*Medical Education and Medical Licensing in Lower Canada: Demographic Factors, Conflict and Social Change**

by Barbara TUNIS**

Between 1815 and 1831 medical education and medical licensing in Lower Canada were the focus of disputes within the medical profession. Two groups were involved; on one side the members of the medical examining boards, mainly British surgeons appointed under the Medical Act of 1788,[1] and on the other a new class of medical practitioners, mainly French-Canadian. The conflict between the two groups was ethnic, political and social. The French-Canadian group was encouraged by the increasing social awareness of its members, their growing political strenght and improved level of professional preparation, to challenge the authority of the Quebec and Montreal Medical Boards and to seek incorporation of the profession. The basic disagreement was over the composition and powers of the medical examining boards; but it also touched on the relative merits of medical education acquired in a variety of ways in Europe, the United States or Lower Canada. At the same time, the controversy represented the initial move of the profession towards self-regulation, and thus towards professional autonomy.[2]

French-Canadian historiography has viewed the conflict over licensing primarily in ethnic and political terms.[3] Anglophone historians of medi-

* This paper is partially based on a research essay submitted in 1979 to Carleton University, "The Medical Profession in Lower Canada: Its Evolution as a Social Group, 1788-1838".

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[1] Eliot FREIDSON, *Profession of Medicine. A Study of the Sociology of Applied Knowledge* (New York: Dodd Mead, 1970), p. 84.

[2] 28 Geo. III, cap. 8, "An Act or Ordinance to prevent persons practising Physic and Surgery within the Province of Quebec, or Midwifery in the Towns of Quebec and Montreal without licence", in *Ordinances Made and Passed by the Governor and Council of the Province of Quebec, 1763-1791* (Ottawa: King's Printer, 1917), pp. 219-20.

[3] J.-E. ROY, *Histoire du notariat au Canada depuis la fondation jusqu'à nos jours*, 4 vols (Lévis: Revue du Notariat, 1899-1902), 2: 498-516; IGNOTUS [Thomas Chapais], "La profession médicale au Canada", *Bulletin des recherches historiques*, 12 (mai 1906): 142-50; Charles-Marie BOISSONNEAULT, *Histoire de la Faculté de Médecine de Laval* (Québec: Les Presses de l'Université Laval, 1953) pp. 62-67; Sylvio LEBLOND, "La médecine dans la Province de Québec avant 1847", *Les Cahiers des Dix*, No. 35 (1970): 75-88.

cine, on the other hand, have virtually ignored these issues, while focusing on the history of institutions, individuals or medical legislation.[4] Yet, a number of other factors, demographic, economic and social, contributed to the conflict as changes occurred both in society and in the profession. The changing structure of colonial society, the shifting pattern of population, the emergence of new social groups and the introduction of new democratic ideas all had important implications for the medical profession.[5]

I

This paper examines the numerical evolution of the licensed members of the medical profession in Lower Canada between 1815 and 1831, and its ethnic composition and geographical distribution in city and country. It then examines changing levels of medical education within the ethnic groups and attempts to relate these to place of practice and certain political and professional actions. Two main sources of data are used: medical certificates and related documents[6] pertaining to 449 candidates for licence to practise medicine in Lower Canada between 1788 and 1838, and lists of physicians and surgeons published in the Quebec *Almanach*.[7] Data on the candidate's medical education are found on those certificates issued before 1831.

After 1815, the medical profession and its institutions were subject to many pressures. Despite the growing French-Canadian population, British immigration changed the ethnic balance of society,[8] especially in

[4] J. J. HEAGERTY, *Four Centuries of Medical History in Canada*, 2 vols (Toronto: Macmillan, 1928), I: 321-24; Maude ABBOTT, *History of Medicine in the Province of Quebec* (Montreal: McGill University, 1931), pp. 71-72; H. E. MacDERMOT, *History of the Canadian Medical Association, 1867-1921*, 2 vols (Toronto: Murray, 1935-58), 1: 1-3. For a legal controversy arising from this dispute see B. TUNIS, "Medical Licensing in Lower Canada: The Dispute Over Canada's First Medical Degree", *Canadian Historical Review*, LV (December 1974): 489-504.

[5] Interpretation of this period is derived from the thesis developed by Fernand OUELLET in *Histoire économique et sociale du Québec, 1760-1850*, 2 vols (Montréal: Fides, 1970) and *Le Bas-Canada, 1791-1840* (Ottawa: Éditions de l'Université d'Ottawa, 1976), and whose findings in general are supported by figures established in this study.

[6] Public Archives of Canada (hereafter PAC), Medical Licences and Certificates, 1788-1838, RG 4, B 28, Vols 47-54. There is reason to believe that these documents are more or less complete. However, the British military surgeon on active duty in the province is not represented. Although he might well practise his profession in a civilian context, he was specifically exempted by the Medical Act of 1788 from the necessity of acquiring a licence to do so. For this reason, the British practitioner may be under-represented in the statistical tables.

[7] *Almanach de Québec*, 1792-1838. The *Almanach* serves as a general rather than a precise source of data. Although published annually, it was never current. At the same time, the accuracy of its lists depended on voluntary submissions from individual medical men.

[8] The population of Lower Canada increased from 335,000 in 1814 to 553,134 in 1831. Georges LANGLOIS, *Histoire de la population canadienne-française* (Montréal: A. Lévesque, 1934), p. 267. French Canadians, who made up seventy-nine percent of the population in 1814 (264,590), represented only seventy-five percent in 1831 (412,717). Ibid., pp. 163, 262. See also Helen I. COWAN, *British Emigration to North America* (Toronto: University of Toronto Press, 1961), pp. 288-89.

the cities. The structure of society changed and a new class of medical men emerged from the middle class. They joined a profession affected by ethnic and social change and internal problems. The old categories of physician, surgeon and apothecary were in the process of being redefined.[9] Apprenticeship, the long-established method of medical education, was being replaced by formal instruction as medicine became more scientific and as the bounds of medical knowledge widened.[10] The size of the medical profession increased rapidly and conflict erupted as the new class of practitioners sought to become established.[11] These changes were not unique to the medical profession in Lower Canada, but also characterized the evolution of the profession in Great Britain,[12] France[13] and the United States.[14] In Lower Canada, however, the situation was more complex as ethnic and political as well as social lines divided the profession.[15] Applications for medical licences came from two sources, the native-born and immigrant. Between 1788 and 1818 the number of licentiates grew from forty-nine practitioners, of British, French and German origin, to eighty-one from four main groups: British-born, American-

[9] This process was affected by the establishment of hospitals, which changed the traditional relationship between the various categories of medical men. Thomas McKEOWN, "A sociological approach to the history of medicine", in *Medical History and Medical Care*, eds: Gordon McLACHLAN and T. McKEOWN (Toronto: Oxford University Press, 1971), pp. 9-10.

[10] Change in medical education in relation to social change is examined in S. W. F. HOLLOWAY, "Medical Education in England 1830-1858: A Sociological Analysis", *History*, 49 (1964): 299-324. Holloway examines the interaction of four systems in a society undergoing a process of social change: medical education, medical knowledge, the social structure of the medical profession and the social structure of the wider society. He sees a rising middle class as pivotal in creating a demand for both medical education and medical care.

[11] In this they conform to the theory of conflict and social change as described in R. DAHRENDORF, *Class and Class Conflict in Industrial Society* (Stanford, Cal.: Stanford University Press, 1959), p. 210: "Conflict groups ... once they have organized themselves, engage in conflicts that effect structure changes."

[12] In 1815 apothecaries in England, representing a new middle class of general practitioners, obtained a separate Act to regulate their members. The professional and social conflict that accompanied this is shown in HOLLOWAY, "Medical Education", pp. 306-16. See also: W. J. READER, *Professional Men, the Rise of the Professional Classes in Nineteenth Century England* (London: Weidenfeld and Nicolson, 1966), pp. 50-53; Rosemary STEVENS, *Medical Practice in Modern England, The Impact of Specialization and State Medicine* (New Haven, Conn.: Yale University Press, 1966), pp. 16-21; Charles NEWMAN, *The Evolution of Medical Education in the Nineteenth Century* (Oxford: Oxford University Press, 1957), chapters I and II.

[13] E. H. ACKERKNECHT, *Medicine at the Paris Hospital, 1794-1848* (Baltimore: Johns Hopkins University Press, 1967), pp. 186-87. Reform in the medical profession in France arose out of the Revolution, in which medical men played a prominent role.

[14] William ROTHSTEIN, *American Physicians in the Nineteenth Century* (Baltimore: Johns Hopkins University Press, 1972), pp. 104-14; Burton J. BLEDSTEIN, *The Culture of Professionalism: The Middle Class and the Development of Higher Education in America* (New York: Norton, 1976), pp. 191-93.

[15] The relationship of ethnic factors to the political, social and economic evolution of Lower Canada is discussed in Gilles PAQUET and Jean-Pierre WALLOT, "Le Bas-Canada au début du XIX^{e} siècle: une hypothèse", *Revue d'histoire de l'Amérique française*, 25 (1971-1972): 39-61. See also G. PAQUET et J.-P. WALLOT, *Patronage et pouvoir dans le Bas-Canada, 1794-1812: un essai d'économie historique* (Montréal: Presses de l'Université du Québec, 1973).

born, Anglo-Canadian and French-Canadian. Rapid numerical growth after 1815 brought the total number of practitioners to 202 by 1831 and 239 in 1838 (Table 1).[16]

Table 1. — NUMERICAL INCREASE IN MEDICAL PRACTITIONERS, 1788-1838.

	1788	*1789-1815*	*1816-31*	*1831-38*
Admissions to the Profession*	36	81	203	129
Number in the Profession**	49 (1792)	81 (1818)	202 (1831)	239 (1838)

Sources: * PAC, Medical Certificates; ** Quebec *Almanach*.

French Canadians made up about one-third of new admissions and an increasing proportion in the profession as a whole and especially in country practice. Although the profession was mainly rural — two-thirds of all practitioners were in country practice throughout this period (Table 2) — the number of British, Anglo-Canadians and even Americans in city practice increased. French Canadians held their own only in the City of Quebec. As the profession continued to enlarge, its uneven ethnic distribution became more evident. In rural districts, which lacked the official posts, hospitals and lucrative practices of the cities, the French-Canadian practitioner shared a precarious economic and social existence along with other members of the liberal professions.[17]

Table 2. — DISTRIBUTION OF MEDICAL PRACTITIONERS IN RURAL AND URBAN AREAS, 1818-1838.

Areas	*1818*		*1831*		*1838*	
	Number	*% of Total*	*Number*	*% of Total*	*Number*	*% of Total*
Rural	53	65	142	70	157	66
Urban	28	35	60	30	82	34
Total	81	100	202	100	239	100

Source: Quebec *Almanach*.

At the same time, socio-economic disparities in the cities stimulated ethnic and political conflict there.[18] The growing strength of the liberal

[16] The discrepancy in these figures, which were gathered from two different sources, cannot entirely be explained. However, certain contributing factors can be ascertained: high mortality among the first licentiates, who were almost all older men in 1788; and emigration of licensed practitioners from the province, increasing markedly after 1815.

[17] The social and political situation of the notary and medical practitioner in rural parishes is described in Richard CHABOT, *Le Curé de campagne et la contestation locale au Québec (de 1791 aux troubles de 1837-38)* (Montréal: Hurtubise, 1975). See also Jean-Jacques JOLOIS, *Jean-François Perrault (1753-1844) et les origines de l'enseignement laïque au Bas-Canada* (Montréal: Presses de l'Université de Montréal, 1969), p. 63.

[18] OUELLET, *Le Bas-Canada*, pp. 247-53, 269-72.

professionals,[19] from the country parishes and the cities, in the Legislative Assembly gave added political impetus to this group. Many were dissatisfied with the Medical Act of 1788, which had empowered the Governor to appoint medical men in the Districts of Quebec and Montreal to examine candidates for medical licence. Only after successful examination before one or other of these boards of examiners and the granting of the board's certificate, could the candidate receive his licence, duly authorized by the Governor. By 1800, the medical boards, which had originally represented all ethnic groups, were predominantly British, and in Quebec, entirely military as well.

As native-born practitioners increased in number they expressed their dissatisfaction with the legislation governing the practice of medicine through political action. Two political groups divided broadly on ethnic and social lines emerged within the profession. The political and ethnic divisions, however, were never entirely identical. Some Anglo-Canadian and American practitioners of the new middle class supported the liberal professionals in the Legislative Assembly, indeed were leaders there, while French-Canadian practitioners from the seigneurial class tended to identify politically with the British administration, centred in the Legislative Council. Medical legislation, introduced in the Legislative Assembly by the one group, was thwarted in the Legislative Council by the other.

The conflict over licensing, while essentially one of power, centred also on medical education and standards, neither of which was defined in the existing Medical Act. The need to provide medical education in Lower Canada was urgent. At the beginning of the period under study, apprenticeship was still the main basis of medical training; students seeking formal education were obliged to go to Europe or the United States to obtain a degree or diploma. Standards of education were of growing concern to both groups, but power to regulate the profession lay with the appointed boards, who used the maintaining of standards to justify their regulatory powers. The British-educated board members judged the medical education of applicants for licence in Lower Canada according to their own belief that British education and, in particular, the British university degree were superior to all others. That this viewpoint would seem to discriminate against the North-American-born candidate was a continuing source of resentment to some members of this group.

It was a period of educational and institutional expansion which saw formal medical teaching introduced into Lower Canada and the first secular hospitals constructed. Each new development, however, was accompanied by conflict. The lay movement in the Legislative Assembly was opposed both by the Roman Catholic Church and by the Anglo-Protestant community. Traditional rivalries between Quebec and Montreal were also

[19] The term "liberal professional", as elaborated by OUELLET (*Le Bas Canada*, pp. 108-18, 123-24, 129), refers to the members of this new middle class, liberal and secular in sentiment, whose representatives sat in the Legislative Assembly of Lower Canada as members of *le parti canadien* and, later, *le parti patriote*. It was not merely a question of racial origin, as this group included Drs Daniel Tracey, E. B. O'Callaghan and the Nelson brothers.

important. That English was the main language of formal medical instruction, whether in Great Britain, the United States or Lower Canada, posed a further problem for the French-speaking medical student. The tension focused on three periods: 1818-21, as the dispute began; 1823, as the British medical man tightened his control on medical licensing; and 1831, as the liberal professional gained elective control of the profession.

The profession's numerical increase resulted in internal competition, while its changed ethnic composition and distribution accentuated socio-economic inequalities. On one side was the dominant educational and economic position of the British medical man and his access to administrative, professional and social power; on the other was the position of the liberal professional practitioner, whose growing numbers, increasing professional and social status, and political power in the Legislative Assembly were to lay the foundation for later self-government of the profession. Medical education, caught up in these changes in the profession and in society at large, became itself a source of conflict and a means of acquiring or distributing power. Various contending groups within the profession, other than ethnic or political, became evident: rural-urban, civil-military, Quebec-Montreal, British-educated or American-educated. Tension between each of these groups would result in conflict which effected change in the profession. Two demographic factors were central: the ruralization of the French-Canadian segment of the profession and the predominantly urban distribution of the British and other anglophone practitioners, particularly in the City of Montreal. These socio-economic facts had political implications for the profession.

On the political level the Legislative Assembly had commenced its fight for control of the civil list.[20] Coinciding with this attack on appointive offices, the civil medical practitioners of Quebec presented a petition in 1818 protesting the military composition of the medical boards and their own lack of participation in the administration of the profession.[21] Repeated attempts in the Legislative Assembly to recall the Medical Act were at last successful in 1831 and a new Medical Act[22] passed, whereby the appointed boards were replaced by boards elected by members of the profession as a whole. This move towards the elective process, which was accomplished by the combined efforts of various groups and interests in the profession, paralleled other political actions of the period.[23] But as

[20] Donald CREIGHTON, "The Struggle for Financial Control in Lower Canada", in *Constitutionalism and Nationalism in Lower Canada*, ed.: Ramsay COOK (Toronto: University of Toronto Press, 1969), pp. 33-57; OUELLET, *Le Bas-Canada*, pp. 311-15.

[21] *Journals of the Legislative Assembly of Lower Canada*, 27 (1818): 44, Petition of the Civil Medical Practitioners of the City of Quebec, 21 January 1818.

[22] 1 William IV, cap. 27, "An Act to repeal a certain Act or Ordinance therein mentioned, and to provide effectual regulations concerning the Practice of Physic, Surgery and Midwifery." (*The Provincial Statutes of Lower Canada*, 15 vols, 14: 164-79).

[23] For instance, parish schools, formerly administered by the clergy, were placed under the control of the Legislative Assembly in 1829. Again, municipal government, previously made up of appointed magistrates, was turned over to elected city councillors in 1830. Elective control of the Legislative Council was a major aim of *le parti patriote*. OUELLET, *Le Bas-Canada*, pp. 266-67. Incorporation of the profession of law was also proposed during these years.

ethnic and political tension mounted and as polarization in the profession and society increased, impasse in all areas ensued. When the Medical Act of 1831 was allowed to expire in May 1837 as a result of the power struggle between the Assembly and the Councils, the Medical Act of 1788 was re-activated.[24]

II

Two hundred and three practitioners, native-born and immigrant, were admitted to practise medicine in Lower Canada between 1816 and 1831 (Table 3). French-Canadian practitioners, with seventy-two admissions, were the largest single group, and constituted slightly more than one-third of all new licentiates. British medical men, many of whom were former military surgeons, numbered sixty-four. As immigration of British medical men declined after 1831, and as admissions of American practitioners became scant,[25] the English-speaking proportion in the profession was maintained by increasing numbers of Anglo-Canadians.

Table 3. — ADMISSIONS TO THE MEDICAL PROFESSION BY ETHNIC ORIGIN, 1789-1838.

Ethnic Origin	*1789-1815*		*1816-1831*		*1831-1838*	
	Number	*% of Total*	*Number*	*% of Total*	*Number*	*% of Total*
French-Canadian	22	27	72	36	45	35
Anglo-Canadian	13	16	45	22	45	35
British	13	16	64	32	34	26
American	22	29	16	8	4	3
Other: French, German, Upper Canadian	11	12	6	2	1	1
Total	81	100	203	100	129	100

Source: PAC, Medical Certificates.

The movement of practitioners in and out of the profession in Lower Canada, as indicated in Table 1, changed its ethnic composition so that French-Canadian medical men, while remaining one-third of admissions, increased their proportion in the profession from twenty-eight percent in 1818 to forty-three percent in 1838 (Table 4). The proportion of native-born Anglophones also increased as practitioners of American, British and

[24] The Education Act of 1829 was allowed to expire in 1836, and rule by magistrate restored. For a socio-economic interpretation of this period see Alfred DUBUC, "Problems in the Study of the Stratification of Canadian Society from 1760 to 1840", in *Canadian Historical Association Report, 1965 ... with Historical Papers* (Ottawa: Canadian Historical Association, 1965), pp. 13-29.

[25] The decreasing admissions of American practitioners may be accounted for in part by the application of the Alien Act in 1817. Most of the American candidates admitted had been resident in the province for several years. Some had applied for licence previously without success; all had to acquire British citizenship and take the Oath of Allegiance. PAC, Medical Certificates, Internal evidence, vols 48-52.

German parentage became licensed, while naturalized Americans, although diminishing in both admissions and proportion, still remained a significant number. The British, however, despite the large number of new licentiates in the years before 1831, were declining in their proportion in the profession. This decline, indicated in the discrepancy between numbers of British medical men admitted and those actually in practice, can be explained in part by emigration in this segment of the profession. From the documents examined, both Anglo-Canadian and British practitioners showed evidence of emigration from Lower Canada before and after 1831.[26]

Table 4. — COMPOSITION OF THE MEDICAL PROFESSION BY ETHNIC ORIGIN, 1818-1838.

Ethnic Origin	*1818*		*1831*		*1838*	
	Number	*% of Total*	*Number*	*% of Total*	*Number*	*% of Total*
French-Canadian	23	28	76	38	103	43
Anglo-Canadian	9	11	33	16	55	23
British	23	28	51	25	42	18
American	16	20	34	17	27	11
Other: French, German, Upper Canadian	10	13	8	4	12	5
Total	81	100	202	100	239	100

Source: Quebec *Almanach*.

Although a diminishing number of British medical men admitted to practise actually remained in Lower Canada, those who did retained a dominant position in the profession. This is shown in part by their continued prominence in urban practice, as seen in Table 5. In 1831 British medical men represented only twenty-five percent of the profession, yet they occupied more than one-third of the combined medical practice of Quebec and Montreal for almost the entire period under study. They dominated the anglophone practice in Quebec (52% of all practice in 1831) and in Montreal shared the city practice with increasing numbers of Anglo-Canadian and American practitioners. Anglo-Canadians, representing an even smaller proportion in the profession (16% in 1831), were also primarily urban, an average of forty-four percent of this group being established in urban practice between 1818 and 1838. American-born practitioners, almost entirely rural before 1831, constituted twenty-eight percent of the profession in Montreal in 1831.

[26] It is assumed that many of these went to Upper Canada; for instance, among British and Anglo-Canadian medical men licensed to practise in Lower Canada between 1821 and 1837, fifteen are found later as licentiates of the upper province. OUELLET (*Histoire économique et sociale*, 2: 349-50) estimates that only twenty-three percent of all British immigrants entering Quebec between 1825 and 1830 remained in Lower Canada. He sees this number even further reduced after 1829.

Table 5. — URBAN MEDICAL PRACTITIONERS (QUEBEC AND MONTREAL) BY ETHNIC ORIGIN, 1818-1838.

Ethnic Origin	*1818*		*1831*		*1838*	
	Number	*% of Total*	*Number*	*% of Total*	*Number*	*% of Total*
CITY OF QUEBEC						
French-Canadian	8	50	9	36	12	46
Anglo-Canadian	2	12	3	12	6	23
British	6	38	13	52	8	31
American	—	—	—	—	—	—
Other*	—	—	—	—	—	—
Quebec, Total	16	100	25	100	26	100
CITY OF MONTREAL						
French-Canadian	2	17	7	20	16	29.0
Anglo-Canadian	3	25	9	26	17	30.0
British	4	33	8	23	13	23.0
American	1	8	10	28	7	12.5
Other*	2	17	1	3	3	5.5
Montreal, Total	12	100	35	100	56	100.0

Source: Quebec *Almanach*.
* German, Upper Canadian, undifferentiated anglophone.

As the number of anglophone practitioners increased in the cities, French-Canadian practitioners, despite their growing proportionate strength, were declining in city practice. Whereas in Quebec in 1818, fifty percent of all licensed medical men were French-Canadian, by 1831 incoming British practitioners had reduced this proportion to thirty-six. In Montreal, French-Canadian medical men in 1831 made up only twenty percent of practitioners.[27]

These figures reflect the changing numerical and ethnic composition of the cities as British immigration moved towards its peak. As many as fifty percent of those immigrants staying in Lower Canada settled in the cities; by 1831, fifty-one percent of the heads of household in Montreal and forty-four in Quebec were anglophone.[28] The Anglophones dominated the economic and commercial life of the cities, especially Montreal.[29] British immigrant medical men and native-born anglophone practitioners were naturally attracted to the cities, where they hoped to find a ready clientele and congenial social and professional contacts. In Quebec a major influence for the incoming British practitioner was the military garrison and its medical establishment, while in Montreal, a small group of

[27] Table 5, based on the Quebec *Almanach*, shows this proportion as eighty percent in 1831. This figure disagrees with the findings of F. OUELLET, based on the 1831 census for Montreal, which shows sixty-seven percent anglophone doctors in Montreal in 1831. "Structure des occupations et ethnicité dans les villes de Québec et de Montréal 1819-1844", *Éléments d'histoire sociale du Bas-Canada* (Montréal: Hurtubise, 1972), p. 185.

[28] Ibid., pp. 180-81. Between 1825 and 1831, the population of Quebec rose from 20,386 to 25,816, that of Montreal from 25,976 to 31,783.

[29] Ibid., pp. 177-202; OUELLET, *Le Bas-Canada*, pp. 248-52, 254-56.

long-established medical practitioners, mainly English, introduced successive generations of Anglo-Canadian medical men into city practice.[30]

The anglophone preponderance in Montreal, accentuated by immigration of British medical men and a growing influx of American practitioners, made it increasingly difficult for French-Canadian practitioners to become established there. Only in Quebec were they able to assert an urban presence. The entry of French-Canadian practitioners into practice in Quebec in the years before 1818 had created an ethnic and professional balance which was maintained throughout the period, and which was to serve as a base for political and professional action. In fact, in the Quebec City area, the well-established French-Canadian medical man[31] formed his own network of influence on the younger entrants to the profession in much the same way as did the British practitioners in Montreal.

Table 6. — RURAL MEDICAL PRACTITIONERS BY ETHNIC ORIGIN, 1818-1838.*

Ethnic Origin	*1818*		*1831*		*1838*	
	Number	*% of Total*	*Number*	*% of Total*	*Number*	*% of Total*
French-Canadian	13	25	60	42	75	48
Anglo-Canadian	4	8	21	15	32	20
British	13	25	30	21	21	13
American	15	28	24	17	20	13
Other**	8	14	7	5	9	6
Total	53	100	142	100	157	100

Source: Quebec *Almanach*.
* Including all areas, except the Cities of Quebec and Montreal.
** French, German, Upper Canadian, including undifferentiated anglophone (1838).

Anglophone practitioners, then, dominated the cities; but they were also well-represented in country practice, where they made up more than fifty percent of rural medical practitioners throughout the period (Table 6). A substantial anglophone clientele was found, not only in the townships,

[30] For example: Charles Blake, an Englishman, and Henry Loedel, a German, partners from 1784, enjoyed the well-to-do practice of Montreal for more than thirty years, together with George Selby, Robert Sym and other English medical men. They were joined by Daniel Arnoldi, an Anglo-Canadian of German origin, who had studied with members of this group and was licensed to practise in 1795. Subsequently, A. F. Holmes, an Anglo-Canadian, licensed in 1816, who had served an apprenticeship to Arnoldi, also entered practice in Montreal. All of these men were appointed to the Montreal Medical Board. Louis RICHARD, "La famille Loedel", *Bulletin des recherches historiques*, 56 (1950): 78-89; Sylvio LEBLOND, "La profession médicale sous l'Union (1847-1867)", *Les Cahiers des Dix*, No. 38 (1973): 188; PAC, Medical Certificates, Internal evidence, vols 47-48.

[31] TUNIS, "Medical Profession in Lower Canada", pp. 98-101. See also Jacques BERNIER, "François Blanchet et le mouvement réformiste en médecine au début du XIX^e siècle", *Revue d'histoire de l'Amérique française*, 34 (septembre 1980): 233-44. Many of Blanchet's students studied, as he did, in the United States. PAC, Medical Certificates, Internal evidence, vols 48-52.

but also amongst the British who had settled in the larger rural centres and in the seigneuries.[32] In distribution, British practitioners, despite their decline in numbers, were represented in all rural areas, while American and Anglo-Canadian practitioners, as might be expected, were more numerous in the District of Montreal (Table 7).

Table 7. — Rural Medical Practitioners in the Districts of Quebec and Montreal by Ethnic Origin, 1818-1838.

Ethnic Origin	*1818*		*1831*		*1838*	
	Number	*% of Total*	*Number*	*% of Total*	*Number*	*% of Total*
District of Quebec						
French-Canadian	2	22.5	18	45	19	61
Anglo-Canadian	—	—	5	13	3	10
British	3	33.0	10	25	7	23
American	1	11.0	4	10	1	3
Other: French, German	3	33.5	3	7	1	3
Total	9	100.0	40	100	31	100
District of Montreal						
French-Canadian	8	21	32	41	42	44
Anglo-Canadian	4	10	13	16	22	23
British	9	23	16	20	11	11
American	14	36	15	19	14	15
Other: German, Upper Canadian	4	10	3	4	7	7
Total	39	100	79	100	96*	100

Source: Quebec *Almanach*.
* Of these, 48 listed "residence unknown".

Only in the District of Quebec did French Canadians form a majority, and then only after 1831. Even in Trois-Rivières, where once four out of five medical men had been francophone, the Anglophones, by 1831, were dominant (Table 8).

Table 8. — Rural Medical Practitioners in Trois-Rivières and Other Districts* by Ethnic Origin, 1818-1838.

Ethnic Origin	*1818*		*1831*		*1838*	
	Number	*% of Total*	*Number*	*% of Total*	*Number*	*% of Total*
French-Canadian	3	60	10	43	14	47
Anglo-Canadian	—	—	3	13	7	23
British	1	20	4	17	3	10
American	—	—	5	22	5	17
Other: French, German	1	20	1	5	1	3
Total	5	100	23	100	30	100

Source: Quebec *Almanach*.
* Including Sorel (1828), Gaspé and St. Francis (1831).

[32] F. Ouellet estimates that by 1831, one-third of the seigneuries in Lower Canada were owned by Anglophones. "La sauvegarde des patrimoines", *Revue d'histoire de l'Amérique française*, 26 (décembre 1972): 339.

[33] Ibid., pp. 337-39; Ouellet, *Le Bas-Canada*, pp. 252-53, 256-58.

The well-established Anglophone in the countryside enjoyed the same occupational and social advantages as the urban Anglophone, whose commercial and financial influence extended into the surrounding areas and dominated the economic life of the village.[33] Whether he was in the majority, as in the townships, or in the minority, as in the District of Quebec, his preferred position in the community drew attention to the disparities between the two ethnic groups.[34]

The medical profession was becoming increasingly rural, sixty-five percent in 1818, and seventy in 1831 (Table 2). Yet, as the Anglophone increased his numbers in the cities, it was the French Canadian who increased most markedly in the countryside. Whereas in 1818 he represented twenty-five percent of all rural practitioners, by 1838 this number had almost doubled to forty-eight percent (Table 6). By 1831, sixty of seventy-six French-Canadian practitioners, or seventy-nine percent, were in rural areas, more than half of these (32 out of 60) in the District of Montreal (Tables 4, 6 and 7). In rural parishes, the French-Canadian practitioner eked a bare living, suffering economic or social distress along with the *curé* and other parishioners.[35] Although the anglophone practitioner might well be among the more prominent members of his rural community, this was not necessarily so. The growing size of the profession meant that these practitioners, too, might find difficulty in establishing a practice, as American medical men in the Eastern Townships sometimes discovered.[36]

All of these factors — the uneven ethnic distribution of the profession, the unequal economic and social opportunity of its various members, and the mobility of the profession occasioned by immigration and rapid population increase — created an unstable situation in the profession. As well as movement out of the province of British and Anglo-Canadian practitioners, a certain emigration of French-Canadian medical men undoubtedly took place,[37] but the extent of this movement remains to be investigated. Within the province, an internal migration of medical men became apparent as the number of practitioners in Quebec City and District reached a maximum in 1831 and then declined (Tables 5 and 7). This decline represented in part a movement of practitioners from the District of Quebec to the District of Montreal,[38] a movement which coincided with mounting demographic pressure in both city and country.[39] These migratory movements also coincided with the growth in size and economic importance of Montreal as that of Quebec declined. The steady increase in British

[34] Ibid., pp. 252-60; OUELLET, "La sauvegarde des Patrimoines", pp. 337-42.

[35] Examples of this are given in CHABOT, *Le Curé de campagne*, p. 84; JOLOIS, *Jean-François Perrault*, p. 63.

[36] McCord Archives, Medical Papers, M 22088, Correspondence of Rotus Parmelee, 1827-28.

[37] Yolande LAVOIE, *L'émigration des Canadiens aux États-Unis avant 1930, mesure du phénomène* (Montréal: Presses de l'Université de Montréal, 1972), pp. 10-11; TUNIS, "The Medical Profession in Lower Canada", pp. 123-25.

[38] Ibid., pp. 123-24.

[39] OUELLET, *Le Bas-Canada*, pp. 247-48, 492-93. Rural migration from the District of Quebec is examined in OUELLET, "La sauvegarde des patrimoines".

medical men in the City of Montreal after 1831, despite their declining numbers in the profession, would seem to be related to this process (Tables 4 and 5). As new admissions of native-born practitioners continued to outnumber all others, Anglo-Canadian and French-Canadian practitioners increased rapidly in numbers in Montreal and District as the Rebellion of 1837 approached (Tables 5 and 7).

Ruralization of the medical profession, especially its French-Canadian segment, bore a direct relationship to its politicization, as this group became increasingly involved in parish politics. Rural practitioners, for instance, were among those liberal professionals challenging the clergy for control of education and parish administration.[40] When the movement to amend the Medical Act gained momentum, rural practitioners, a number of whom were elected to the Legislative Assembly, were to play a prominent part. Their contribution, disproportionate to their representation in the profession, was made possible by virtue of their role as representatives of a majority in the overall population of the province.

As demographic, socio-economic and political pressures continued to mount, increasing resentment was felt by various portions of the medical profession, both rural and urban, towards the dominant position of the British medical man. In Montreal and District this was directed towards the urban anglophone practitioner; in Quebec, towards the British military surgeon. In both areas, dissatisfaction focused on the Medical Boards and their preferential composition, a situation which had been brought to the attention of the Legislative Assembly by the petition of the civil medical practitioners of Quebec in 1818.

III

Another source of contention was that the Medical Act of 1788 did not define educational qualifications and standards. Within the framework of the Act the decision as to the candidate's medical competence lay entirely in the hands of the board. Moreover, certain preferential clauses were included in the Act. For instance, military surgeons on active duty in the province could practise medicine without being required to have a civilian licence. Another clause exempted from the board's examination all former military or naval surgeons who had held a warrant or commission. The same exemption applied to "such persons as shall have taken a degree in any University".[41] The interpretation of this clause in particular was to be disputed as increasing admissions to the profession drew attention to the varying levels of educational preparation amongst its members.

Private classes in medicine were offered periodically in both Quebec and Montreal, but regular medical education, at least before 1823, could only be obtained outside the province. Formal medical education had been

[40] CHABOT, *Le Curé de campagne*, pp. 83-90.
[41] 28 Geo. III, cap. 8, in *Ordinances of the Province of Quebec*, pp. 219-20.

available in Great Britain and France for many years, but because long and costly absences were involved in this type of training, only the sons of the more well-to-do families could afford to follow this course. Traditionally, these were sons of seigneurial families, prosperous merchants or established professionals, French-Canadian or anglophone. Those from less prosperous families, sons of farmers, lesser professionals or small businessmen, who began their education in the *collèges classiques*, continued to learn the profession of medicine by apprenticeship, with or without the addition of formal training at some later date. In the post-1815 period, as the standards for medical education in Lower Canada were being upgraded from apprenticeship only to the addition of some formal medical education attached to a hospital or an institution of learning, it became increasingly difficult for less prosperous students to obtain the necessary study. In order to alleviate this situation, the Montreal Medical Institution, a medical school attached to the Montreal General Hospital, was founded in 1823, and in Quebec medical lectures were instituted at the Emigrant Hospital and later at the Marine and Emigrant Hospital. Medical teaching, however, was not permitted in the religious hospitals, and no medical degree was offered in Canada until 1832. As the Montreal Medical Institution offered its classes in English only, the language difficulty faced by French-Canadian students continued much as before.

Those who were able to leave Lower Canada for their medical training could study in Great Britain, in France or in the United States. In Great Britain the medical student could earn a diploma in one of the Royal Colleges in London, Edinburgh or Dublin,[42] or follow a programme of lectures and practical experience in one of the large city hospitals. He could earn a degree in Dublin or in one of the Scottish universities; at Edinburgh, lectures were integrated into bedside teaching in the hospital, a system which would soon become established in Canada.[43] Some students secured diplomas in both Britain and France. In Paris, renowned for its clinical teaching and empirical method, the student could obtain a diploma in one of the large hospitals, or a degree in the university.[44]

A diploma or degree could also be obtained in the United States. It was closer, less expensive, and the required period of study was considerably shorter. There were also disadvantages. What had started as a two-year degree course attached to a university, designed to supplement the apprentice system, had been reduced to one year because of the difficulty students found in returning for the second year. As the one-year degree was accepted in the United States as equivalent to a licence to prac-

[42] R. STEVENS, *Medical Practice in Modern England*, pp. 12-13.

[43] CANADA, ROYAL COMMISSION ON HEALTH SERVICES, *Medical Education in Canada*, report prepared by J. A. MacFarlane (Ottawa: Roger Duhamel, 1965), pp. 13-14. This system had already been adopted at the College of Philadelphia. The Montreal Medical Institution, later McGill College, was based on the Edinburgh model of its Scottish-educated founders. McGill University Archives, Minutes of the Montreal Medical Institution, 1823-24 [*sic*].

[44] A. CASTIGLIONI, *Histoire de la Médecine* (Paris: Payot, 1931), pp. 621-22. See also ACKERNECHT, *Medicine at the Paris Hospital.*

tice, the system flourished. The oldest of these universities, the University of Pennsylvania, was attached to a hospital and maintained a recognized standard of education, but there was only one other large hospital in the northern United States, in New York City.[45] Thus a proliferation of smaller proprietary medical schools sprang up, each offering medical lectures, some attached to a local college, and most without clinical facilities. Under pressure of competition, ever diminishing periods of study were required. It was possible for a student who had completed three years of apprenticeship, to obtain a degree of Doctor of Medicine by following one course of lectures of twelve to fourteen weeks' duration. As there were no preliminary educational requirements for such a course, the quality of medical graduates could be open to question. Between 1810 and 1840, all medical colleges in the United States offered a medical degree on the basis of one year's study or less.[46] Both French and Anglo-Canadian students took advantage of the American medical colleges. By 1815, the American degree, preceded by well-grounded apprenticeship and followed by examination for licence to practise in Lower Canada, was an accepted procedure (Table 9).

Table 9. — MEDICAL EDUCATION OF 203 CANDIDATES ADMITTED TO PRACTISE, 1816-1831.

Ethnic Origin	*Formal Medical Education Completed in*					
	Lower Canada		*U.S.*		*Europe*	
	Number	*% of Total*	*Number*	*% of Total*	*Number*	*% of Total*
French-Canadian	18	25.0	19	26.5	19	26.5
Anglo-Canadian	16	36.0	7	16.0	10	22.0
British	6*	9.0	1	2.0	30	47.0
American	2	12.5	—	—	—	—
Other**	3	—	—	—	1	—
Total	45	22.0	27	13.0	60	30.0

Ethnic Origin	*Apprenticeship Only*		*Military Surgeons*		*Insufficient Data*		*Totals*
	Number	*% of Total*	*Number*	*% of Total*	*Number*	*% of Total*	
French-Canadian	12	17.0	1	1	3	4	72
Anglo-Canadian	11	24.0	—	—	1	2	45
British	6*	9.0	16	25	5	8	64
American	10	62.5	—	—	4	25	16
Other**	1	—	—	—	1	—	6
Total	40	20.0	17	8	14	7	203

Source: PAC, Medical Certificates, Vols 48-52.
* Three of these fulfilled apprenticeship in Lower Canada.
** Two German, three Upper Canadian, one French.

[45] U. S. BUREAU OF EDUCATION, *Contributions to the History of Medical Education and Medical Institutions in the U.S.A., 1776-1876*, report prepared by N. S. Davis (Washington, 1877), pp. 23-27.
[46] Ibid., pp. 42-44.

The type of medical education chosen by the prospective medical student, whether local, American or European apprenticeship, diploma or degree, was determined in large part, not by language of instruction or by quality of teaching, but by his family's economic and social status. In the minds of the educated public, however, there was no doubt as to the relative value of each of these training methods: European training was perceived as being vastly superior to any other form of medical education, American training came next, and apprenticeship last. To the medical boards, the relative merit and status of these levels of education in the absence of defined standards was a continuing problem; the introduction of formal medical teaching within the province further complicated the issue. Certificates granted by the medical boards to successful candidates for licence between the years 1816 and 1831 provide sufficient data to present a comparative table of their educational qualifications (Table 9).

Just as immigration altered the ethnic composition and distribution of the profession in Lower Canada, so too did it affect the general educational level of its members. As was to be expected, the most highly qualified of new licentiates were immigrant British medical men. Of sixty-four British immigrant practitioners admitted to practise in Lower Canada between 1816 and 1831, forty-six, or seventy-two percent, had acquired formal medical education in Europe; sixteen were military surgeons, and eleven held a degree in medicine, all but one from a Scottish university (Table 10).

Table 10. — Degrees and Diplomas Obtained in the United States and Europe by 91 Candidates Admitted to Practise, 1816-1831.*

Ethnic Origin	*United States*			*Europe*			*Total*
	Degree	*Diploma*	*Total U.S.*	*Degree*	*Diploma*	*Total Europe*	
French-Canadian	16	4	20 (53%)	5	13	18 (47%)	38
Anglo-Canadian	4	3	7 (44%)	3	6	9 (56%)	16
British	1	—	1 (3%)	11**	24	35 (97%)	36
Other	—	—	— —	1	—	1 —	1
Total	21	7	28 (31%)	20	43	63 (69%)	91

Source: PAC, Medical Certificates, Vols 48-52.

* American candidates are excluded because of insufficient data.

** Five of these were held by military surgeons. Not included are ten British candidates holding military commissions but no degree.

Native-born candidates, both French and Anglo-Canadian, were also gaining in formal preparation. More than one-third of all Anglo-Canadian candidates for licence and twenty-five percent of French-Canadian candidates during this period had completed some formal medical study at institutions in Lower Canada. The majority of these, almost all of whom were from Montreal and the District of Montreal, had attended the Montreal Medical Institution (Table 9).[47] Moreover, despite the expense of

[47] Seventeen out of eighteen French-Canadian and fifteen out of sixteen Anglo-Canadian candidates between 1824 and 1831 had attended at least one year at this Institution. PAC, Medical Certificates, Internal evidence, vols 50-53.

travel abroad, a further nineteen French-Canadian (26.5%) and ten Anglo-Canadian licentiates (22%) had followed some medical study in Europe between 1816 and 1831. Of these, five French Canadians and three Anglo-Canadians held European degrees (Table 10). Some candidates began their study in Lower Canada and completed it abroad, while others took out licence to practise first and later secured the degree.[48] A student with means could stay for as many years as he could afford.[49]

It was not only the need for formal medical study that drew these students to Europe; Europe in the post-1815 years was a centre of intellectual, scientific and cultural ideas. The wars had extended medical knowledge and experience, increased mobility and stimulated exchange of ideas. As medicine became more scientific, medical men began to acquire a new status and a sense of professionalism. The introduction of medical journals and medical societies symbolized these new ideas which permeated the profession abroad and travelled back across the Atlantic. Even after a medical degree could be obtained in Lower Canada, many students continued to go abroad for further study.[50]

Yet the number of native-born medical students studying in the United States was also substantial. Between 1816 and 1831, nineteen French-Canadian (26.5%) and seven Anglo-Canadian candidates (16%) presented medical diplomas or degrees obtained in the United States, more than half of these from educational institutions in the larger centres of Philadelphia and New York.[51] By the end of the decade, a pattern of study for medical students in the Quebec area began to emerge: a course of lectures at the Emigrant Hospital followed by a degree obtained in the United States. The smaller proportion of Anglo-Canadian medical students at American universities may reflect a certain prejudice against the American degree. But another and more obvious reason was the establishment of the Montreal Medical Institution which made available British-style medical education within the province. Although French-Canadian medical students, particularly those from the District of Montreal, also attended the Institution, at least before 1831, French Canadians held no prejudice against the American degree and continued to seek this honour. The questionable merit of the American degree was to lead to a legal decision against its acceptability to confer exemption from the board's examination.

Nevertheless, in both Districts throughout the period, it would seem that those students who could afford to do so, chose to study in Europe. As the level of formal education increased, education solely by apprenticeship declined to an average of twenty percent of all medical licentiates in Lower Canada in the period 1816-31. Among those educated solely by

[48] Thus G.-J. Vallée was licensed in Lower Canada in 1824 and then studied in Paris; A. F. Holmes, licensed in 1816, received an MD (Edin.) in 1819.

[49] For instance, Pierre Beaubien, MD (Paris), 1822, studied and practised ten years in Paris. PAC, Medical Certificates, vol. 51: 1232-43.

[50] CASTIGLIONI, *Histoire de la Médecine*, pp. 621-22; ACKERKNECHT, *Medicine at the Paris Hospital*, pp. 191-94; HOLLOWAY, "Medical Education in England", p. 305.

[51] PAC, Medical Certificates, Internal evidence, vols 49-52.

apprenticeship, French-Canadian licentiates decreased to seventeen percent, Anglo-Canadian to twenty-four percent. Americans showed the least reduction with 62.5 percent of all admissions to practise still educated by apprenticeship between 1816 and 1831 (Table 9).[52]

Since city practice is held to attract the better qualified members of the profession by virtue of its superior medical facilities, its professional opportunities and its amenable social environment,[53] it might be expected that improvements in the educational and professional qualifications of the native-born practitioner would be reflected in his economic, social and professional status. Was there, in Lower Canada, a link between education and place of practice for the native-born practitioner?

Although specific data have not been tabulated, certain observations can be made. In general, evidence suggests that those licentiates of the period 1816-31, both French-Canadian and Anglo-Canadian, who had studied in Europe, were the most likely to set up an urban practice.[54] Again, as a general statement, those educated in the United States after 1815 tended to be in rural practice. Exceptions were F.-X. Tessier, who attained prominence in Quebec, and A. Lusignan, in practice in Montreal. Quebec showed a higher ratio of British-educated practitioners (five out of nine French-Canadian doctors in 1831), while Montreal, with its nucleus of Scottish-educated medical men, absorbed the native-trained Anglo-Canadian and American practitioners. Of seven French-Canadian practitioners resident in Montreal in 1831, four had studied in Europe, two held American degrees and two had attended the Montreal Medical Institution. Those members of the profession who became established before 1815 do not seem to show the same relationship between education and place of practice as those in the later period. For example, both François Blanchet, who received his medical degree from Columbia University in 1801, and Dr Joseph Painchaud, licensed in 1811 and educated by apprenticeship, were leading members of the profession in Quebec. In the same way, Robert Nelson, licensed in 1814, received recognition as a surgeon in Montreal and abroad. In these cases, experience gained in the War of 1812 must also be taken into account.

As the profession increased in size after 1815 and the better positions, rural and urban, were filled, occupational competition intensified. The rapid elevation in level of education of practitioners and the introduction of well-qualified British medical men placed added pressure on the profession and was a factor in its changing demographic pattern. It might be

[52] This estimate, based on internal evidence (PAC, Medical Certificates), may be misleading. Most immigrant Americans admitted were older practitioners who had been in the province for several years and whose petitions for licence showed more concern over eligibility for citizenship than for educational attainment.

[53] Elizabeth GIBBS, "Professionalization of Canadian Medicine, 1850-1970", Paper presented to the Canadian Historical Association in London, Ontario, June 1978, p. 25.

[54] PAC, Medical Certificates; Quebec *Almanach*. For example, G.-J. Vallée and P. Beaubien who had studied in Paris and A. F. Holmes and John Stephenson, MD (Edin.), were in practice in Montreal; C.-N. Perrault, MD (Edin.) and W. E. Holmes, MRCS (London) entered practice in Quebec.

argued that the urban-rural distribution of practitioners was related solely to the ethnic character of the community in which they practised: that the French-Canadian practitioner served country districts and the City of Quebec, areas of high French-Canadian concentration, while anglophone practitioners gravitated naturally to the urban centres and the mercantile and commercial anglophone society of Montreal. This undoubtedly was true in that the vast majority of the French-Canadian population lived outside the cities. Yet the urban-rural distribution of the profession as shown in this study does not entirely justify this conclusion. In 1831, for instance, Anglophones represented seven to eight percent of the population of the District of Quebec,[55] whereas the proportion of anglophone medical men in the District was fifty-five percent (Table 7). The presence of the anglophone practitioner in the cities and the larger rural centres and townships was as much related to economic, educational and social factors as to the ethnic distribution of the population. The uneven ethnic distribution of the profession and the resultant under-representation of the French-Canadian practitioner in the cities, twenty-eight percent in 1831 (Table 5), demonstrate these facts: the anglophone practitioner was in the majority in the profession, he enjoyed the more profitable practice. Until the demographic and professional balance could be adjusted, his dominant place in the profession would continue.

It was not only educational qualifications and professional experience, nor even economic attraction that determined place of practice or advancement in the profession: social position and political and professional affiliation were also important. This was shown particularly in the cities, where British medical men continued to occupy the foremost positions. Among these were the appointments as medical attendant to the religious hospitals, posts originally held by French military surgeons, but which by 1814, were held almost exclusively by British medical men.[56]

The British and military composition of the medical boards also remained unchanged. The status of the British military surgeon, both educational and social, was even more apparent in the appointments of two former military surgeons to the Quebec and Montreal medical boards. William Hacket, MD, licensed to practise medicine in Lower Canada in 1816, was appointed almost immediately to the Quebec Medical Board; and William Robertson was appointed to the Montreal Medical Board in 1817. Well-qualified Anglo-Canadian medical men also received appointment to city positions, some acquiring the prestige and privileges of the urban British medical man. Thus John Stephenson, MD, educated in Scotland, was appointed to the Montreal Medical Board in 1823, while W. E. Holmes, MRCS (London), son of Dr William Holmes of the Quebec Medical Board, was similarly appointed in Quebec one year later.

[55] OUELLET, "La sauvegarde des patrimoines", p. 338.

[56] Medical appointments to the religious hospitals were made by the Bishop with the concurrence of the Sisters. ABBOTT, *History of Medicine*, pp. 34-35; M.-J. and G. AHERN, *Notes pour servir à l'histoire de la médecine dans le Bas-Canada; depuis la fondation de Québec jusqu'au commencement du XIX^e siècle* (Québec: Imprimerie Laflamme, 1923), pp. 207-8.

It is significant that the only French Canadian to be appointed to either medical board before 1824 was Thomas Fargues, MD (Edin.), 1811,[57] who was appointed to the Quebec Medical Board in 1816. Stepson of Sir Thomas Dunn, a prominent member and former president of the Executive Council, Fargues had spent many years in study and practice in England. His social and political background had little in common with that of the liberal professional practitioners. For the majority of the latter, despite their rising educational level, their status in the profession remained unchanged and an increasingly rural way of life was evident.

IV

Political action to challenge the composition and powers of the medical boards was initiated by members of the profession in Quebec. The presentation of the petition of the civil medical practitioners of Quebec in 1818 occurred exactly at the time when French-Canadian practitioners in that city were at the height of their urban strength (Table 5). As has been shown, the petition was also a response to their elevation in educational and professional preparation. Participation in the War of 1812 had broadened the professional background of both French and Anglo-Canadian practitioners and provided a milieu for social and political camaraderie which enhanced a sense of social and professional self-awareness.[58] The presentation of this petition, which did not achieve its objective at this time, marked the beginning of the political drive to correct what seemed to be injustices in the profession and to secure elected medical boards.

Political action following the petition unfolded on two main fronts: the first against the medical boards, to challenge their authority and their interpretation of the Medical Act; the other, in the Legislative Assembly, to amend the Act and to seek incorporation of the profession. The first point of dispute was the status of the American medical degree. In 1818, close on the heels of the petition, two candidates, each holding a degree acquired in the United States, challenged the decision of the Quebec Medical Board that they should submit to its examination, and sought exemption from this under the Medical Act of 1788.[59] The political nature of the case is seen in that one of the candidates was the son of Louis Bourdages, a leading member of *le parti canadien*, with which party both candidates were later affiliated.[60] Social overtones were also present as native-born candidates faced a board made up of British military surgeons. The British-

[57] Ibid., pp. 206-7; W. Stewart WALLACE, ed., *The Macmillan Dictionary of Canadian Biography* (Toronto: Macmillan, 1963), p. 224.

[58] J.-J. LEFÈBVRE, "La vie sociale du grand Papineau", *Revue d'histoire de l'Amérique française*, XI (mars 1958): 463-516; J. B. THOMPSON, "Wolfred Nelson", *Dictionary of Canadian Biography, IX: 1861-1870* (Toronto: Toronto University Press, 1976), p. 594.

[59] Case of R. Bourdages and T. Fortier, PAC, Medical Certificates, 5 May 1818-13 October 1818, vol. 49: 616-17, 649-90, 691-96.

[60] Louis Bourdages, and later R. S. Bourdages, each served as Member of the Legislative Assembly of Lower Canada, where they represented rural counties in the District of Montreal. F.-J. Audet, "Louis Bourdages", *Proceedings and Transactions of the Royal Society of Canada*, Third Series, XVIII (1924): 73-101.

educated medical board, referring the question of the American degree to the Attorney-General, received the decision that "any University", as stated in the Medical Act, could not refer to "foreign" universities, and thus only a degree from a British university could exempt the candidate from examination by the Board.[61]

The status of apprenticeship was next to be disputed. In 1821, John Nelson, of the District of Montreal, contested the decision of the Quebec Medical Board that his apprenticeship to his brothers, Wolfred and Robert, was insufficient to allow him to qualify for the Board's certificate and that he must thus continue his studies at a "Public Medical School". Nelson maintained that as such a school did not exist in Lower Canada, the Board had ordered him to seek further education at an American university, an action outside the powers conferred on the Board by the Act. After prolonged and heated argument on paper with members of the Quebec Medical Board, Nelson was examined and passed by the Montreal Board, from whom he secured his certificate.[62]

In spite of the political, social and ethnic differences between the civil medical practitioners and the members of the medical boards, the two groups shared common ground in their desire to establish educational standards for the profession. Since the Medical Act did not define such standards, the decision of the boards to impose their own was challenged. Each own political, social and professional precepts. Following the incident involving Nelson, both medical boards required candidates prepared solely by apprenticeship to pursue further study before being granted licence to practise. Although this raised educational standards in the profession, the arbitrary means by which this end was achieved was resented.

The dispute which began in 1818 and which became increasingly ethnic and political, was really just the beginning of a wider struggle which involved not only medical education and medical licensing, but also the construction of secular hospitals and the administration of medical care. Parallel to this wider conflict and the changing policies of the medical boards, a renewed attempt to amend the Medical Act was made. Two petitions were presented in the Legislative Assembly in 1823: one from practitioners, mainly urban, in Quebec, Montreal and Trois Rivières;[63] the other from practitioners in the District of Montreal,[64] where for the first time, the voice of the rural practitioner was heard. Both petitions were concerned with establishing educational standards, but whereas the Quebec petition centred on the need to amend the existing Medical Act, that of the District of Montreal urged its total recall and the replacement of the

[61] PAC, Medical Certificates, vol. 49: 677-84.

[62] Case of John Nelson, PAC, Medical Certificates, 29 September 1820-3 September 1821, vol. 49: 837-57.

[63] PAC, Executive Council, 1764-1867, Petitions and Addresses, 1773-1840, RG 1, E 16, Vol. 2, Part 2, No. 17, "Petition from Physicians and Surgeons that a modification may be made to the law governing medicine" [1823].

[64] Ibid., Vol. 1, Part 2, No. 17, "Petition from the Surgeons and Physicians of the District of Montreal for a better observance of the law re their profession" [1823].

appointed medical boards with boards made up of members elected by the profession at large. While a certain tension could be detected between Quebec practitioners and those of the Montreal District, the immediate stimulus for the more radical approach of the Montreal group can be found in a changed professional situation in the City of Montreal and the new composition of its medical board.

William Robertson, associated with the Montreal General Hospital and member of the Montreal Medical Board, had requested the Governor of the Province to dismiss the present board and to appoint a new one to be composed of the officers of the Hospital, who were also the professors in its teaching institution.[65] Although raising the standard of medical education was the objective, this unilateral action, to which Lord Dalhousie gave his agreement, was bitterly opposed by many in the profession. Furthermore, the exclusion of non-British-educated medical men from appointment to the medical staff of Montreal's only teaching hospital further restricted opportunity for professional advancement among other members of the profession, and drew attention to the inferior position seemingly accorded them by the British-educated officers of the Hospital.

Ethnic, political and social tension escalated as urban and rural practitioners of Montreal and District, anglophone and francophone, combined to express their disapproval in petition to recall the Act.[66] Of forty-one persons whose signatures appear on this petition of 1823,[67] eighteen were French-Canadian, the remainder almost all either American or Anglo-Canadian. Those signing the petition represented more than fifty percent of the members of the profession in Montreal and District (41 of 77) and demonstrated the combined resistance of native-born practitioners to those of British origin and education. Prominent on the list of signatures were those of the Nelson brothers, R. S. Bourdages and Daniel Arnoldi, a member of the previous board, whose commission had been revoked. Pressure to recall the Medical Act and to secure the incorporation of the profession was stepped up and repeated attempts made in the Legislative Assembly in succeeding years to gain this objective.

Ethnic and professional tensions were less apparent in Quebec, where the more equally balanced ethnic composition of the profession and the

[65] The conflict which surrounded the founding of the Montreal General Hospital, the beginning of teaching in the Montreal Medical Institution, and the creation of the Montreal Medical Board of 1823 has been variously described in the literature. While ABBOTT in *History of Medicine* and LEBLOND in "La médecine dans la province de Québec avant 1847" discuss its ethnic and political context from two different viewpoints, ROY in his summary of the medical profession in Quebec in *Histoire du notariat* ignores the episode. On the other hand, Abbott passes over the existence of the 1831 Board entirely, an event documented by both Leblond and Roy. See also TUNIS, "Medical Licensing in Lower Canada". The demographic and social aspects underlying this conflict have not heretofore been examined.

[66] PAC, RG 1, E 16, Vol. 1, Part 2, No. 17, "Petition from the Surgeons and Physicians of the District of Montreal" [1823]. See also *Canadian Courant and Montreal Advertiser*, 1 November 1823.

[67] The exact number of medical men who signed the petition cannot be known as the petition is torn. The number of medical men in Montreal and District in 1823 was between seventy-five and seventy-nine. Quebec *Almanach*, 1824, pp. 79-80.

relative stability of the French-Canadian practitioner allowed for a degree of professional co-operation not possible in Montreal. The Emigrant Hospital, for instance, which was supervised by the Legislative Assembly, was staffed by French and Anglo-Canadian medical men.[68] Two of these were among the native-born practitioners appointed to the Quebec Medical Board in 1824.[69] Other professional ventures[70] entailed co-operation between all ethnic groups. Members of the Quebec Medical Society joined in petition for recall of the Medical Act, and their added pressure was at last successful in March 1831, when a new Medical Act was secured.[71]

Nevertheless, the dominant feature in the political and professional drive for new medical legislation was the strength of the rural practitioner. Medical representatives piloting the Bill in the Legislative Assembly came from rural counties, and rural medical practitioners were subsequently elected to the new medical boards.[72] In Montreal and District tension in the profession reached a new high on the occasion of the election of the Medical Board of 1831, when the controversial Board of 1823 was defeated.[73] Here again, rural practitioners predominated (30 out of 44 present, or 68%).

These events of 1831 coincided with the peak in ruralization of the profession and its growing numerical concentration in the District of Montreal (Table 7). They also occurred in a period of mounting social and economic instability and at the height of British immigration. Political differences arising in the profession before 1831 persisted and increased in intensity to culminate for some members in active participation in the Rebellion of 1837-38.

Medical education and medical licensing remained a source of conflict until after the incorporation of the profession in 1847.[74] Two systems of medical education emerged. In Montreal, the Medical Faculty of McGill College, successor to the Montreal Medical Institution, received degree-granting power in 1832; in Quebec, lectures begun at the Emigrant Hospital under the sponsorship of the Legislative Assembly, were continued at the Marine and Emigrant Hospital, and became formalized in the establishment

[68] In 1825 these were: F. Blanchet, J. Painchaud, W. E. Holmes, J. Morrin, C.-N. Perrault and W. A. Hall. *Journals of the Legislative Assembly of Lower Canada*, 34 (1825), Appendix I.

[69] Those appointed were: C.-N. Perrault, W. E. Holmes and J. Morrin.

[70] For example, the first medical journal to be published in Canada, *Le Journal de Médecine*, edited by F.-X. Tessier, appeared in 1826. A bilingual journal, it drew contributions from both ethnic groups. The Quebec Medical Society was founded in the same year by the active co-operation of all members of the profession. BOISSONNEAULT, *Histoire de la Faculté de Médecine de Laval*, pp. 113-14, 121-26.

[71] 1 William IV, cap. 27 (*Provincial Statutes of Lower Canada*, 14: 164-79).

[72] Each board was composed of twelve members. Four members of the Quebec Board and seven of the Montreal Board were from rural districts. Quebec *Almanach*, 1832.

[73] PAC, Medical Certificates, Vol. 53, Election of Members of the Montreal Board, 11 July 1831. TUNIS, "Medical Licensing in Lower Canada", deals with this controversy.

[74] LEBLOND, "La profession médicale sous l'Union": 165-203; ABBOTT, *History of Medicine*, pp. 71-72.

of l'École de Médecine de Québec in 1845. Authority to confer degrees was given after the School was absorbed by l'Université Laval in 1853.[75]

V

Out of the conflict in the medical profession, before and after 1831, came significant change. The rise of a new middle class allowed for the emergence of a new group of native-born medical men, whose increasing numerical and political strength enabled its members to challenge the dominant position in the profession of the British military doctor. The power base of the medical establishment was the Governor and the Executive Council, that of the liberal professionals, the Legislative Assembly. Although conflict in the profession was centred on the control of the medical examining boards, the end result, because of the political allegiance of each group, was determined by the wider political struggle in the legislature.

Rapid growth in the profession after 1815 changed its ethnic composition and distribution and drew attention to occupational and socio-economic disparities between various groups in the profession. Ruralization of the French-Canadian portion of the profession, particularly in the District of Montreal, led to increased political activity by members of this group. Common professional and class interest cut across political and ethnic divisions as French-Canadian, Anglo-Canadian and immigrant American practitioners combined to protest the dominance of the urban British doctor. In Quebec, where socio-economic and professional needs were more nearly satisfied, ethnic tension was less apparent.

Members of each ethnic group took their place in the medical hierarchy, or in the conflict, according to political precepts, social and professional contacts, and educational attainment. Whereas aspiring practitioners, both French and Anglo-Canadian, faced the same problem of kind and availability of medical school, the Anglo-Canadian, in general, had the advantage of social and professional contacts and, in the Montreal area, educational facilities. French-Canadian medical students, by choosing to study in the United States, weakened their qualifications in the eyes of the British-educated members of the medical boards.

To the British medical man, education and status were closely linked. The preponderance of British-educated medical men and their dominant position in the profession ensured that the system of medical education established in Lower Canada would be based on that of Great Britain. The raising of standards of medical education by the medical boards,

[75] BOISSONNEAULT, *Histoire de la Faculté de Médecine de Laval*, p. 166. Similarly, L'École de Médecine et Chirurgie de Montréal, founded in 1843 by English-speaking members of the profession received the power to grant degrees once it had obtained affiliation with university. L.-D. MIGNEAULT, "Histoire de l'École de Médecine et Chirurgie de Montréal", *Union Médicale du Canada*, 55 (1926): 598. See also, ABBOTT, *History of Medicine*, pp. 63-66.

while intended to increase the professional competence of new licentiates, was also a means of controlling entrance to the profession. To the liberal professional, this should be determined not only by the measure of merit but also by the decision of one's peers.

The British did not, however, succeed in establishing a class basis for the profession, although British standards prevailed. It might well be held that the strict control exerted under the British system prevented a proliferation of medical schools in Lower Canada as occurred in the United States.[76] Access to the system in Lower Canada was broader than in Britain, closer to the precepts of the liberal professional by whose action medical licensing was placed under the elective process in 1831. Although the events of 1837-38 reversed this legislation, and although ethnic, political and social tensions continued to plague the profession, a more moderate approach was accepted, and the regulation of the profession, the first step towards autonomy, was eventually turned over to its members.

RÉSUMÉ.

Entre 1815 et 1831 la profession médicale se partageait en deux groupes, distincts sur les plans ethnique, social et politique, l'un et l'autre cherchant à contrôler l'accès à la pratique. Une couche nouvelle de médecins autochtones, en majorité canadiens-français, s'éleva contre les jurys d'examen composés avant tout de chirurgiens militaires britanniques nommés par le gouverneur en vertu de la loi de 1788. À l'affût de statut social et de reconnaissance professionnelle, ces nouveaux membres des professions libérales eurent recours à l'influence de leurs représentants à l'Assemblée législative. Après 1815, des changements rapides se produisirent : les docteurs britanniques et anglophones dominèrent la pratique dans les villes, tandis que les Canadiens français exercèrent de plus en plus dans les campagnes. De telles disparités socio-économiques et professionnelles accentuèrent les tensions entre les deux groupes, qui furent encore renforcées par les différences de niveau dans la formation médicale, au fur et à mesure que l'apprentissage le cédait à des études plus formelles. Une nouvelle loi régissant la profession fut votée en 1831 mais elle ne survécut pas aux événements de 1837-38.

[76] This is also suggested by Joseph F. KETT, "American and Canadian Medical Institutions, 1800-1870", *Journal of the History of Medicine and Allied Sciences*, 22 (October 1967): 351-55.