

## PART 1: Hospitals and Health Care in Montana and Alberta, 1880-1950

# Dying IN THE WEST

Despite different national contexts, communities in Montana and neighboring Alberta faced similar challenges in providing health care in the decades between 1880 and 1950. Conditions in the West often meant that people in need of nursing had no nearby family members, and although hospitals did not see their function as providing care for dying people, the history of hospitals in Montana and Alberta shows that some institutions accepted their role as a substitute home. The two elderly Métis hunters shown here, Andre Nault and Ambroise D. Lepine (right), visited in the hospital where Lepine had been admitted in 1923. Lepine died at age eighty-four a week after this photograph was taken.

by Dawn Nickel

Angeles, photographer, Glenbow Archives, Calgary, Alberta, NA-4267-4

*In Montana and Alberta,* over the span of seven decades, terminally ill people and their families inhabited a type of borderland of their own. Crossing between home and hospital, between hope and pain, and from the land of the living to the land of the dying, patients and loved ones traversed a landscape that was fraught with suffering, frustration, and heartache. Doctors may not have been able to cure, and a family's resources and love might not have kept the grim reaper from the door indefinitely, but there was always "something" that could be done to aid the dying on their final journey. Although the politicization of care for the dying emerged in the late twentieth century, concerns about where terminal care ought to be provided and by whom have preoccupied patients, families, physicians, and policy makers for at least the past hundred years.<sup>1</sup>

Today most Canadians and Americans die in a hospital. However, this has not always been the case. Throughout the late nineteenth and into the twentieth century, the doctors and managers of most hospitals in North America preferred not to admit dying patients, and most people viewed care of the dying as a family matter to be handled in the home.<sup>2</sup> As late as 1945, a group of social workers studying the care of two hundred terminally ill patients in Boston concluded: "It is well known that hospitals have to discourage or refuse both admission and holding of patients who are untreatable and in the terminal stage."<sup>3</sup> Yet, conditions in the West often meant that the dying had no nearby family members, and in these instances, various types of hospitals offered valuable end-of-life care.<sup>4</sup> As this comparative look at Alberta and Montana reveals, regardless of where terminal care took place, women were almost always instrumental in its provision.

Despite different national contexts, Alberta and Montana have regional similarities. Approximately two hundred miles of international border



Regional similarities, including largely rural settlement patterns and an unequal ratio of men to women, affected the delivery of health care in Alberta and Montana. Women, who provided most of the care for the sick and dying, were few in number, and the populations needing services were spread across vast spaces. A cabin used as an early hospital in Calgary, Alberta, is marked by an X on the right edge of this 1884 view of part of the early city that includes the I. G. Baker mercantile company's buildings on the left, freight wagons circled above the hospital, and tipis and Red River carts near the Elbow River in the foreground.

and geographical features such as plains, rivers, and mountain ranges link the two, and they have similar early histories relative to the presence of native populations and white contact, homesteading and agricultural settlement, railroad companies and towns, and cattle and sheep ranching. Both evolved from federal territories, with Montana admitted as the forty-first state in 1889 and Alberta becoming the ninth Canadian province in 1905. In addition to the overlapping histories and movements of native peoples of the region, the early decades of the twentieth century were also marked by back-and-forth homestead migration across the forty-ninth parallel.<sup>5</sup> And throughout the twentieth century, Montana and Alberta have to varying degrees shared multifaceted agricultural and mining economies.

*(continued on page 33)*

# Public Health and Health Care Policy

IN MONTANA AND ALBERTA

IN ADDITION to the nursing they provided to terminally ill patients under the auspices of religious and private hospitals, Montana and Alberta women also made significant contributions to the efforts to establish and expand public health care in the state and province, an effort that directly affected the availability of hospital care.

In the earliest years, the vast distances between population centers combined with a paucity of nurses, physicians, and hospitals initially served as barriers to the development and delivery of public health or medical services. Even in the late 1800s, health care services in Montana and Alberta looked very similar. Public health matters were handled



Gardner, photographer, Glenbow Archives, Calgary, Alberta, NA-402-1

In addition to the nursing they provided to terminally ill patients, women also made important contributions to political efforts to expand access to health care in Alberta and Montana; these efforts, although primarily focused on programs for women and children, also significantly increased the number of hospital beds available for the care of the dying. The members of the United Farm Women of Alberta (UFWA) were particularly successful in their lobbying for health-related legislation. Pictured are members of the 1919 UFWA board: (back row, left to right) Mrs. J. W. Field, Mrs. J. Dowler, Mrs. M. J. Sears, Mrs. O. S. Welch, Mrs. Macquire, Mrs. Charles Henderson, and (front row, left to right) Mrs. A. M. Postans, Mrs. J. F. Ross, Mrs. W. H. [Irene] Parlbay (also an Alberta legislator from 1921 to 1935), Mrs. Paul Carr, Miss Mary W. Spiller.

within local jurisdictions and consisted primarily of efforts to deal with crises such as outbreaks of contagious diseases.

Statehood in Montana after 1889 and provincial status in Alberta after 1905 did not dramatically change the delivery of health care services. For one thing, the diseases and other health issues that arose remained similar in both places. As with the rest of North America, the most aggressive public health efforts were concentrated in towns and cities and focused primarily on epidemic, not endemic, disease.

Indeed, it was smallpox epidemics that precipitated the creation of state and provincial boards of health in both Montana and Alberta. The Montana State Board of Health was created on March 16, 1901.<sup>1</sup> At that time, health officials struggled to deal with issues related to smallpox vaccination and quarantine that were as contentious as the disease was contagious.<sup>2</sup> In the next few years, Progressive Era reform efforts and the political activism sparked by efforts to obtain women's suffrage encouraged the Board of Health to take steps to improve water and food sanitation and other public health issues.

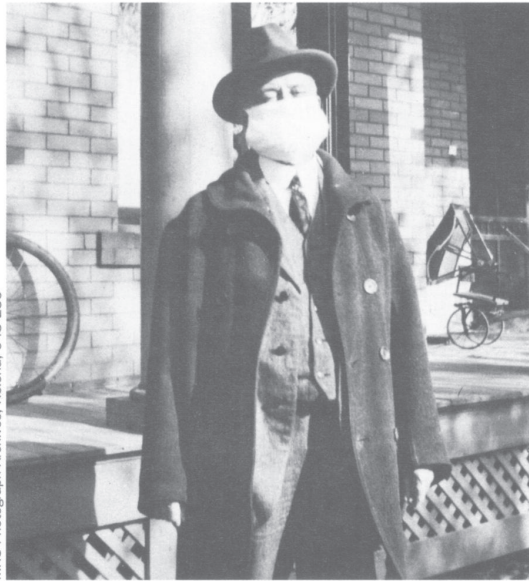
Alberta's Provincial Board of Health was established under the jurisdiction of the Department of Agriculture as part of the Public Health Act assented to in March 1907. By continuing the work of an earlier and smaller territorial department, the province hoped to get a firmer grip on the health conditions of a rapidly growing population, an effort supported by politically minded women. One of the Alberta Board of Health's primary purposes was public health inspection. To that end, provincial health inspectors devoted themselves to the regular inspection not only of slaughterhouses and piggeries but also of jails, schools, churches, and hospitals.

By about 1915, two differences in Alberta and Montana's health care can be discerned. The first related to the degree of government intervention in hospital development, with the Alberta government clearly more engaged in building, supporting, and monitoring hospitals. As historian Terry Boychuk points out, local governments in the prairie provinces of Canada were exceptional in their readiness to assume direct responsibility for hospital care.<sup>3</sup> In 1898, the government of the North-West Territories passed An Ordinance to Regulate Public Aid to Hospitals. Starting that year and continuing through the next sixty years, each approved hospital in Alberta was eligible to receive a per diem payment for every patient admitted. The per diem rate ranged

from twenty-five to fifty cents per patient per day. Approved hospitals included religious, community, and government hospitals but with few exceptions excluded private hospitals owned by individuals. Hospitals received their subsidies twice a year, based on their provision of sworn vouchers. Since they were potentially eligible for a subsidy, hospitals in Alberta were also exposed to scrutiny, and from the time that the hospital ordinance was passed in 1898 through the first half of the twentieth century, inspectors for the Department of Public Health visited most Alberta hospitals on a regular basis.<sup>4</sup>

Prior to 1945, Montana state health officials exhibited a completely laissez-faire attitude toward the existence and business of hospitals in the state, and most hospitals in Montana operated without government support or oversight. By 1915, officials from the State Board of Health regularly inspected hotels, restaurants, slaughterhouses, confectioneries, and bake shops and licensed only those establishments that met the conditions of sanitary inspection. However, hospitals in the state were not subjected to inspection or licensing until 1941, when the state legislature passed a law that dictated that all hospitals in the state receiving maternity patients be inspected and licensed. Even that program was curtailed by 1945, due to lack of personnel. The reasons that Montana hospitals operated for so many decades without state oversight remain unclear, but a shortage of inspection personnel played a large part.

Montana's lack of inspectors was at least partly due to lack of funding for health matters in the state. Indeed, the second difference between Alberta and Montana in the area of hospital development relates directly to government financial support. In the U.S., the federal government launched major health care programs, especially for maternal and infant care in the 1920s and more widely after the onset of the Great Depression; in Alberta, major health care initiatives remained primarily a provincial responsibility, with some federal participation to share costs coming later in the century. Despite diverse political philosophies, the three consecutive provincial governments that held power in Alberta prior to 1950 appeared to be committed to making health care a priority. When elected in 1905, Alexander Rutherford and his Liberal cabinet understood that as part of Canada's western hinterland, Alberta was expected to serve national and imperialist interests.<sup>5</sup> A healthy and growing population was absolutely necessary to meet those expectations. The federal Liberals were



MHS Photograph Archives, Helena, 943.236

**By the late 1910s, widespread infectious disease outbreaks had generally abated, and thus no one was prepared for the influenza pandemic that hit in fall 1918. Tens of thousands of people fell ill, and thousands died in Alberta and Montana. Montanan A. B. Kimball (above) is dressed for work during the epidemic, wearing a protective mask.**

instrumental in encouraging and supporting the development of health programs by their provincial counterparts, but pressure from the populace was even more important.

The differences in government response to health issues in Alberta and Montana were no doubt related to the power of the United Farmers of Alberta (UFA).<sup>6</sup> Over the first decade and a half of Alberta's provincehood, the UFA and especially the United Farm Women of Alberta (UFWA) pressured the governing provincial Liberals to keep health care a priority. The UFWA successfully lobbied the government to pass a flurry of health-related legislation during the second decade of the new century. Most of the new health programs were aimed at improving conditions for mothers and children. By 1921, the UFA had formed its own political party and had successfully wrested power from the provincial Liberals. By the time it was elected, the UFA had, with the instrumental assistance of the UFWA, fashioned a new public understanding of health problems, as well as a desire among Alberta's population for government solutions to those problems.<sup>7</sup> Throughout its political tenure between 1921 and 1935, the UFA promoted the ideal of accessible and affordable medical care to

people all across Alberta, with special attention paid to the party's largely supportive rural base.

Just as the political landscape evolved so did the types of medical issues addressed through public health measures. By the late 1910s, widespread infectious and contagious disease outbreaks and epidemics had generally abated in Alberta and Montana. The scourge of smallpox had receded, as had the terror of typhoid, and the use of antitoxin for diphtheria was doing much to eradicate that disease. Unfortunately, the worst was yet to come, with nobody prepared for the havoc brought on by the arrival of the influenza pandemic. The worldwide pandemic was brief but deadly, killing millions of people in a matter of months. The populations of Montana and Alberta were dominated by young adults, the exact group that the flu attacked most severely. The first cases of influenza in Alberta were reported in October 1918. By the end of 1919, there were thirty-eight thousand reported cases with over four thousand fatalities. Montana was also hit hard, with thirty-seven thousand cases and five thousand deaths over the same two-year period. With professional nursing care in short supply, women often volunteered to fill the critical nursing shortages in hospitals.<sup>8</sup>

When the catastrophic flu was behind them, the Boards of Health in both Alberta and Montana began to focus on other longstanding public health problems. Tuberculosis was a serious problem in both places for the first several decades of the twentieth century, and both Alberta and Montana established state-run sanitariums, but the most pressing health concerns facing both Montana and Alberta by the late 1910s were related to the care of birthing mothers and newborn infants. Appalling statistics on maternity-related deaths caused deep concern among both state and provincial health officials. For example, Montana State Board of Health officials claimed that Montana was in the "unenviable position" of having the highest reported maternal mortality rate of any state included in the national statistics in 1919 and the highest infant mortality rate of any of the states in the American Northwest.<sup>9</sup> Similarly, by 1921 Alberta had the highest recorded maternal and infant mortality rates in Canada.<sup>10</sup>

Throughout the first half of the twentieth century, in Alberta and Montana, as in most of the rest of North America, public health officials generally took a two-pronged approach to improve maternity care. They first focused on providing health care services to women who delivered their babies at home,

especially those in isolated communities and rural areas, where the infant mortality rates were appalling, often twice or more than the city rates.<sup>11</sup> The second approach was to attempt to increase the availability of hospital-based maternity care.

In Alberta, the Municipal Hospitals Act of 1917 was a major legislative initiative in the development of hospitals and an important step in improving maternal and infant health outcomes across the province. A Public Health Nurses Act passed in 1919 went far toward providing public health services in urban centers but did nothing to lower the high death rates associated with childbirth in the isolated rural communities. To address the latter, in 1919 Alberta accepted a proposal put forward by the UFWA to enact a District Nursing Program, only the second province to establish such a program. The program was tailor-made to address the health needs of farm families and provided natal care before, during, and after birth, as well as other public health services, such as school inspections and immunizations, emergency care, and even dentistry and veterinary services. Efforts to continue to improve birthing conditions for Alberta women stalled during the economic depression of the late 1920s and early 1930s, but the provincial government's commitment to improving maternity care was revived in April 1944 when the Social Credit government's Maternity Hospitalization Act went into effect, guaranteeing free hospital services for new mothers and infants.

Montana lacked both the money and the strong lobbying power of an organization such as the United Farm Women of Alberta. The problem of high maternal and infant mortality rates was not given much priority until 1921 when the federal government passed the Sheppard-Towner Act. The act, which promoted health and welfare for expectant mothers and infants, made funds available to states in proportion to population, if the state committed matching funds. The Sheppard-Towner program was in place in Montana by May 1922 and was administered by officials from the Montana State Board of Health's Division of Child Welfare. Much of the first year was devoted to promoting the program to physicians as well as the public and trying to improve an inadequate birth and death registration system.<sup>12</sup>

Although few in number, the women who administered the Sheppard-Towner program in Montana, many of whom were physicians and nurses, were as committed as the UFWA women in Alberta to the idea that rural populations deserved the same level of health care services as urban populations. To realize their goals, these women attempted to garner support for the development of a county nursing system that would have paralleled the district nursing system in Alberta. But the Sheppard-Towner program was discontinued in Montana at the end of its initial five-year term, and the county nursing scheme never materialized. Although there may have been some support for both plans, the desperate economic



**When the flu epidemic ended, public health officials in Montana and Alberta focused on the longstanding problem of high rates of maternal and newborn mortality, especially in rural areas. Alberta enacted a UFWA proposal for a District Nursing Program to provide natal care and other health services to farm families. Above, District Nurse Martha Hagerman assists a mother and child at a child welfare clinic in Medicine Hat in 1932.**

MHS Photograph Archives, Helena, PAC 96-71.1 13

Glenbow Archives, Calgary, Alberta, NA-3953-8



Although Montana lagged behind Alberta in providing health care for mothers and children, the federal Sheppard-Towner Act, passed in 1921, gave Montana and other states funds to promote the health and welfare of expectant mothers and infants. Montana supporters of the program hoped to develop a county nursing system that would have paralleled Alberta's district nursing system. However, the Sheppard-Towner program lasted only five years and the county nursing idea never materialized. This photograph from Montana's health department taken circa 1925 shows "Miss Margaret Thomas holding [a] baby clinic." The poster on the curtain in the back shows an idyllic landscape labeled "A Birdseye Map of Healthland and the Child Health."

conditions that persisted in Montana throughout the 1920s and 1930s likely prevented the implementation of the new plan, and the Sheppard-Towner program was repealed nationally in 1929 due to pressure from organized medicine. Additionally, even if a county nursing program had been created, a nursing shortage that existed in Montana for most of the first half of the twentieth century would have limited its possibilities.<sup>13</sup>

Overall, infant and maternal mortality rates improved in Alberta and in Montana between 1920 and 1950. Although historians disagree about whether or not the hospitalization of birth contributed to the drop in infant and maternal mortality rates across

North America during this period, medical professionals of the era clearly believed hospitalization would improve outcomes.<sup>14</sup> Health experts urged women to go to hospitals to give birth, and many Alberta women listened, especially after they were guaranteed free care in hospital. In 1938, about 66 percent of births in Alberta took place in hospitals, and by 1949 over 97 percent of Alberta's babies were born in hospitals, many of them in Alberta's municipal hospitals.<sup>15</sup>

The improvements in maternal and infant health were welcome at a time when Montana and Alberta, like other parts of North America, faced the effects of a deepening economic crisis that started in the

1920s and did not abate until the mid-1940s. Poverty increased health problems, with families less and less able to afford the costs of health care as the economic depression worsened. Although the impact of the New Deal on health care in Montana awaits further research, Michael Grey's study of the rural health programs introduced by the New Deal's Farm Security Administration (FSA) between 1939 and 1941 suggests that at least a few Montana counties participated in one or more of the new medical care programs.<sup>16</sup>

Overall, at the state level in Montana, health issues not related to maternal or infant health were not a priority again until 1945, when the federal government launched another major health initiative with its Hill-Burton Program. The program injected funds into states that, after meeting certain requirements, became eligible for a grant to aid in hospital construction.<sup>17</sup>

In Alberta, the devastating conditions of the depression were in large part responsible for the defeat

of the UFA in 1935. When the Social Credit government took over the province, they kept health care a priority and, despite the trying economic times, continued to support health care programs.<sup>18</sup> Again, legislative acts expanded health care options for Albertans at both ends of the life cycle, especially in relation to location of health care. In particular, legislation made tuberculosis and cancer care in clinics and hospitals free for all Albertans, in 1936 and 1940, respectively. In addition, free hospital care for pregnant women was introduced under the Maternity Hospitalization Act in 1947, the same year that free hospitalization was guaranteed to old age pensioners.

Thus, by the middle of the twentieth century, efforts to improve health care had resulted in improved and expanded hospital facilities throughout the region. At the same time, nationally as well as regionally, care of the dying was also shifting to hospitals. By 1950, over half of all deaths in Canada and the United States occurred in hospitals.<sup>19</sup> +



**Overall infant and maternal health improved in Montana and Alberta between 1920 and 1950, in part due to increased access to hospital care. The moms and babies above were photographed at "Connor Clinic" in Montana's Bitterroot Valley, circa 1925.**

(continued from page 26)

The population patterns of Montana and Alberta have also been roughly analogous. For example, until 1930, the state and the province had roughly the same number of people. The 1910 U.S. census listed about 376,000 inhabitants in Montana, while the 1911 Canadian census recorded some 375,000 people living in Alberta. In 1920, Montana claimed approximately 548,000 residents compared to 588,000 in Alberta in 1921. Over the next two decades, with their settlement booms ended, both Montana and Alberta grew more slowly. Montana never regained the economic momentum of the settlement period, but significant migration to Alberta resumed in the 1940s, fed by the petroleum industry. In 1951, there were more than 939,000 people living in Alberta, whereas Montana's population remained just under 591,000 in 1950.

Two demographic trends in particular affected health care during the period between 1880 and

discrepancy was recorded in 1911, when there were nearly 150 males for every 100 females. This ratio had serious implications for a range of health and welfare issues, including care of the dying. Women were expected to provide care, yet there were so few of them.<sup>7</sup>

Because few historians have studied the history of western hospitals, there remains much to learn about the nature and purposes of hospitals in the region.<sup>8</sup> Although most historians do not pursue the topic of regional difference, they do suggest that there are unique historical characteristics of hospital development in the West.<sup>9</sup> Paul Starr, for example, argues that at the turn of the twentieth century both the West and the South had significantly more proprietary hospitals (ones owned and operated by an individual or a group of individuals) than the East, where nondenominational hospitals dominated, or than the

## Women were expected to provide care, yet there were so few of them.

1950: rurality and sex ratios. In both Montana and Alberta, rural populations dominated numerically until the 1950s. The sodbusters arrived in the 1890s when dryland farming techniques, innovations in farm machinery, and rising international wheat prices made semiarid farming in Montana and Alberta an attractive option. An aggressive immigration campaign launched by Canada's Dominion government in 1896 enticed settlers to the Canadian West to take advantage of free land available through the Dominion Lands Act of 1872—almost a direct copy of the U.S. Homestead Act of ten years earlier. Promotional efforts by railroads, the state, and developers were also instrumental in attracting farmers to these areas.<sup>6</sup>

An unequal sex ratio was a product of the specific type of economic development in this part of the West. Prior to the emergence of the farmer's frontier, the economic cornerstones of both Alberta and Montana were industries dependent upon a large and steady supply of male workers. Thousands of men, diverse in age, ethnicity, and social status, worked in mines, on ranches, or on railroad construction. The 1890 census for Montana shows nearly twice as many males as females in the state. In Alberta, the highest

Midwest, which had a disproportionate number of religious hospitals. Starr claims that the western and southern states had fewer private philanthropists and that this resulted in a higher percentage of profit-making institutions.<sup>10</sup>

Until 1950, most hospitals in Alberta and Montana were outliers from national trends. For example, in Canada the secular voluntary general hospital (one operated by a nonreligious, nonprofit institution) is generally cited as the most common form of hospital until at least the mid-twentieth century, and in the U.S. the private charitable hospital is seen as the most common. However, very few of the hospitals that opened in Alberta and Montana between 1880 and 1950 would fit either description. In Alberta, even by the 1950s, only 3 percent of all of the hospital beds were in secular voluntary general hospitals while community hospitals, specifically municipal hospitals, accounted for nearly 50 percent of all hospital beds. Furthermore, religious nursing orders, not charities, operated most of the large hospitals in Alberta's cities. In Montana, religious hospitals also dominated the urban landscape, but there the Protestant order of deaconess nursing sisters was part of the religious

hospitals mix, along with the more numerous Catholic hospitals. In Alberta, hospitals owned by Protestant church organizations did exist but in much smaller numbers.<sup>11</sup> Both Montana and Alberta supported the creation of state institutions for the mentally ill, for veterans, and for tuberculosis patients, but discussion of these state-run hospitals, and those operated by the federal government, most of which served the native populations, will require fuller attention and analysis elsewhere.<sup>12</sup>

The early hospitals in Alberta and Montana usually operated out of private residences, some of which were tiny and others large enough to have served for a while as boardinghouses or other similar enterprises. If houses were not available, hospitals were set up in any number of oddly suited structures. For instance, one of Calgary's earliest hospitals is believed to have been an eight-bed hospital operated by a Mrs. Hoad in a small house by the Bow River. The house, whose front door was rumored to have been riddled with bullet holes, had previously been operated as a brothel. When the Sisters of Charity of Our Lady of Evron arrived in Trochu, Alberta, in 1909, there were no buildings available, and they had no choice but to set up hospital services in a granary. The modest beginnings of these small institutions were often exemplified by the lack of necessary and important hospital equipment. For example, in keeping with the "true pioneer spirit of the West," when the Sisters of St. Francis of New York opened Sacred Heart Hospital in 1911 in Havre, Montana, the first patients admitted were required to bring along their own beds since the hospital was not yet fully furnished.<sup>13</sup>

Until at least the 1920s, hospital services, especially surgery, were offered in some hotels in Montana and Alberta. In a study of medicine in the mining West, Duane A. Smith and Ronald C. Brown suggest that operations frequently took place in hotels, boardinghouses, and private homes because patients preferred not to enter hospitals, which many still viewed according to their eighteenth- and nineteenth-century reputation as death houses instead of as places to get well. Smith and Brown may be correct, but practicality may have been more of a factor than choice since hotels were often the only site of medical and surgical care in towns or districts where there were no hospitals. In Montana, the Coleman Hotel in Glasgow and the Prairie Inn in Chester were just two of the many

hotels where patients could receive medical and surgical care during the 1910s and '20s.<sup>14</sup>

Another distinctive part of Alberta's and Montana's health care options was the small, homelike proprietary hospitals, most of which were opened by women, that dotted the hospital landscape in both places. Although health officials in Alberta would not approve the per diem payments granted to public hospitals for most private hospitals, they took other measures to support the creation of these small institutions. As early as 1921, Alberta health officials recognized the importance of these privately run hospitals, which one writer suggested "might more properly be called a nursing home, than a hospital." To that end, hospital inspectors began to visit the hospitals regularly with the goal of rendering private establishments "such advice and assistance as may enable them to become self-sustaining," and in 1925 Alberta legislated such "visits" by passing the Private Hospitals Act. In Montana, government action (or inaction) did not help or hinder the development of privately owned hospitals, and the numbers of hospitals run by women multiplied during the early decades of the twentieth century.<sup>15</sup>

By the 1940s and '50s, the majority of the largest and best-supported hospitals in the region, usually in the urban centers, were thoroughly modern and equipped with state-of-the-art medical technology. Meanwhile, both general and proprietary hospitals in the more isolated areas retained their rough and rugged character. For example, in 1940, two registered nurses opened the Oilfields Hospital in an abandoned cook car in Alberta's Turner Valley, close to Calgary. The two nurses lived in a dug-out basement for the first six months that they operated their six-bed enterprise. Despite its meager beginnings, within a decade the hospital had become a thriving twenty-four-bed hospital. In his memoir, Dr. Ron Losee recalled an appendectomy that he performed in June 1950 in the upstairs closet of the Ruby Valley Hospital in Sheridan, Montana. The female patient, Dr. Losee remembered, lay "supine on a homemade operating table, an automobile lamp shining down on her belly button."<sup>16</sup>

Limited health care options and demographic characteristics meant that hospitals in Alberta and Montana acted as multipurpose institutions, serving a clientele of people who were admitted for diagnosis



Religious hospitals dominated the urban landscapes in both Alberta and Montana and sometimes served smaller communities as well, often under difficult conditions. When the Sisters of Charity of Our Lady of Evron arrived in Trochu in central Alberta in 1909, the lack of a suitable building forced them to set up the town's first hospital services in a granary, pictured on the left in the 1910 photo above.

or treatment or because they had no place else to go for caregiving. In particular, the transient and numerically dominant male populations in Montana and Alberta meant that many people lacked family members who lived close enough to provide care during times of illness. Thus, although hospital administrators might have preferred otherwise, some hospitals expected and were expected to provide caregiving services to the sick and dying.

The importance of the hospital in surrogate care was patently obvious to health officials in territorial Alberta. Through the provision of a per diem subsidy program that paid from twenty-five to fifty cents per patient per day, the territorial government provided hospital care in nonprivately owned hospitals for individuals who lacked caregiving alternatives. In the

Brainard, photographer, MHS Photograph Archives, Helena, 948-355



In their early days, many small health care institutions lacked important hospital equipment. In 1911, when the Sisters of St. Francis of New York opened Sacred Heart Hospital (above, 1913) in Havre, Montana, the first patients had to bring their own beds because the wards were not yet furnished.

annual report of the Department of Agriculture in 1898, a writer remarked on the “peculiarly appropriate field for hospital work in the North-West Territories [territorial Alberta].” The reason, he claimed, was that a large proportion of the settlers were unmarried



Unlike urban areas in the East and the Midwest, the small towns in the West relied on small, privately owned hospitals to provide treatment for illness and sometimes to nurse the dying. For example, Mrs. William Meadors began caring for patients in her home in Sidney, Montana, in 1907. In 1913, Dr. J. S. Beagle rented Meadors's house to accommodate his hospital (top). The interior view (above left), taken in 1915, shows nurses Esther Thorson and Christine Finkelson Carberry posed in the ward. Nurse Carberry (later Carrico) was in charge of this hospital and the new Sidney hospital built in 1915-16. Above right, a doctor and nurses demonstrate surgical procedures at the Sidney Hospital, circa 1914.

men who often lived alone, miles away from “the nearest charitably inclined neighbor who could look after them in time of sickness or accident.”<sup>17</sup> Although not explicitly stated, it is reasonable to assume that most charitably inclined neighbors in the territory, in this inspector’s opinion, would be female. In particular, in Montana and Alberta, Catholic nuns and the women who owned small proprietary hospitals often performed such acts of charity, including caring for dying people who had no nearby family members.

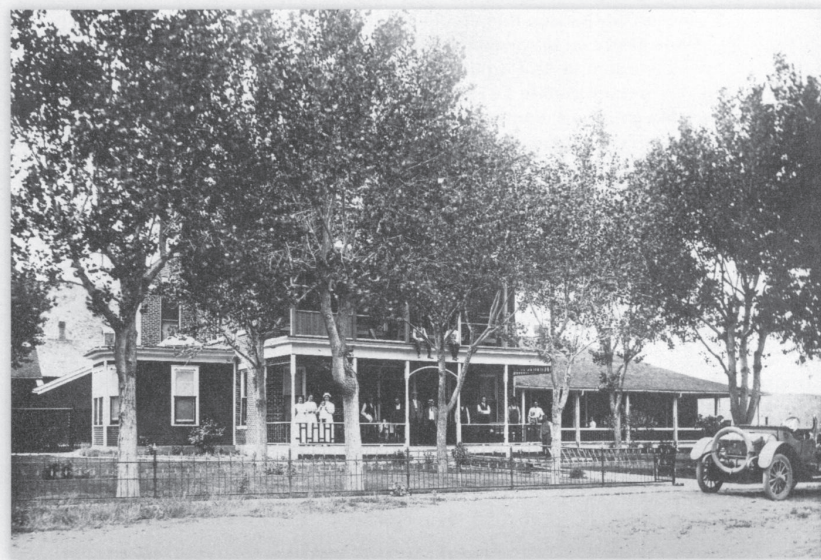
Hospitals owned and administered by Catholic nursing orders were of particular importance to the care of the dying. Often the first hospitals to open in the North American West, Catholic hospitals proved to be the most enduring. In 1925, such hospitals accounted for 30 percent of all hospital beds in Alberta and nearly 40 percent of all hospitals in Montana. By the 1950s, hospitals operated by Catholic nuns accounted for nearly 35 percent of all hospital beds in Alberta and 50 percent of all hospital beds in Montana.<sup>18</sup>

The relationship of Catholic nurses to care of the dying has been explored in some detail. Nuns tended to the immediate physical needs of their sick patients, but they also prepared souls for eternity. Todd L. Savitt and Janice Willms observe that in the late nineteenth century, the Sisters of Providence, owners and operators of a hospital in Missoula, Montana, sometimes seemed as concerned with converting patients as they were with caring for them. But nuns also wanted their hospitals to be successful business

ventures and carefully avoided promoting an image of their hospitals as centers for dying.<sup>19</sup>

Religious hospitals appeared to accept all patients, including non-Catholics and patients needing nursing care. For instance, when Dr. George A. Kennedy, Alberta’s inspector of hospitals, visited the Grey Nuns’ Holy Cross hospital in Calgary in August 1901, he found that one of the ten patients did not need hospital treatment. Apparently, a Mrs. Ferland, who had been admitted for “la grippe” in April, merely suffered from old age in Dr. Kennedy’s opinion. He advised the hospital administrator that Mrs. Ferland was not a proper subject for hospital treatment and suggested “the advisability of having her friends look after her.” Under his watch, “fit subjects for hospital treatment” appear to have been those patients who required medical attention and were admitted to the hospital on the order of a physician, not patients who required surrogate caregiving services. However, from the nuns’ perspective, their hospital was more than just an institution that provided medical care. Like other Catholic nursing sisters in the West, nuns in Alberta believed that the need for nursing care was justification for hospitalization.<sup>20</sup>

Prescriptive nursing literature written by and for nuns regularly referred to physical as well as spiritual care of the dying. A poster entitled “Duties of a Nurse to Herself,” which hung in the Misericordia Hospital in Edmonton, Alberta, in February 1907, highlights the commitment that nuns had to the provision of compassionate physical care to the dying:



Catholic nursing orders were often the first to open hospitals in communities in the North American West. Catholic nuns tended to the immediate physical needs of their sick patients but also prepared their souls for eternity. The Sisters of Charity of Providence operated St. Clare's Hospital (left, June 3, 1913) in Fort Benton, Montana, from 1886 to 1959, when they opened a new hospital. The sisters sold this hospital to the community in 1974.

When it is clear that your patient is dying, your quiet self-possession and unobtrusive sympathy will be of the first importance. Do all in your power for your charge; even if [he or she is] unconscious there are numberless things to do for the dying person. Moisten the lips frequently, wipe away the sweat gathering on face and hands. Keep the feet as warm as possible. Fan the forehead. Allow the friends of the patient to do anything that can add to his comfort. The doctor must be notified immediately when death occurs.

This advice reinforces the idea that even as death approached, there was always something to be done for the dying. The excerpt also confirms that nurses, not doctors, attended dying patients, and further attests to the likelihood that regardless of where terminal care took place, women provided care to the dying.<sup>21</sup>

The development of female proprietorships or private hospitals provides another indication of women's influence in the provision of surrogate care. Women who opened private hospitals in Montana and Alberta exhibited the same degree of control over their institutions as Catholic nuns. As owners, they made decisions about the types of admissions they would accept, the length of patient stays, and the costs of nursing care.

Although female proprietorships appear to have existed in large numbers in the North American West and elsewhere, they have never received more than a passing comment by a few hospital historians. Paul Starr briefly mentions that in the late nineteenth century women operated "medical boardinghouses" that provided a mixture of hotel services and nursing and were more convenient for physicians who lost time by having to make house calls. Other historians have referred to female-operated hospitals in more disparaging tones. For example, in his survey of the early

history of hospitals in Canada, G. Harvey Agnew derides these private hospitals for providing "little more than room and board with virtually no medical supervision." In *Early Medicine in Alberta*, Heber C. Jamieson acknowledges the existence of female proprietorships in a rather off-hand manner when he laments that the first hospitals in Alberta were little better than rooming houses run by unqualified



MHS Photograph Archives, Helena, PAc 78-3

Since Alberta and Montana remained primarily rural in the first half of the twentieth century, most of the hospitals operating in the region focused on providing patient care rather than on research or teaching. However, several of the larger hospitals did have nursing schools. Above, Sister Honora Collins of St. Patrick Hospital in Missoula, Montana, instructs student nurse Doris Marty on intravenous procedures in 1946. The "patient" is another student in St. Patrick's School of Nursing. St. Patrick Hospital, established in 1873 by Sisters of Providence Mary Victor and Mary Edward, continues to be one of the major health care centers in the region, although the School of Nursing closed in 1978.

nurses. He asserts that, while many of these "nurses" had little medical experience, their common attributes were "goodwill, charity, and sympathy." He further claims that the small houses that passed for hospitals in various centers were "taken over" when the pioneer medical men arrived in the province.<sup>22</sup>

Although these historians note the existence of female proprietorships, they fail to recognize the historical significance of these hospitals. Despite their small size, and regardless of whether the women

Like other Catholic nursing sisters in the West, nuns in Alberta believed that the need for nursing care justified hospitalization. In 1907, Misericordia Hospital in Edmonton, Alberta, displayed a poster, "Duties of a Nurse to Herself," that listed compassionate attentions, such as moistening the lips and keeping the feet warm, to provide "when it is clear that your patient is dying." This photograph shows the institution in 1900, when it was the Maternity Hospital of the Misericordia Sisters. It is now a community hospital in a modern facility.



operating them had professional nursing designations, these institutions were much more than mere boardinghouses for the sick. The availability of these small hospitals meant that patients had access to critically important surgical and medical services, as well as nursing services, usually in communities where no other hospital options existed. This may explain why some women proprietors ended up providing terminal care. Contrary to Jamieson's claim, many female hospital owners had completed formal nursing training. For example, out of nine female proprietorships operating in Montana in 1931, five were owned by registered nurses.<sup>23</sup> For other women, informal experience as midwives or practical nurses may have been as valuable a prerequisite for running a hospital as professional nursing credentials.

Regional variation shaped the history of female proprietorships. Rather than being a nineteenth-century phenomenon, as Starr suggests, female proprietorships only began to emerge in Alberta and Montana after the turn of the twentieth century, and they remained a force in small-town Montana and Alberta through-

out the first half of the century. For example, by 1922 there were fifty-nine private hospitals in Alberta, and women ran all of them. Graduate nurses were in charge of twenty-four of them, with the remainder operated by certified midwives or practical nurses. Although a comprehensive inventory of female proprietorships in Montana still needs to be undertaken, evidence shows that there were dozens in operation throughout the first half of the twentieth century.

When the Hospital Survey Committee compiled its inventory of Montana hospitals in 1945, it included twenty-two small "below standard institutions" in the list of sixty-five hospitals then operating. From other research, it is apparent that

## Maternity Home

MRS. F. D. KELLISON, Owner and Manager

**The Best Equipped  
Home in the West**



Nice, light, airy rooms fully furnished  
with all modern equipments.

REASONABLE TERMS  
Write for Information and Reservations.

Telephone 6254 - 948 North 30th Street

BILLINGS, MONTANA

Polk Billings & Red Lodge City Directory, 1919, 43

Maternity homes were one type of female proprietorship that became fairly common after the turn of the twentieth century, providing another indication of women's influence in the provision of health care in Montana and Alberta. As maternity home and hospital owners, women decided the types of admissions they would accept, lengths of patient stays, and costs of nursing care. Though it was not their express purpose, women who ran their own small institutions also sometimes cared for dying patients.



**Female hospital proprietors often had formal nurse's training or informal experience as midwives or practical nurses. The Columbus Hospital School of Nursing class of 1914 in Great Falls, Montana, pictured here, included (left to right): Miss Presley, Viola Savage, Bertha Vickey, Laura McKinnon, Beula Jones, Celia O'Neill, Virginia Flanagan, and Winifred Rogers.**

the majority of these small hospitals were female proprietorships. The fact that so many private hospitals still operated in Alberta and Montana as late as the 1940s underlies their continuing importance in this region.<sup>24</sup>

Small-town physicians, as well as patients, depended upon the availability of female proprietorships. Contrary to Jamieson's claims, physicians did not take over small hospitals run by women but rather women often took over small hospitals run by doctors. Sources suggest that the number of male proprietorships in Montana fell as the number of female proprietorships rose. In Montana, in 1912, there were nineteen male proprietorships, most of them owned and operated by male physicians, and only three female proprietorships. By 1933, there were six male proprietorships and nine female proprietorships, and by 1936 women owned and operated five private hospitals in the state and men owned and operated only two. Finally, by 1950, there were only two sole proprietorships left operating in Montana, both of them owned by women.<sup>25</sup>

Alberta never did have many small hospitals owned by male physicians. There, and in Montana after the 1910s, the arrival of a trained physician in a community that lacked hospital facilities often

prompted the opening of the small, female-operated hospital. In fact, in 1934, when a Dr. Olson arrived in Coutts, Alberta, he paid scant attention to the national border when he convinced two women to open the "Border Hospital" to serve the residents of Coutts as well as of Sweet Grass, Montana. Dr. Olson cooperated with the two female proprietresses of the Border Hospital for three years, when the closing of the hospital coincided with the closure of a large oil refinery in Coutts.<sup>26</sup>

Few records generated by the women or their hospitals have survived, but newspaper ads and articles from the period, as well as provincial hospital inventories and government records, suggest that the women who ran these private hospitals did provide nursing care at both ends of life. These institutions had particular implications for care of the dying. People who were critically ill often sought care in these small institutions. For example, although space restrictions would have made the long-term care of significant numbers of terminally ill patients difficult, hospital inspection reports in Alberta show that cancer patients were operated on and cared for in these hospitals, and some died there.<sup>27</sup>

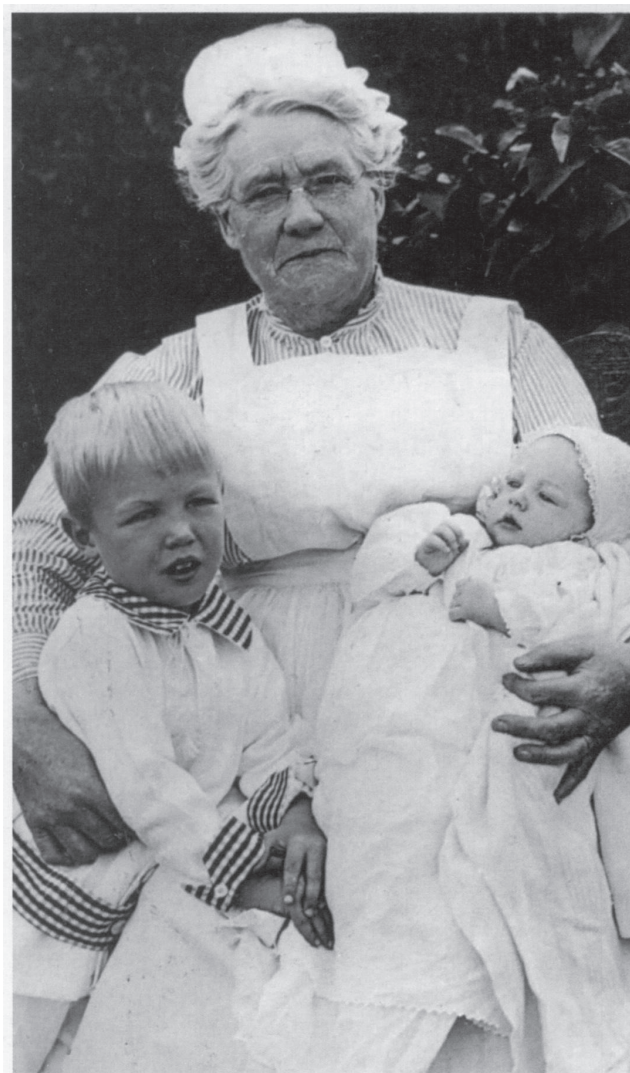
The early history of female proprietorships and other small hospitals in Montana and Alberta is

best characterized as fluid and changing. Hospitals opened, changed hands, burned or closed down, and then opened under new names and new management. Once established, hospital services became essential services, and communities appear to have adapted to the ongoing changes in hospital ownership or management. Such was the case in Livingston, Montana. After Dr. Byron Pampel arrived in Livingston in 1899, he practiced for several years without access to a hospital before he opened his own hospital in 1908. He operated the hospital with the assistance of Anna Morgan as matron for only one year. According to entries in his daybook, beginning in 1910 Dr. Pampel began to deliver babies and see patients at the Maternity Hospital owned by Elizabeth Rae. In 1921, he started treating patients at "Mrs. Robinson's hospital," and during 1928 he started to record the names and ailments of patients he visited at the "Lott Hospital." At first glance one might assume that these hospitals were maternity hospitals since Dr. Pampel did attend births in them. However, he also performed appendectomies, amputations, and other operations, especially at the hospitals owned by Edith M. Lott and Ellen M. Robinson, over the many decades that he practiced in Livingston.<sup>28</sup>

As the community grew, so too did the need for more hospital services. Both Mrs. Robinson and Miss Lott steadily expanded their hospital operations over the years. In 1933, the seven-bed Robinson Hospital was a general hospital with services in medicine, surgery, diabetes, gynecology, obstetrics, and pediatrics. Attending staff at the time numbered four, with one graduate nurse regularly employed. In the late 1930s, overcrowding caused Mrs. Robinson to move the hospital to larger quarters. The hospital remained in operation until 1942, when she closed the hospital and returned to private nursing.<sup>29</sup>

**Small-town physicians, as well as patients, relied on women to run hospitals. Elizabeth Rae, pictured here on September 16, 1917, arrived in Livingston, Montana, in 1892 to be a nurse in the Northern Pacific Railway Hospital. She later opened her own Maternity Hospital, where Dr. Byron Pampel delivered babies and saw patients. She is pictured here with the Bickett sons, William Francis, born July 10, 1914, and Wallace, born July 16, 1917.**

The Robinson hospital may have had trouble competing with the larger and busier Lott Hospital. Miss Lott opened her hospital in 1928 and was so successful that within a year she had to move the hospital to a larger building. Her hospital, according to a newspaper article, had for many months been badly crowded and the need for more room had become "urgent." The house that she purchased was an eleven-thousand-square-foot, four-story building with over thirty rooms. Miss Lott owned and operated the Lott Hospital until 1947, when she sold it to a few local doctors. Later descriptions claimed that Miss Lott, who was apparently too kindhearted to ever send anyone away, was forced to sell her hospital due to financial hardship. Kindhearted she may have been, but she was also emphatic about who was in



Yellowstone Gateway Museum of Park County, Livingston, Montana, permanent collection, 2006.044.2405

In 1921, Livingston's Dr. Pampel started treating patients at "Mrs. Robinson's hospital" and by 1928 at Lott Hospital (right), where in addition to attending births, the doctor performed appendectomies, amputations, and other operations. Edith M. Lott ran her hospital from 1928 until she sold it to several local doctors in 1947. Both Mrs. Robinson and Miss Lott relied on their hospitals for their livelihoods, but both had reputations as generous community caregivers who did not turn away patients.



Livingston Enterprise, Centennial Scrapbook (Livingston, Mont., 1982), 90

control of the hospital over her twenty-year tenure. Her ad in the local newspaper listed the name, address, and phone number of the hospital, followed by her claim, "under my personal supervision."<sup>30</sup>

Although private hospitals operated to the benefit of the community, the women who ran them opened them in order to make a living. For instance, when Ellen Robinson opened the Robinson Hospital in the early 1920s, she was a widow who needed to support her two sons. Mrs. Robinson's provision of hospital services appears to have earned her respect and affection within Livingston's medical community. That the medical men likely held her in relatively high esteem was apparent at her funeral in March 1952, when five local physicians, including Byron Pampel, served as honorary pallbearers at her large funeral.<sup>31</sup>

A spirit of mutual dependence, not conflict, characterized the relationship between female hospital owners and medical professionals. Female owners ran the hospitals, but they conducted their businesses in close association with local physicians and surgeons. Good relations with doctors and surgeons were imperative. Income from referred patients and

surgical procedures was the bread and butter of the hospital operations. Likewise, doctors depended on the convenience of having hospital accommodation and nursing services provided by the female proprietors. The availability of the small private hospitals meant that doctors could dedicate themselves more completely to providing medical care without the worries of managing a hospital. The relationships between physicians and the operators of these private hospitals, most of whom were nurses, were clearly interdependent, if not egalitarian.

It is hard to tell from the newspaper reports how many terminally ill patients were admitted to the Robinson or Lott hospitals. As suggested earlier, space restrictions might have made the admission of terminal patients less likely, or at least less feasible financially. In 1931, daily rates at the Robinson Hospital were four dollars for a private room, but operating room fees earned Mrs. Robinson between five dollars and ten dollars per surgery. A steady supply of surgical patients, especially those admitted for minor surgeries, would ensure Mrs. Robinson a steady income, income that would not accrue from

terminally ill patients paying four dollars per day for nursing care. Still, as suggested by the endurance of their reputations as generous community caregivers, Miss Lott and Mrs. Robinson likely did not turn away a dying patient if that patient had no other caregiving alternative. The man who managed the Lott Hospital after Miss Lott sold it remembered that Miss Lott had “never asked if a patient could pay for treatment.” As this man observed, Miss Lott was “one of the most lovable persons you ever saw, but you can’t run a hospital on love.” A nurse who worked at the hospital recalled that Miss Lott “finally went broke just being so good to people.”<sup>32</sup>

Female proprietors were equally instrumental in their provision of hospital services in Alberta. As in Montana, the ever-growing demand for hospital services resulted in the expansion of hospital services by female owners. Maria Elizabeth Van Haarlem of

Lethbridge entered the hospital business in 1909 when she set aside two rooms in her rented house to receive patients. Twenty years later, she sold her twenty-seven-room hospital, complete with an operating room, physiotherapy room, and a modern laboratory, to the Sisters of St. Martha of Antigonish. Other women were unable to meet the increasing demands on their small institutions. In Claresholm, Alberta, Mrs. Taylor tried to keep up with an increasingly busy hospital in small-town southern Alberta until early December 1927. She had owned her hospital for less than two years but had decided to close it effective March 1928. The demands upon the institution had outgrown the accommodation and Mrs. Taylor was “not prepared” to make the financial investment to expand the facilities. In 1927, 385 patients were admitted to the hospital—131 more patients than the previous year.<sup>33</sup>



A. E. Cross, photographer, Glenbow Archives, Calgary, Alberta, NB-54-161

**In Alberta, as in Montana, an ever-growing demand resulted in the expansion of hospitals by their female owners. Maria Elizabeth Van Haarlem of Lethbridge entered the business in 1909 with two rooms in her rented house and, twenty years later, sold a twenty-seven-room hospital, complete with operating room, physiotherapy room, and modern laboratory, to the Sisters of St. Martha of Antigonish. The facility is pictured here as St. Michael's Hospital after the Sisters acquired it.**



Although most businesses would have welcomed more clients, Mrs. Taylor claimed that for a privately owned hospital the increasing patient demand had a debilitating effect, especially since the indigent patient load had been particularly heavy during 1927. For instance, the December 16 *Claresmont Review-Advertiser* reported that Charles A. Swanson, a farmer from the district who had been a patient in the Claresholm hospital for two months, had died,

apparently from liver cancer. He was estranged from his wife and daughter, who resided in North Dakota. Given the effects of drought and grasshoppers on farmers in the district during 1927, there is a good likelihood that Mr. Swanson was one of the indigent patients whose care pushed Mrs. Taylor to close the hospital.<sup>34</sup>

The question of who should bear the costs of the care of the dying evolved over the course of the



In Alberta, as in Montana, an ever-growing demand resulted in the expansion of hospital services by female proprietors. Alberta and Montana took different approaches to developing health care facilities and programs, but in both places women's activism and interest in new health programs aimed at improving conditions for mothers and children resulted in greater availability of hospital care for everyone. The photograph at left shows the women of the Prairie Circle ladies group operating a fair booth to raise funds to start the first hospital in Cereal, Alberta, circa 1916.

services for mothers and infants, the results for dying people in Montana and Alberta were largely the same. Although hospitals did not intend to provide care for dying people, they accepted their role as a substitute home even as they worked to become centers for the treatment of acute episodic care. In hospitals, as in family homes, women provided the majority of care to dying people.

Part 2 of this article, which will appear in the Winter 2009 issue, focuses on Daniel and Lizzie Slayton of Lavinia, Montana, and chronicles one family's painful journey through terminal illness during the late 1920s. It offers a closer look at the role of the patient in his or her own care and the network of caregivers who provided support to the dying in the home, including professional care by physicians and trained nurses.

twentieth century. As the description of public health and health care policy that begins on page 27 reveals, Alberta and Montana sometimes took different approaches in developing hospitals and other health care programs, but by 1950 the number of hospital beds available in both places had risen significantly. Although hospital care became more available in large part due to the demands placed on health care professionals and policy makers to improve health care

**Dawn Nickel** received her PhD in history from the University of Alberta and currently teaches at the University of Victoria and serves as a policy research director for the Province of British Columbia. This article draws upon her dissertation research, which was aided by the Montana Historical Society's James H. Bradley Fellowship and the Charles Redd Center for Western Studies Graduate Award.

Service Archives in Harpers Ferry, West Virginia (hereafter NPS Archives) also have lists, specific site reports, and other related materials. Other sources include the *Congressional Record* for proposals before 1916; Yellowstone National Park Archives, Gardiner, Montana (hereafter YNPA); Glacier National Park Archives, West Glacier, Montana (hereafter GNPA); the Montana Historical Society Research Center, Helena, Montana (hereafter MHS); as well as several published articles and NPS reports. Some lists and files offer only the name of a proposed park.

1. *Congressional Record*, 1873–1916.

2. National Park Service, “List of Proposed Areas, 1930–1935,” file L58, box 1, NPS Archives. The list was created in 1930 and then supplemented with new areas as they were proposed between 1931 and 1935.

3. Roger Toll, “List of Areas Studied, 1928–36,” box 7, Roger Toll Papers, entry 63, Records of the National Park Service, Record Group 79 (hereafter RG 79), NA.

4. National Park Service, “Land Acquisition Program Recommended for Historic Sites, Oct. 23, 1937,” pt. 5, box 376, Central Classified Files 601, RG 79, NA.

5. National Park Service, “Report on the Status of Projects—New Areas and Extensions Established, Oct. 14, 1939,” RG 79, NA.

6. National Park Service, “Summary of Proposed Monuments 1939,” NPS Office of Park Planning.

7. National Park Service, “Proposed Area Resumes, Aug. 29, 1947,” file L58, box 1, NPS Archives.

8. National Park Service, “Estimates for Administration, Protection and Maintenance of Areas Proposed for Establishment as National Monuments, 1947,” file L58, shelf 2, NPS Archives.

9. L. C. Hadley, “Suggested Areas Resumes, 1957,” Historic Files Collection, NPS Office of Park Planning.

10. National Park Service, *Parks for America* (Washington, D.C., 1964).

11. National Park Service, “The Colonial Period of American History Suggested Sites and Site Types, 1970,” Historic Files Collection, NPS Office of Park Planning.

12. National Park Service, “Authorized and Proposed National Park System Areas, 1972,” file L58, box 1, NPS Archives.

13. Chief of Planning to Regional Directors, Aug. 24, 1979, “Potential New Area Studies Under Section 8, P.L. 94–458,” folder 6, box 224, GNPA.

14. National Park Service, “FY 1981 Study Proposals, North Atlantic Region Office,” New Area Studies, Correspondence/Misc. Files, 1976–, NPS Office of Park Planning.

15. National Park Service, “New Area

Study Inventory, 1988,” NPS Office of Park Planning.

16. National Park Service, “New Area Studies and Authorizations, 1970–1990, 1991,” Files of the Chief of Planning, NPS Office of Park Planning.

17. National Park Service, “Special Resources Study Inventory, Aug. 30, 1993,” Files of the Chief of Planning, NPS Office of Park Planning.

18. Civil War Advisory Commission, “Report on the Nation’s Civil War Battlefields, 1993,” Report to Committee on Energy and Natural Resources, U.S. Senate, <http://www.cr.nps.gov/hps/abpp/cwsac/cwso-1.html>.

19. National Park Service, “Special Resource Study Candidates for FY 1996, Nov. 8, 1994,” Files of the Chief of Planning, NPS Office of Park Planning.

20. National Park Service, “NPS Special Resource Studies Fiscal Years 1989–1998,” Files of the Chief of Planning, NPS Office of Park Planning.

21. National Park Service, “Special Resource Study Inventory, 2000,” Files of the Chief of Planning, NPS Office of Park Planning.

22. National Park Service, “List of Reports Sent by DSC [Denver Service Center] to Regional Records Centers, 2001,” General Files, Technical Information Center, Denver Service Center, Denver, Colorado.

23. National Park Service, “SRS Reports and On-Going Studies, Aug. 2001,” Files of the Chief of Planning, NPS Office of Park Planning.

24. National Park Service, “Potential National Park System Units, Apr. 8, 2002,” Files of the Chief of Planning, NPS Office of Park Planning.

25. Active Files of the NPS, filed by project name, NPS Office of Park Planning.

26. Box 635, Central Classified Files, entry 10, RG 79, NA.

27. Box 2922, *ibid.*

28. Box 2923, *ibid.*

29. Box 2933b, *ibid.*

30. Box 2997, *ibid.*

31. Box 3031, *ibid.*

32. Box 2106, Administrative Files, entry 11, RG 79, NA.

33. Box 2107, *ibid.*

34. File L14, L34, YNPA.

35. File L58, L39, YNPA.

36. Alan K. Hogenauer, “Gone, But Not Forgotten: The Delisted Units of the United States National Park Service,” *George Wright Forum*, 7, 4 (1991), 2–19.

37. Roy Mattison, “Preliminary Report on Historic Sites of Montana in the Missouri River Basin,” 1955, MHS.

38. Alan K. Hogenauer, “An Update to ‘Gone But Not Forgotten’: The Delisted Units of the U.S. National Park System,” *George Wright Forum*, 8, 3 (1991), 26–28.

## Dying in the West, Part 1

1. A few historians of health and medicine have undertaken comparative Canadian-American studies, but virtually all of them reflect on the different roads each nation took. See Georgina D. Feldberg, *Disease and Class: Tuberculosis and the Shaping of Modern North American Society* (New Brunswick, N.J., 1995); Antonia Maioni, *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada* (Princeton, N.J., 1998); and Terry Boychuk, *The Making and Meaning of Hospital Policy in the United States and Canada* (Ann Arbor, Mich., 1999).

2. Charles Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System* (Baltimore, 1987), 113, 306; David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890–1950* (Montreal, 2002), 8.

3. Ruth Abrams et al., “Terminal Care in Cancer: A Study of Two Hundred Patients Attending Boston Clinics,” *New England Journal of Medicine*, 232, no. 25 (1945), 721.

4. There has been little written on the history of health and medicine in either Montana or Alberta. For a history of the medical profession in Montana during the “frontier” period, see Paul C. Phillips, *Medicine in the Making of Montana* (Missoula, Mont., 1962). For Alberta, see Heber C. Jamieson, *Early Medicine in Alberta: The First Seventy-five Years* (Edmonton, 1947).

5. John W. Bennett and Seena B. Kohl, *Settling the Canadian-American West, 1890–1915* (Lincoln, Neb., 1995), 2; David M. Wrobel and Michael C. Steiner, *Many Wests: Place, Culture, and Regional Identity* (Lawrence, Kans., 1997), 12.

6. Laurie K. Mercier, “‘You Had to Make Every Minute Count’: Women’s Role in Montana Agriculture,” in *Montana Heritage: An Anthology of Historical Essays*, ed. Robert R. Swartout Jr. and Harry Fritz (Helena, Mont., 1992), 132.

7. U.S. Bureau of the Census, *The Statistical History of the United States*, Series A 195–209 (New York, 1976), 30; Dominion Bureau of Statistics, *Census of Prairie Provinces 1926, Population and Agriculture Manitoba, Saskatchewan, Alberta* (Ottawa, 1931), xii–xiii.

8. A brief discussion of hospitals in the American West can be found in Duane A. Smith and Ronald C. Brown, *No One Ailing Except a Physician: Medicine in the Mining West, 1848–1919* (Boulder, Colo., 2001), xiii, xiv, 22, 28, 98, 138.

9. Most studies of hospitals focus on the urban, usually eastern or midwestern, hospitals with limited attention given to hospital development in the U.S. South or West. Notable exceptions include

Vanessa Northington Gamble, *Making A Place for Ourselves: The Black Hospital Movement, 1920-1945* (New York, 1995); and Gagan and Gagan, *For Patients of Moderate Means*.

10. Paul Starr, *The Social Transformation of American Medicine* (New York, 1982), 170. See also Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, rev. ed. (Baltimore, 1999), 20.

11. Gagan and Gagan, *For Patients of Moderate Means*, 10; Stevens, *In Sickness and in Wealth*, 23; Boychuk, *The Making and Meaning of Hospital Policy*, 42. Overall, Protestant nursing orders were a less significant force in hospital development across North America, but in Montana the deaconess movement had gained a strong footing by the 1930s. See Ellen Baumler, "Montana Deaconess School to Intermountain: A Centennial of Restoring Hope for Children, 1909-2009," *Montana The Magazine of Western History*, 59, no. 1 (2009); and Pierce C. Mullen, "Frontier Nursing: The Deaconess Experience in Montana, 1890-1960," in *Disease and Medical Care in the Mountain West: Essays on Region, History, and Practice*, ed. Martha L. Hildreth and Bruce T. Moran (Reno, Nev., 1997), 82-94.

12. On the development of the Montana state tuberculosis sanitarium, see Connie Staudohar, "Food, Rest, and Happiness: Limitations and Possibilities in the Early Treatment of Tuberculosis in Montana," parts 1 and 2, *Montana The Magazine of Western History*, no. 4 (1997), 44-55; 48, no. 4 (1998), 48-57.

13. Jamieson, *Early Medicine in Alberta*, 33; *St. Mary's, Trochu, Alberta, Canada: Seventy-Five Years of Caring* (Trochu, Alberta, 1984), 5; Roland K. Fisher, *Montana Hospitals: A Heritage in Transition* (Helena, Mont., 1989), 75.

14. Smith and Brown, *No One Ailing Except A Physician*, 22; Fisher, *Montana Hospitals*, 31, 59.

15. Alberta, Department of Public Health (hereafter DPH), *Annual Report 1921* (Edmonton, 1922), 14-15.

16. Sue Hart, *The Call to Care, 1898-1998: Saint Vincent Hospital and Health Center* (Billings, Mont., n.d.), 76; J. Ross Vant and Tony Cashman, *More than a Hospital: University of Alberta Hospitals, 1906-1986* (Edmonton, 1986), 194-246; *In the Spirit of Good Medicine: A Story of Health Care in the High River Hospital District* (Billings, Mont., 1990), 18; R. E. Losee, *Doc: Then and Now with a Montana Physician* (New York, 1994), 36.

17. North-West Territories, Department of Agriculture (hereafter DOA), *Annual Report 1898* (Regina, Sask., 1899), 89.

18. Barbra Mann Wall, "Unlikely Entrepreneurs: Nuns, Nursing, and Hos-

pital Developments in the West and Midwest, 1895-1915" (PhD diss., University of Notre Dame, 2000); author's calculations for Montana and Alberta from American Medical Association, *American Medical Directory* (Chicago, 1925), 953-54, 1731. Figure for Alberta is from Boychuk, *The Making and Meaning of Hospital Policy*, 46. Montana figure is from author's calculations from American Medical Association, *American Medical Directory* (Chicago, 1950), 1185-86.

19. Wall, "Unlikely Entrepreneurs," 9; Todd L. Savitt and Janice Willms, "'Sisters' Hospital': The Sisters of Providence and St. Patrick Hospital, Missoula, Montana, 1873-1890," *Montana The Magazine of Western History*, 53, no. 1 (2003), 35-36.

20. North-West Territories, DOA, *Annual Report 1901* (Regina, Sask., 1902), 144; North-West Territories, DOA, *Annual Report 1898*, 94; Pauline Paul, "A History of the Edmonton General Hospital: 1895-1970" (PhD diss., University of Alberta, 1997), 72.

21. Wall, "Unlikely Entrepreneurs," 482; Sister Mary Berenice Beck, *Handmaid of the Divine Physician: The Religious Care of the Sick and Dying*, rev. ed. (Milwaukee, Wisc., n.d.); John Gilpin, *The Misericordia Hospital: Eighty-five Years of Service in Edmonton* (Edmonton, 1986), 54.

22. Starr, *The Social Transformation of American Medicine*, 157; G. Harvey Agnew, *Canadian Hospitals, 1920-1970: A Dramatic Half Century* (Toronto, 1974), 5; Jamieson, *Early Medicine in Alberta*, 88-89. A book by James Clark Fifield, published in 1933 in cooperation with the American Medical Association, provides an inventory of hospitals in Canada and the U.S. by state and province. The inventory suggests that female proprietorships existed throughout North America. See James Clark Fifield, *American and Canadian Hospitals: A Reference Book of Historical, Statistical and Other Information on the Hospitals and Allied Institutions of the United States and Possessions and the Dominion of Canada* (Minneapolis, Minn., 1933).

23. Author's calculations drawn from Fifield, *American and Canadian Hospitals*, 688-97.

24. Alberta, DPH, *Annual Report 1933* (Edmonton, 1935), 29; Kraenzel, "The Hospitals of Montana," 11.

25. American Medical Association, *American Medical Directory* (Chicago, 1912), 71; Fifield, *American and Canadian Hospitals*, 688-97; American Medical Association, *American Medical Directory* (Chicago, 1936), 979; American Medical Association, *American Medical Directory* 1950, 1185-86. Joan Lynaugh has identified the egalitarian relationship

between nurses and doctors in the early twentieth century as an intriguing area for further study. As she shows in her study of community hospitals in Kansas City, the "social, economic, and educational gap between a trained nurse and a physician in 1905 probably was quite narrow. Physicians had not yet gained the level of control over hospitals that they would eventually come to have. Joan Lynaugh, *The Community Hospitals of Kansas City, Missouri 1870-1915* (New York, 1989), 188.

26. Women's Institute of Coutts, Alberta, *The History of the Border Country of Coutts, 1890-1965* (Lethbridge, Alberta, 1965).

27. Laurel Halladay, "'We'll See You Next Year': Maternity Homes in Southern Saskatchewan in the First Half of the Twentieth Century" (master's thesis, Carleton University, 1996), 65; Alberta, DPH, *Annual Report* (1920), 23-34.

28. Dr. Byron Pampel, Physician's Daybooks, 1899-1938, Byron Lee Pampel Records, SC 307, Montana Historical Society Research Center, Helena. Elizabeth Rae operated a maternity hospital in Livingston from approximately 1894 to 1927. Ellen Minot Robinson moved to Livingston in 1888, earning the distinction of being the first graduate nurse to practice her profession in Park County. She married in 1907 and moved to Seattle but returned to Livingston three years later as a widow with two young sons. *Livingston (Mont.) Park County News*, June 17, 1927, Mar. 13, 1952.

29. Fifield, *American and Canadian Hospitals*, 694; *Livingston (Mont.) Park County News*, June 13, 1929.

30. *History of Park County, Montana* (n.p., 1985), 91; *Livingston (Mont.) Park County News*, Jan. 6, 1928.

31. *Livingston (Mont.) Park County News*, Mar. 13, 1952.

32. Fifield, *American and Canadian Hospitals*, 694; Fisher, *Montana Hospitals*, 87.

33. A. Johnston, *Lethbridge: Its Medical Doctors, Dentists, Drug Stores* (Lethbridge, Alberta, 1991), 10.

34. *Claresholm (Alberta) Local Press*, Dec. 9, 16, 1927; *Claresholm (Alberta) Review-Advertiser*, Dec. 16, 1927.

#### PUBLIC HEALTH AND HEALTH CARE POLICY IN MONTANA AND ALBERTA

1. On the formation of the Montana State Board of Health, see Ellen Leahy, "'Montana Fever': Smallpox and the Montana State Board of Health," *Montana The Magazine of Western History*, 53, no. 2 (2003), 32-45.

2. George Rosen, *A History of Public Health*, rev. ed. (Baltimore, 1993), 76, 162-67, 255; Judith Walzer Leavitt, *The*

*Healthiest City: Milwaukee and the Politics of Health Reform* (Princeton, N.J., 1982).

3. Boychuk, *The Making and Meaning of Hospital Policy*, 42.

4. North-West Territories, DOA, *Annual Reports*, 1898–1904; Alberta, DPH, *Annual Reports 1906–1950* (Edmonton, n.d.).

5. Doug Owram, *Promise of Eden: The Canadian Expansionist Movement and the Idea of the West, 1856–1900* (Toronto, 1980).

6. The UFA was formed in 1909 when two farmer organizations, the Society of Equity and the Alberta Farmers Association, joined together. For more on the activities of the UFA and its influence on provincial health politics, see Paul Victor Collins, “The Public Health Policies of the United Farmers of Alberta Government, 1921–1935” (master’s thesis, University of Western Ontario, 1969); Bradford James Rennie, *The Rise of Agrarian Democracy: The United Farmers and Farm Women of Alberta, 1909–1921* (Toronto, 2000).

7. Collins, “The Public Health Policies of the United Farmers of Alberta Government,” 16.

8. Alberta, DPH, *Annual Report 1918* (Edmonton, 1919), 9; Janice Dickin McGinnis, “A City Faces an Epidemic,” *Alberta History*, 24, no. 4 (1976) 1–11; Alberta, DPH, *Annual Report 1920* (Edmonton, 1921), 9.

9. Montana State Board of Health, *Twelfth Biennial Report 1923–1924* (Helena, Mont., 1925), 37. Claims that Montana had the highest maternal mortality rate in the country must be approached with caution. Prior to 1933, when the U.S. adopted uniform registration procedures for death and disease reporting, health statistics for the country were often incomplete and inconsistent. Judith W. Leavitt and Ronald Numbers, *Sickness and Health in America: Readings in the History of Medicine and Public Health*, 3rd ed. (Madison, Wisc., 1997), 3.

10. Nanci Langford, “Childbirth on the Canadian Prairies 1880–1930,” *Journal of Historical Sociology*, 8, no. 3 (1995), 289; Nanci Langford, *Politics, Pitchforks and Pickle Jars* (Calgary, 1997), 60–68.

11. Alberta, DPH, *Annual Report 1936* (Edmonton, 1938), 14; Langford, “Childbirth on the Canadian Prairies,” 299 n. 7.

12. Frances S. Bradley, “Why a Child Welfare Division in the State Board of Health?” *Northwest Medicine*, 25, no. 3, (1926), 150.

13. Montana Nurses Association, *Nursing in Montana* (Great Falls, Mont., 1961), 91. In Alberta, a nursing shortage began with the onset of World War II, according to Janet C. Ross-Kerr, *Prepared to Care: Nurses and Nursing in Alberta* (Edmonton, 1998), 58.

14. For a discussion of the decline in Canadian maternal mortality rates, see Wendy Mitchinson, *Giving Birth in Canada, 1900–1950* (Toronto, 2002), 283–84.

15. Alberta, DPH, *Annual Report 1938* (Edmonton, 1939), 6; Alberta, DPH, *Annual Report 1950* (Edmonton, 1952), 95.

16. Michael R. Grey, *New Deal Medicine: The Rural Health Programs of the Farm Security Administration* (Baltimore, Md., 1999), maps pp. 6, 140.

17. For a contemporary discussion of the Hill-Burton Program in Montana, see Carl Kraenzel, “The Hospitals of Montana: Existing Facilities and Attendant Problems,” *Montana Experiment Station Bulletin 438*, October 1946, copy in MHS.

18. William Aberhart and his Social Credit party ranked health care issues sixth on a list of ten major issues identified in their 1935 platform. Alberta Social Credit Party, “1935 Socred Platform,” [http://www.socialcredit.com/subpages\\_history/1935\\_platform.htm](http://www.socialcredit.com/subpages_history/1935_platform.htm), accessed May 8, 2005.

19. National statistics for the United States show that in 1949, 49.5 percent of deaths took place in institutions, the majority in general hospitals. In 1950, Canadian figures show that 50.9 percent of deaths in Canada took place in hospitals. Donna M. Wilson et al., “Location of Death in Canada: A Comparison of Twentieth-century Hospital and Nonhospital Locations of Death and Corresponding Population Trends,” *Evaluation and the Health Professions*, 24 (December 2001), 390; Marilyn J. Field and Christine K. Cassel, eds., *Approaching Death: Improving Care at the End of Life* (Washington, D.C., 1997), 39.

#### Cromwell Dixon

1. *Helena (Mont.) Independent*, Oct. 1, 1911.

2. *Chicago Record-Herald*, July 27, 1907.

3. *Kansas City Star*, Mar. 27, 1906; *Columbus Citizen*, Sept. 9, 1905; *Columbus Dispatch*, Mar. 21, 1906.

4. *St. Louis Republic*, Oct. 7, 1907.

5. James W. Buel, *Louisiana and the Fair: An Exposition of the World, Its People and Their Achievements* (St. Louis, Mo., 1904), 1437.

6. Frank W. Wiley, *Montana and the Sky: The Beginning of Aviation in the Land of the Shining Mountains* ([Helena, Mont.], 1966), 34; James J. Horgan, *City of Flight: The History of Aviation in St. Louis* (Gerald, Mo., 1984), 59.

7. Thomas Chalkley “Chalk” Benbow was born December 29, 1864, at New Providence, Iowa. He grew up to adulthood in Colorado, and in 1886, he and his wife, Ida, moved to Montana

and settled on a homestead in the foothills of the Beartooth Mountains near Absarokee. According to a family history written by Benbow’s daughter Dorothy Benbow Ragsdale, Chalk began drawing plans for a dirigible as early as 1901 and received a patent on his design that year. In 1902, a model of Benbow’s “Montana Meteor” was on display in a Red Lodge saloon. Benbow’s idea generated sufficient interest that the American Aerial Navigation Company was organized with a capital stock of thirty thousand dollars; Pat Lavelle of Columbus served as president and George Pierson of Red Lodge, secretary-treasurer. The company sold five thousand dollars worth of stock, which permitted Benbow to go east to work with Carl Myers to develop his airship. On October 28, 1903, at the Carl Myers Balloon Farm in Frankport, New York, the *Montana Meteor* (also called the *Montana Butterfly*) made a flight that received nationwide acclaim. Benbow made three trial flights with ropes attached and then two free flights within the confines of the Aeronautic Concourse at the 1904 World’s Fair, but it was found that the power of the propellers could not keep him from drifting. The last flight ended in failure when the dirigible became entangled in the fence wire. The airship was disqualified and out of the competition for the one-hundred-thousand-dollar prize and not flown again during the expo. This seemed to end the flying career of Benbow. The *Meteor* was eventually sold to George Lowry of Butte. After the World’s Fair, Benbow returned to Montana and spent the rest of his life developing the Benbow Mine and other chrome mines near Rock Creek. He died December 17, 1932. Dorothy Benbow Ragsdale, “A History of Thomas Chalkley Benbow,” <http://earlyaviators.com/ebenbow1.htm>, accessed June 30, 2009.

8. *St. Louis Republic*, Nov. 1, 1904, p. 1.

9. *Columbus Citizen*, Sept. 9, 1905, p. 9.

10. *Columbus Dispatch*, July 29, 1906, p. 8.

11. “A Home-Made Airship,” *Scientific American*, Aug. 3, 1907, 83.

12. “How to Make Hydrogen,” *Scientific American*, Apr. 1, 1911, 253.

13. *Columbus Dispatch*, June 10, 1907, p. 3.

14. *Columbus Dispatch*, June 28, 29, July 1, 1907; *Columbus Ohio State Journal*, July 1, 1907.

15. *Columbus Dispatch*, July 22, 1907; *Ohio State Journal*, July 5, 1907; *Chicago Record-Herald*, July 27, 1907.

16. Reprinted in *Columbus Dispatch*, Aug. 20, 1907, p. 12; *Mansfield (Ohio) News*, Aug. 27, 1907.

17. *St. Louis Globe-Democrat*, Oct. 21, 1907, p. 10.