message. The metaphors of health and disease were also informed by contemporary images. Up until the early part of the twentieth century, disease tended to be represented as some sort of monster. It was a throw back from an earlier, unenlightened time and it

threatened to undermine the progress already achieved. With the advancement of medical imaging, these older images of disease were joined by more realistic ones. Disease began to look like the actual microbes that were its root cause. While these photo microscopic images were, if anything, more monster-like because they were so completely foreign, they also began to take on the characteristics of order. Illustrators and film-makers emphasized the uniformity of the germ, and its ability to reproduce on a massive scale. Germs developed machine-like productive capabilities, endlessly reproducing exact replicas of themselves, to the where they saturated the body's ability to cope.

By World War Two, the reproductive efficiency of microbes was imagined in militaristic terms. Germs became an army of invading evil soldiers waging war against the human immune system. However, unlike the monsters of earlier times who embodied the chaos they created, these militaristic microbes were the epitome of order and efficiency. It was their singleness of purpose and efficiency of action which rendered them such effective producers of physiological chaos. Once the war was over, the external threat of foreign soldiers gave way to an internal threat posed by rebellious teens, 'maladjusted' adults, sexual 'perverts,' and communists sympathizers. Germs became the monster within, an invisible, but devastating foe.

In contrast to the ordered disorder wrought by disease, science was an oasis of rationality. Sometimes revered as heroes, other times admired for their quiet dedication, doctors and scientists were invariably shown as efficient, hardworking and selfless professionals. As objective men of science, medical experts remained emotionally detached from the problems of their patients. Health care workers were rarely shown

enjoying a normal social life with colleagues, friends and family. This tended to create the illusion that medical experts existed entirely for their patients. Their personal lives were sacrificed for the sake of preserving the public's health. Portrayals of health care workers as cool, efficient professionals helped to reassure viewers that doctors, scientists and nurses were objective authorities, but they also helped to exclude viewers from the world of science. The tireless devotion and intellectual brilliance of health experts set them apart from ordinary people. Their authority as experts was beyond question for the simple reason that they were the only ones who fully understood the intricacies of human health.

The complexity of science was further emphasized by images of the scientific process. Science laboratories appeared as mysterious places in which people with superior knowledge used the resources of modern technology to determine health and analyse the diseases of the human body. Sometimes audiences were given the opportunity to see through the lens of a microscope into the real world of microbiology. Yet, the image was likely more mysterious than illuminating. It was clear, however, that health and disease could not be determined simply by how a person "felt". Germs, viruses and bacterium, could infest a body causing serious, if not irreparable damage, before a person knew anything about it. The assurance of safety was in knowing that there were experts who had both the knowledge and technology to protect them.

Tipping the balance between the good forces of medicine and the evil forces of disease was the 'ordinary' citizen. The citizen's tendency towards over-indulge in dissolute activities weakened their immune system and left them vulnerable to disease. Illness was accompanied by a variety of symptoms. Medical symptoms might include a

runny nose, fever, blisters, growths, fatigue, etc. Accompanying these physiological changes were the signs of social transformation. As patients, individuals suffered a loss of social status. Depending on the nature of their illness, women lost their looks and sexual appeal. They ceased to be good wives and mothers, and in some cases they even lost their reproductive capabilities. For men, disease undermined their strength and vitality. It rendered them incompetent as providers which, in turn threatened their status within the family.

The image of the diseased citizen became a metaphor for all that was troubling about contemporary culture. Sick citizens became the symbols and symptoms of the decay, immorality, domestic dissolution, and economic insecurity which seemed to be undermining the progress of the nation. Thus, the promotion of public health, was not just about helping people to stay well; it was also about advancing the social values of the nation. By framing their images of disease within prevailing notions of race, class and gender, public health advocates augmented pre-existing structures of social power and transformed health from a personal consideration to a social obligation. In short, good health became synonymous with good citizenship, but as long as individuals continued to be productive workers, loving parents, and patriotic citizens, their obligation to be healthy was met.

Appendix A: Distribution of Health Literature by Division, 1921-1930, 1941-1960

Year	Child & Maternal	VD	Nutrition	Industrial Health	Mental Health	Information Services
1920						
1921	12,000					
1922	365,503	545,161				
1923		180,000				
1924		198,100				
1925	338,467					
1926	313,717	125,889				
1927		90,805				
1928		140,000				
1929						
1930	69,000					
1941	80,000					300,000
1942	90,000	15,000		12,000		318,660
1943	110,000					381,205
1944	120,000					174,945
1945		712,940	407,000			
1946	76,000			3,700		138,550
1947	c100,000		98,250	135,000		2,115,000
1948				65,000		
1949	c120,000					
1950						5,000,000
1951	c340,000					4,000,000+
1952						5,600,000
1953						
1954			1,000,000	28,200		7,000,000
1955			900,000			8,500,000
1956						10,195,000
1957			7,300			6,228,240
1958			7,850			8,340,000
1959			118,300		2,155,000	9,900,000
1960			1,000,000			8,500,000

Canada. *Sessional Papers*, covering the fiscal year from April 1st, 1920 to March 31st, 1960.

* Departmental Reports were not consistent in their reports. Years which fail to list a distribution figure may indicate poor record keeping rather than a lack of activity. Given the tendency towards under reporting, all figures should be regarded as approximations only.

Appendix B: Distribution of Departmental Magazines, 1920-1930, 1941-1960.

CMB – Canadian Mother's Book, 1920-1939
CMC – Canadian Mother and Child, 1940-1960+
IHB – Industrial Health Bulletin, 1941-1953
CNN – Canadian Nutrition Notes, 1945-1959
NHR – National Health Review, 1940-1946
CHW – Canada's Health and Welfare, 1946-1960+
Info. – Requests for Information

Year	CMB	CMC	IHB	CNN	NHR	CHW	Info. Requests
1920							
1921	12,000						
1922	150,000						
1923							7,315
1924							
1925	55,951						
1926	72,346						
1927							
1928							
1929							
1930							
1941		80,000			48,000		500
1942		120,000					96,285
1943		110,000					66,199
1944		120,000					47,700
1945				7,000			
1946		76,000	3,700		---	70,000	30,500
1947		120,000	35,000		---	80,000	38,000
1948			35,000		---	83,000	
1949		120,000		8,000		80,000	200,000
1950		120,000		8,000		80,000	350,000
1951		120,000					
1952							
1953			28,200				
1954							
1955							
1956							27,000
1957							28,000
1958				7,850		720,000	24,000
1959				8,000		720,000	23,000
1960						720,000	22,000

Canada. *Sessional Papers*, covering the fiscal year from April 1st, 1920 to March 31st, 1960.

* Departmental Reports were not consistent in their reports. Years which fail to list a distribution figure may indicate poor record keeping rather than a lack of activity. Given the tendency towards under reporting, all figures should be regarded as approximations only.

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MG 28-I-63, Dominion Council of Health, 1919-1961:
Reels C-9814, C-9815, C-9816, C-9817.

MG 28-I-332, Health League of Canada Collection:
Executive Series, 1920-1982: Vols. 1-14.
Management Series, 1920-1980: Vols. 14-23.
Provincial Divisions and Local Branches Series, 1919-1979: Vols. 43-71.
Health Series, 1920-1980: Vols. 71-153.

Metropolitan Life Insurance Company (MLI)
Annual Reports, 1944-1960.
Publications, 1915-1961.
Welfare Advertisements, 1940-1960.
Scrapbooks

National Film Board of Canada (NFB)
Selected files relating to specific films.

Films

All films were found at the National Archives of Canada.

* Early educational films rarely included production credits. I have listed whatever production credits were available.

Accidentally Yours. NFB, 1950.

Accidents Don't Happen: The Safety Supervisor. Prod. Michael Spenser. Dir. Ronald Weyman. NFB, 1951.

Accidents Don't Happen: Early Handling of Spinal Injuries. NFB, 1946.

Accidents Don't Happen: Falls. Dir. Donald Mulholland. NFB, 1946.

Accidents Don't Happen: Handling. NFB, 1946.

Accidents Don't Happen: Machines. Dir. Donald Mulholland. NFB, 1946.

Accidents Don't Happen: Organization. Dir. Donald Mulholland. NFB, 1946.

Accidents Don't Happen: Safe Clothing. Dir. David Bairstow. NFB, 1945.

Accidents Don't Happen: Someone's Guilty. NFB, 1952.

Accidents Don't Happen: They are Caused. NFB, 1947.

Ages and Stages: From Sociable Six to Noisy Nine. Dir. Judy Crawley. Crawley Films, NFB, 1953.

Ages and Stages: He Acts His Age. Dir. Judy Crawley. Crawley Films, NFB, 1949.

Ages and Stages: Ten to Twelve. Prod. Judy Crawley. Dir. Edmund Reid. NFB, 1956.

Ages and Stages: The Frustrating Fours and Fascinating Fives. Dir. Judy Crawley. Crawley Films, NFB, 1953.

Ages and Stages: The Teens. Dir. Edmund Reid. Crawley Films and NFB, 1957.

Ages and Stages: The Terrible Twos and Trusting Threes. Dir. Judy Crawley. Crawley Films, NFB, 1951.

Are You Positive? US, 1957.

Are You Safe at Home. Prod. Peter Cook. Dir. George Gorman. NFB, 1949.

Avec Ces Armes. USA, 1940.

Baby's Toilet and Bath. USA, 1916.

Battle for Survival. USA, c. 1940.

Behind the Menu. NFB, 1950.

Behind the Shadows. Prod. A. Windsor. Dir. Leo Lipp. USA, c.1950.

Borderline. Prod. Grant McLean. Dir. Fergus McDonnell. NFB, 1956.

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Canada Carries On: The Outlaw Within. Prod. Guy Glover. Dir. Morton Parker. NFB, 1951.

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City Without Diphtheria. USA, c. 1940.

Community Health In Action. USA, 1940.

Community Organizing. Can., 1942.

Confessions of a Cold. USA, 1924.

Damaged Lives. Dir. Edgar G. Ulmer. 1933.

Defeat Diphtheria. UK, 1941.

Dishwasher Named Red. USA, 1946.

E.A. Patrol. NFB, 1950.

End of the Road. Dir. Edward A. Griffith. ASHC, 1918.

Every Body's Handicapped. NFB, 1953.

Explorations: Unseen Enemy. CBC Television, July 30th, 1959.

Family Circles. Prod. Gudrun Parker. Dir. Morten Parker. NFB, 1949.

Fat Chance. USA, 1920.

Feeling of Hostility. Prod. & Dir. Robert Anderson. NFB, 1948.

Feeling of Rejection. Prod. & Dir. Robert Anderson. NFB, 1947.

Feelings of Depression. Prod. Tom Daly. Dir. Stanley Jackson. NFB, 1950.

Fight for Life. USA, 1940.

Fight Syphilis. ASHC, 1943.

Fight Tuberculosis. Can., 1935.

Food for Freddy. Dir. Judy Crawley. NFB, 1953.

For Your Information. Can. RCAF, c. 1942.

Friend at the Door. NFB, 1950.

Hashslinging to Foodhandling. USA, 1945.

Health is Victory. ASHC, 1942.

Health is Vital to Victory. Can., c.1940.

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Health Series: Hygiene - Food and Growth. U.S.: Department of Biology and Public Health, M.IT. and Eastman Co., c. 1929.

Health Series: Hygiene - Good Foods, Fruits and Vegetables. U.S.: Department of Biology and Public Health, M.IT. and Eastman Co., c. 1929.

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Health Series: Physiology - How Teeth Grow. Mass., U.S.: Department of Biology and Public Health, M.IT. and Eastman Co., c. 1929.

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Health Series: Physiology - The Living Cell. Mass., U.S.: Department of Biology and Public Health, M.IT. and Eastman Co., c. 1929.

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Hygiene for Health. RCAF, 1945.

Invisible Armour / L'Amure Invisible. NFB, 1948.

It's Up to You RCAF, 1943.

Joe and Roxy. Prod. Julian Biggs. Dir. Donald Haldane. NFB, 1957.

Knife and Fork: Supper's Ready. NFB, 1944.

Know for Sure. The Research Council of the Academy of Motion Pictures, Arts and Sciences, 1942.

Know Your Baby. Crawley Films, 1947.

Let's Keep the Killer Down. USA, 1941.

Let's Open Our Eyes. USA, 1938.

Life of a Healthy Child. Prod. Dr. A.F. Hill. USA, 1932.

Longer Trail. Dir. Fergus McDonell. NFB, 1956.

*Merry-Go-Round.*USA, 1961.

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Starlight Story. NFB, c. 1950.

Stigma. Prod. Tom Daly. Dir. Stanley Jackson. NFB, 1958.

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Teeth are to Keep. NFB, 1949.

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Test for Love. UK., c.1935.

That They May Live. Can., 1942.

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Thought for Food. NFB, 1943.

Three Blind Mice. Dir. George Dunning. NFB, 1945.

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Venereal Diseases. Can., c.1925.

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