Returning Home

Historical Influences on Home Healthcare in Canada

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In this article, the historical context of home healthcare in early 20th century Canada is examined with an emphasis on key events and groups that shaped nursing in the home as the primary form of healthcare. Ways in which home healthcare evolved are also addressed, including the movement from an emphasis on the home as the point of care for both preventative and curative services, to the separation of healthcare functions into public health, treatment of illness and injury, and pregnancy care—each with its own practitioners and regulators as hospital-based systems became the desirable norm. We conclude that the nature and status of home-based nursing evolved in response to public expectations of what comprised "best care" and who was responsible for providing (and funding) it. At a certain level, the home offered independent-minded nurses a level of autonomy and inscrutability unparalleled in hospital-based settings. As hospitals took preeminence as preferred sites for healthcare, the same geographic, cultural, and economic barriers that complicated access to hospitals also provided nurses unique opportunities in the home as relatively autonomous caregivers.

Healthcare services in Canada are increasingly being delivered in home settings as a result of new technologies, downsizing in acute care services, and shifting philosophies to provide care "closer to home." Early Canadian nursing—which encompassed prevention and care of illness, injury, and pregnancy—occurred primarily in family homes. Then, as now, private homes were the sites of cultural

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Nightingale's influential Notes on Nursing: What It Is and What It Is Not *was geared toward women caring for their family members in private homes. Nightingale defined "nurse" broadly as almost every woman, as most "in England [have], at one time or another of her life, charge of the personal health of somebody, whether child or invalid—in other words, every woman is a nurse." In a similar vein, every home was a health center; it was those without familial resources who entered hospitals for care.*

encounters where, for example, newly immigrated English nurses negotiated with Aboriginal families to perform Western treatments of illness. Similarly then, as now, healthcare provided in private homes avoided the careful scrutiny of regulators; nursing practice priorities could be defined and negotiated away from the administrative reach of physicians and healthcare bureaucracies. Moreover, today's trends reflect past practices, where home care is increasingly provided by unlicensed healthcare aides, often through contracted services, and often by transnational workers. Home care, in other words, is not a new phenomenon. As will be seen, in the Canadian context, the recent shift away from hospital-based care is best understood as a *return* to the home after a half-century absence.

In this article, we examine the historical context of home healthcare in early 20th century Canada, highlighting key events and groups that shaped nursing in the home as the primary form of healthcare, and then consider historical continuities between past and current issues in home healthcare. Ways in which home healthcare evolved are also addressed, including the movement from an emphasis on the home as the point of care for both preventative and curative services, to the separation of healthcare functions into public health, treatment of illness and injury, and pregnancy care—each with its own practitioners and regulators as hospital-based systems became the desirable norm. At a certain level, the home offered independent-minded nurses a level of autonomy and inscrutability unparalleled in hospital-based settings. As will be seen, as hospitals took preeminence as preferred sites for healthcare, the same geographic, cultural, and economic barriers that complicated access to hospitals also provided nurses unique opportunities in the home as relatively autonomous caregivers.

The Centrality of the Home in Early Canadian Nursing

Before the advent of hospital-based training schools for nurses in the 1870s and 1880s, a nurse was generally understood as a woman who gave care in private homes to those who were ill or giving birth—typically members of her own family (Keddy & Dodd, 2005). Indeed, Nightingale's influential *Notes on Nursing: What It Is and What It Is Not* (1860/2010) was geared toward women caring for their family members in private homes. Nightingale defined "nurse" broadly as almost every woman, as most "in England [have], at one time or another of her life, charge of the personal health of somebody, whether child or invalid—in other words, every woman is a nurse" (p. 49). In a similar vein, every home was a health center; it was those *without* familial resources who entered hospitals for care. Canadian hospitals were, in that period, commonly run by charitable and religious organizations to provide care to the sick poor, transient workers, and newcomers without familial support

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(McPherson, 2003; Young & Rousseau, 2005). Hospitals were neither desirable as places to work, nor as places to receive care. In healthcare, home was the best.

Toward the end of the 19th century, both the function and status of hospitals started to change. In the wake of a hospital reform movement, hospitals began serving patients from all classes of society. Most significantly for nursing, hospitals also started playing an important educational function. New general hospitals were built to accommodate nurses' training schools. The opening of the first hospital training school for nurses at St. Catharine's General Hospital (1874) marked the shift toward nursing as a respectable, hospital-based profession. Along with hospital wards, kitchens, treatment rooms, and operating theatres, most general hospitals included nursing classrooms and residences. Under this new model of hospital-based healthcare—one that would dominate for the next century—nursing students would staff wards while learning their trade (McPherson, 2003). Nursing students followed a highly regimented, 3-year apprenticeship program that gave visibility to the idea of nurse as a respectable and knowledgeable woman. By the turn of the 20th century, hospitals were firmly set as sites for nursing education. Still, the goal of that education was not hospital employment. Rather, it was to prepare nurses for work outside the hospital—as "private duty" nurses in family homes (Keddy & Dodd, 2005; McPherson, 2003; Young, 2010).

Most of the first-generation of trained nurses worked as private duty nurses, living with patients in their homes for varying lengths of time, depending on need (Keddy & Dodd, 2005; Young, 2010). Prior to the Second World War, 43% of nurses worked in private duty (Keddy & Dodd, 2005). They were paid by families, and sometimes by private insurance policies. Highly qualified (and relatively expensive), private duty nurses cared for the ill and injured, newborns and mothers, children and elderly. Although nurses wore uniforms to differentiate themselves from domestic workers, their duties often also involved cleaning, cooking, and child care. The personal and domestic nature of private duty rendered the trained nurse in the home a "subservient quasi-family member, under the authority and direction of the physician as well as the patient and family members who paid her" (Keddy & Dodd, 2005, p. 50). Over time, and undoubtedly related to the growing view of hospitals as efficient sites for medical care, private duty nursing was seen as a waste of nursing skills and money (Peter, 2002). Reflecting back, private duty nurses described missing the autonomy of their work. According to

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McPherson, "the perils inherent in the unregulated private healthcare market were more than compensated for by the autonomy, variety, mobility and equality [private duty nurses] enjoyed" (cited in Keddy & Dodd, 2005, p. 46). Professional autonomy was an inherent part of nursing outside of hospital settings—something appreciated by private duty nurses who lived in patient homes, as well as by nurses who visited patients in their homes, as we will see next.

Visiting Nursing and the Victorian Order of Nurses

At its roots, "visiting nursing" was a charitable service for the sick poor at home (Stuart, 1994). Religious groups were the first to have visiting nurses in Canada. Some, like the Margaret Scott Nursing Mission in Winnipeg, continued as the primary visiting nursing service in their communities well into the mid-20th century. The Victorian Order of Nurses (VON), established in 1897, boasted of being the first nursing service to offer fully qualified nurses who had undergone an additional 6 months of formal "district nursing" training (Penny, 1996). The VON was organized as a national body with local branches supported by local boards. Nurses were expected to collect fees from patients based on their ability to pay, with funds supplemented by donations and government grants (Penny, 1996).

The VON determined to serve those not able to access or contract services of physicians or private duty nurses because of geographic isolation or impoverishment (Penny, 1996). Not only did this policy conveniently avoid competition with private duty nurses and physicians, but the nurses, like their American counterparts (Buhler-Wilkerson, 2007), also experienced considerable autonomy because physicians typically did not oversee patient care (Stuart, 1994). In addition, "while VON nursing work compared with private duty nursing, the former had the advantage of greater institutional support, companionship of colleagues, better pay, and more steady employment" (Keddy & Dodd, 2005, p. 50). And, unlike private duty nurses, nurses working with the VON were usually the social superior of the patient and could exert some authority (Keddy & Dodd, 2005).

By 1913, the VON had expanded to 52 branches across Canada, with 270 nurses to care for 40,000 patients a year (Penny, 1996). Although it also ran two-nurse cottage hospitals, VON was mainly an urban visiting nurse service (Richardson, 1998). With recent immigrants among its clientele, VON actively sought out and responded to needs by offering referrals to direct-relief agencies, and

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services specific to immigrants (Penny, 1996). Other visiting nursing services also strategized how to meet immigrants' unique needs. For example, the Margaret Scott Nursing Mission intentionally used "foreign" nursing assistants, reporting that "these helpers are ... very useful among our cosmopolitan population" (Bramadat & Saydak, 1993, p. 108). VON nurses also provided tuberculosis care, school health services, public education, maternal pre- and postnatal care, well-baby-care home visits, assistance with deliveries, home emergency nursing, care of the chronically ill, and contract work for life insurance companies (Bramadat & Saydak, 1993; Penny, 1996). The VON did not provide midwifery services as was the initial vision of its founder. Acquiescing to the Ontario Medical Society demand to stay away from obstetric care (Penny, 1996), the VON did not provide midwifery even in remote places where there was no access to a physician. In contrast, the Grenfell Mission (established in 1893) provided midwifery services in sparsely settled areas in Newfoundland and Labrador through its visiting nurse service (Coombs-Thorne, 2010). Although nursing care in both homes and hospitals was generally under the authority of physicians, the home as the nurses' domain remained largely uncontested—even more so as physicians moved away from "house calls" toward care in hospitals.

Spanish Flu and the Rise of Public Health Nursing

The year 1918 was pivotal for nursing in Canada. It was the year that the Spanish Influenza pandemic swept across the globe, affecting as many as 100 million people and killing 22 million worldwide (Groft, 2006). Emerging at the tail end of the Great War, the devastating effects of the Spanish Flu compounded the depletive effects of a prolonged war—and exemplified the value of good nursing. The first wave of the Spanish Flu hit American shores in March 1918. Highly virulent, the virus brought on a sudden onset of symptoms that often escalated quickly to pneumonia and death. The second wave hit Canada in September 1918, when 400 college students in Quebec became ill. By November the disease had reached remote regions of Alberta; eventually as many as 4,000 died in that province alone (Groft, 2006). Because there were neither immunizations to prevent the illness nor medical means to treat it, care centered on relieving symptoms, bolstering resistance, and preventing spread of the disease. Quarantined families were dependent on nurses to come to their homes—often to care for entire families. Supportive nursing measures such as blankets, soup, fresh air, and "tender loving care" were critical to patient recovery (Groft, 2006).

The Spanish Influenza pandemic in Canada exposed a need for preventive and coordinated healthcare services (Groft, 2006). The Canadian government moved swiftly to create a department of health in June 1919, as the third wave of the epidemic was waning. That same year the *Public Health Nurse's Act* was enacted. This act legislated that there be established, in connection with the Provincial University, a special course of study for nurses that would include topics such as sanitation, personal hygiene, public health, prenatal care, infant and child welfare, and inspection and instruction of school children (Ross-Kerr, 1998). In 1920, Canada's first department of public health nursing was established at the University of Toronto (University of Toronto, 2010). Over the next two decades public health nursing, a concept coined and initially developed by nurse activist Lillian Wald in 1893, surged in Canada. Populations considered at risk for contracting and spreading disease—particularly immigrant, working poor, and Aboriginal families—became recipients of targeted education and immunization campaigns led by nurses. And, as with the private duty and visiting nurses who had come before, the family home was viewed as a key site to offer public health services.

Nursing on the Edge: Outpost Nursing

Healthcare in Canada was (and is) complicated by the geographic, linguistic, and cultural barriers posed by Canada's widely dispersed settler, immigrant, and Aboriginal communities. One of the challenges of the government mandate to provide preventative services to people across Canada in the 1920s and 1930s was the vast geographic landscape. This challenge was familiar to visiting and public health nurses who worked in rural areas, even more so for outpost nurses who worked in northern and other remote regions of the country. Missionaries who had been providing healthcare in remote regions since the 1860s (Rutherdale, 2005) were joined in the 1920s by the Red Cross and Indian Health Services as key purveyors of healthcare in remote settings. As interest in public health surged in Canada following

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the Spanish Flu pandemic, the question of how to reach populations in remote regions became more urgent. Like the early rural public health nurses (McKay, 2005), outpost nurses traveled on foot, by car, on horseback, by dog sled, on snowshoes, and on airplanes and trains to pay visits to the homes and schools assigned them. Unlike public health nurses, however, the outpost nurse role encompassed preventative, curative, and, often, midwifery care. Hailed as "pioneers in every sense of the word" these nurses have been "acclaimed for their success in caring for patients under difficult circumstances, for pushing the boundaries of 'appropriate' feminine behavior, and for helping to lay the foundation for government involvement in Canadian health care" (Elliot, 2010, p. 245). Living at an outpost provided nurses with a more independent lifestyle than in urban centers, something that has underlined the identity both claimed by and granted to outpost nurses since.

Outpost nursing generally involved unmarried women of European descent relocating to isolated Aboriginal communities somewhere in a vast landscape vaguely referred to as "the North." Outpost nurses provided comprehensive healthcare, including medical diagnosis and treatment that was recognized—even celebrated—as beyond their professional scope. As recruitment material emphasized ways in which outpost nurses were like "mini-doctors" (Rutherdale, 2012), those who were successful found ways to adapt their nursing skills and professional relationships to settings they experienced as jarringly foreign, isolated, and isolating. Some opened their homes to patients while awaiting construction of clinics; others immersed themselves in community life, attending both feasts and funerals. Still others married locally. In the case of outpost nursing, then, "home" involved more than the structure housing individual families; it involved immersion into the community, with a related blurring of professional and private lines where negotiating difference was both a challenge and a reward of the work (Elliot, 2010).

Resonance With Home Care Challenges Today

Examining the evolution of home health nursing in Canada brings new perspectives to our understanding of home healthcare today. In a 3-year study on religious, spiritual, and cultural plurality in home healthcare, which germinated this historical examination of the Canadian home care context, Reimer-Kirkham and colleagues (2012) found that understanding the home as a

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Canadian Red Cross outpost nurse.

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site, both historically and currently, where social differences, with accompanying relations of power, are negotiated is important to understanding the delivery of home health services. In this study nurses spoke about "doing a dance" when they enter a home, where they work to build relationships that transcend linguistic, cultural, and class differences to provide appropriate, efficient care. Although nurses spoke to "being a guest" in someone's home and those receiving care take up various practices to offer hospitality as one would to a guest (e.g., offering tea), there were undercurrents where professional expertise was employed, accepted, and/or resisted in negotiating this guest relationship. Pastor (2006), in her concept analysis of home care, referred to this "dance" as a critical attribute of home care, where the healthcare provider works to gain entry into the care recipient's home. Home caregivers were also influenced by assumptions of what makes a "safe home," both for themselves as visitors and for the patients (Box 1).

The range of difference across linguistic, ethnic, class, and religious lines faced by home healthcare workers today likely equals or surpasses that of earlier eras, yet seldom are today's home healthcare workers as isolated and independent as our "forbearers." In Reimer-Kirkham and colleagues' study (2012), detailed in Box 1, home healthcare workers spoke to choosing home healthcare as a site of practice because they enjoy the autonomy. Not only does autonomy give them more direct problem-solving and stronger relationships with their patients, it also allows them freedom to converse on topics such as spirituality and prayer they might not address in hospital settings. Such autonomy also results in moral distress, in light of the dysfunction present in some of the households, and the complexity of the health challenges. For the most part, the rhetoric of "home is best" is accepted at face value in this study, although some question whether the shift of services from hospital to home is "not so much mandate as it is mantra," in the words of one nurse (Cochrane et al., 2012; Reimer-Kirkham et al., 2012). Despite a government philosophy of "home is best" in Canada, required services are not always available or accessible.

Understanding home care challenges—those of negotiating difference, safety, complexity, and access—not as "new" or "unprecedented" but rather as historical continuities—is important for nursing educators, practitioners, and researchers. It allows us to step back from the intensity of the current home health climate and the discourses of complexities, workload, and "home is best," to consider nursing's essential role in providing *and* ensuring high-quality care in the home. Although historical research does not answer all of our questions—including the relative cost of care provided by families and invisible groups of caregivers—it convinces us that the home has long been central to healthcare in Canada; has long involved intimate encounters between cultural, religious, linguistic, and other lines of difference; and has long been the (mostly) uncontested domain of nurses.

Not only do we concur with historian Buhler-Wilkerson's (2001) assertion that decent care at home is possible, provided there is public policy and political will to fund it, but also that nursing, as the professional group historically most experienced with and invested in home care, has a critical role to play in its future.

Box 1. Research Study: Home Health

"Considering Place: Religious, Spiritual, and Cultural Plurality in Home Health" is a 3-year study funded by Social Sciences and Humanities Research Council of Canada (2009–2012) that examines the accommodation and negotiation of religious, spiritual, and cultural plurality in the provision of healthcare services *in the home*, and the social, gendered, economic, and political contexts that shape these dynamics. Research Team: Drs. Sheryl Reimer-Kirkham, Sonya Grypma, Barbara Pesut, Sonya Sharma, and Rick Sawatzky with Marie Cochrane (Project Coordinator), Dorolen Wolfs (Health Researcher) and Collaborators Joan Anderson, Sally Thorne, Paddy Rodney, Jens Zimmerman, Michael Wilkinson, Jas Cheema, Gloria Woodland, Lori Beaman, and Pamela Klassen. See: http://www.twu.ca/academics/nursing/research/spirituality-and-health.html

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