Abstract. This study explores some of the important questions raised but not answered in William Canniff’s standard century-old study, The Medical Profession in Upper Canada, 1783-1850. Primarily based on the original medical licenses issued between 1819 and 1841, an array of manuscript material belonging to the Civil Secretary of Upper Canada and the Colonial Office, and documents pertaining to the Medical Board of Upper Canada, this article argues that the disallowance of legislation for the establishment of a colonial College of Physicians and Surgeons in 1839 can only be fully understood in the context of demographic, political, and medical developments which included factors such as ethnicity, tensions between the colony and mother country, and rivalry between medical schools. It explains why the issues of the 1830s continued into the 1840s and undermined any possibility by the profession of forming a single, self-regulating, and unified medical body for licensing and educating practitioners.

Résumé. Cet article examine quelques unes des questions importantes que soulève sans y répondre le livre de William Canniff, The Medical Profession in Upper Canada, 1783-1850, ouvrage paru il y a un siècle mais qui fait toujours autorité. S’appuyant principalement sur les originaux des licences médicales délivrées entre 1819 et 1841, sur de nombreux manuscrits appartenant au Secrétaire civil du Haut-Canada et sur des documents concernant le Bureau médical du Haut-Canada, cet article démontre que le rejet d’une législation permettant l’établissement d’un college colonial de médecins et de chirurgiens ne peut être parfaitement compris qu’à la lumière des développements démographiques, politiques et médicaux, en tenant compte des facteurs ethniques et des rivalités, d’une part entre coloniaux et Britannique et d’autre part, au sein des collèges et des écoles de médecine. L’article explique pourquoi les tensions des années 1830 ont continué durant les années 1840 et ont miné toute possibilité de constituer un seul corps médical unifié chargé de la délivrance des licences et de l’enseignement de la médecine.
The debate over how to professionalize the medical profession of Upper Canada mustered the attention of the imperial and colonial governments, old and new members of the profession, social and political reformers, and the public. The pinnacle of the profession’s early efforts to develop a self-regulatory body culminated in 1839 when the Medical Board of Upper Canada was metamorphosized into an incorporated, self-governing and provincially based College of Physicians and Surgeons. The Board’s intention was to monopolize and standardize licensing and education, an effort which failed until the creation of the College of Physicians and Surgeons of Ontario three decades later. This short-lived colonial college, moreover, existed without counterpart anywhere within the British Empire. Because its powers infringed upon the Royal College of Physicians and Surgeons and related bodies, the colonial statute upon which it was based was subsequently disallowed by the Colonial Office.1

The historical context of the first Medical Board remains largely unexplained and critically unexamined despite the long-standing contribution of William Canniff in his standard century-old work, The Medical Profession in Upper Canada, 1783-1850. In a recently reprinted edition of Canniff’s book, editor Charles Roland has posed some important questions. He has enquired as to why there was a controversy over the activities of the Medical Board of Upper Canada in the mid-1830s. Was this controversy linked to reform politics? What policies governed existing laws whereby British graduates were not examined by the Medical Board of Upper Canada, but other graduates, such as those from American schools, were. Who constituted the Medical Board, and why were some not active practitioners?2

This article reconsiders the formative development of the medical profession in Upper Canada. First, I examine the nature and changing demographics of the profession in the 1820s and 1830s. Second, I look at the impact of the 1827 legislation governing medical licensing and the nature and powers of the Medical Board of Upper Canada. A third section discusses the divisive issue of medical education, its promotion, and its control. A final section suggests why the ideological and political differences of the 1830s extended into the post-1840 period and contributed to the inability of the profession, as a whole, to form a single, self-regulatory body.

STATE OF THE PROFESSION

William Canniff, who admitted the incomplete nature of his work, listed 271 biographical entries for Upper Canada between 1783 and 1850. However, if one gleans the size of the profession on the basis of extant medical licenses of Upper Canada, one finds that this figure under-
estimates the numbers: 311 licenses were issued between the establishment of the Medical Board of Upper Canada in 1819 and the creation of the College of Physicians and Surgeons in 1839. There were also an undetermined number of unlicensed practitioners, "empirics," and quacks, some from non-credited schools.

Licensing patterns changed markedly following the passing of revised legislation in 1827, "An Act to amend the Laws regulating the Practice of Physic, Surgery, and Midwifery in this Province," a consolidation of all previous legislation governing medical licensing. Significantly, the number of annual licenses between 1819 and 1826 differ from those issued between 1827 to 1836. The period up to 1826 reveals modest activity by the Medical Board; an average of 4.5 licenses were issued per year, and only one license was awarded exclusively by statute. But the 10-year period 1827-36 witnessed the number of practitioners licensed per year rising to 25.5, a sixfold increase over the previous decade. Moreover, the number of practitioners licensed after 1827 by the Medical Board (47.5%) was now roughly equal to those physicians who were licensed under statute (52.5%), over whom the Board had no legal authority.

Overall Upper Canada had fewer practitioners per capita than either the United States or Great Britain. Relative shortages of medical care in Upper Canada tended to exist in the more remote and less settled rural areas as opposed to well-established towns and villages, but this is understandable in light of the economic state of the colony; it was commonly described as cash-poor, and many newly arrived medical practitioners who went to all parts of the province, including the developing frontier, found it difficult to procure a living. In 1838 the estimated population of Upper Canada was close to 400,000 among whom were approximately 300 medical practitioners, or 1:1,333 population; this ratio represented roughly 50 percent percent fewer doctors than in New England.

In contrast to the countryside, York (Toronto) and Kingston, the two largest urban centres, had a disproportionate number of doctors per population. In 1836 Toronto boasted 15 doctors in a population of 6,000, or 1:400. Toronto’s number of doctors per population was thus nearly twice as high as Boston’s, suggesting a relative glut. Interestingly, these figures on urban Upper Canada roughly parallel New England’s urban statistics for the same years, where there existed the highest number of doctors per population ever at 1:542—an overflow, creating what one American contemporary termed a "crisis." One can infer that Toronto practitioners experienced similar pressures, as New England physicians, to move into rural practices.
For many doctors, it was—as Constance McGovern writes of the American experience—"an uncertain profession." Even in more developed regions of New England, 64 percent of doctors initially failed to establish a long-term practice, with 39 percent failing at least three times. While no comparable figures exist for Upper Canada, qualitative evidence suggests a similar pattern. The difficulty of establishing a paying practice may explain why other doctors included among the licenses left little record. Clearly, some Upper Canadian practitioners unable to establish a viable practice simply moved on, probably to the United States, or back to Great Britain.

The following example aptly illustrates the hardships of becoming established as a practitioner. A former naval surgeon appointed to troop transport ships and former student of Sir Astley Cooper, the Englishman William Rees, arrived at Quebec City in 1822. He was appointed to the Emigrant Hospital and worked in a temporary posting as Assistant Health Officer of the port of Quebec for three years. He also engaged in private practice and had several medical apprentices. Believing that there were greater opportunities in Upper Canada, Rees was licensed there in 1830 by the Medical Board. As a tory Rees ran for political office in 1834, tinkered with the notion of opening a school of medicine, and opened a vaccination clinic for the destitute. He also scrambled to find official appointments, being contracted as medical attendant to the York jail, surgeon to a government survey expedition, and assistant surgeon to the Queen's Rangers regiment. In 1841 his fortunes changed when he became medical superintendent of the Toronto Temporary Lunatic Asylum—Upper Canada's first such institution.

**THE MEDICAL ACT OF 1827**

Before the late 1820s the laws governing the medical profession in Upper Canada were weakly enforced because the colony had initially suffered a chronic shortage of qualified personnel. In this early period, doctors who had acquired their background through apprenticeship were as welcome as university graduates. In these more desperate days, even quacks had their defenders. This pragmatically based tolerance changed dramatically as more qualified personnel arrived with the many immigrants who poured into the Canadas after 1817. Now the question of what to do to regulate migrant and growing numbers of practitioners fostered concern.

Following pressure from existing practitioners, the Upper Canadian government passed legislation in 1827 to make it more difficult to receive a license. Under the *Medical Act*, unless an applicant held a diploma or license from a designated, bona fide British university (Cambridge, Oxford, and later McGill College), belonged to the Royal Col-
lege of Physicians and Surgeons in London, or had held a commission or warrant in the British forces as a military surgeon, he had to submit to the Medical Board’s examination. All applicants also had to swear an affidavit stating that they were the person named in the diploma, license, or commission. In addition, whereas medical practitioners resident in the province and active in their craft before the War of 1812 had been allowed to practise unrestricted, they now had to produce a certificate before a magistrate and give an oath as to their place of residence, their background, and habitation in the province during the War of 1812. Military doctors and female midwives remained unhampered in their right to practice without a license, but they were the exceptions. Anyone else had to show a certificate from at least three licensed practitioners—the Medical Board and its surrogates—stating that they had examined the candidate. Then the Lieutenant Governor still held the option of granting the applicant a license. Those who gave a false affidavit faced prosecution for perjury. Any unlicensed practitioners were subject to prosecution for a misdemeanor and risked up to six months imprisonment and a weighty £25 fine.

The Medical Act was immediately and rigorously enforced and even reasonable appeals to the highest colonial authorities failed. To illustrate, there was the case of the Irish-trained Dr. James McCague, in Canniff’s words, “a fine-looking, portly Irishman with a frank countenance and genial manners, with a tendency to be ‘wild’,” and a “great favourite everywhere.” McCague arrived in 1827 and practised 10 miles north of York on Yonge Street, but his certificates had given him only a license to practise within a certain jurisdiction in the old country. These certificates, moreover, came from an unidentified university not listed under the new legislation (probably Trinity College, Dublin), thereby precluding McCague from any legal exemption. Yet Chief Justice John Beverley Robinson, who examined his credentials upon the request of Major Hillier, recognized that McCague had “enjoyed superior advantages of instruction,” and that his qualifications were “in fact superior to those of many who are and may be admitted to practice here.” Lieutenant Governor Maitland was notified by Robinson of his opinion, but to no avail, for even the highest governing official could not subvert the law. McCague therefore had to undergo the Medical Board’s examination, which he passed on 2 January 1828. His examination was less than a month after Robinson had reached his decision in the matter, suggesting that political influence had expedited the process, but nothing else. Numerous other cases besides McCague’s exist where arguably qualified practitioners were not exempted by this legislation and were obligated, often reluctantly, to undergo the scrutiny of the Medical Board. Simply, paternal authority was circumscribed by the rule of law.
The approval of physicians, surgeons and apothecaries was not merely an issue of medical competence. Loyalty and character were also carefully taken into account in approving applicants. Ensuring loyalty had preoccupied British-Canadians since the American Revolutionary War and the War of 1812. In the 1820s, loyalty again loomed as a political issue with the "Alien Question," that is, a restoration of civil rights to American settlers. Settlers of American descent and some recent immigrants urged political reform and looked to changing the British constitutional form of government towards greater provincial autonomy and American-style democracy. Doctors were considered influential and among the educated elite. The Anglican Archdeacon Strachan worried as early as 1826 that, in light of the growing importance of medicine in Upper Canada, many practitioners had studied or would be studying in the United States, "and it is to be presumed that many of them are inclined towards that country." He thus strongly urged the Lieutenant Governor to provide more politically reliable methods of introducing medical knowledge into the colony.

Married to Ann Wood McGill, a Cornwall physician's daughter and widow of the Montreal merchant Andrew McGill through whom he had strong ties to the British elite of Lower Canada, especially to James McGill, Strachan played an instrumental role in developing McGill's medical faculty and the Royal Institution for the Advancement of Learning in Lower Canada. He is better known as a foremost member of Upper Canada's tory world and so-called "Family Compact." His interest in the establishment of King's College at Toronto, a university like McGill's along British lines, reflected a strategy to ensure that colonial medical graduates acquired and then exhibited the correct moral and intellectual attributes of a British gentleman, including a strong sense of loyalty, in addition to receiving proper training in his profession. In part, efforts by Strachan and his associates to direct the course of medical education in the Canadas were designed to meet the ideological threat of Yankee republicanism. Yet despite Strachan's towering presence and influence, the Medical Board of Upper Canada never acted as either his personal or the Family Compact's tool. Herein lay the roots of the conflict between many reform-minded members of the medical profession and the tory-dominated executive council to which Strachan belonged.

As defined by the legislation of 1818 and 1819, the Medical Board of Upper Canada usually consisted of five persons appointed by the Lieutenant Governor, with any three members constituting a quorum. During its early history, those who dominated the Board were Dr. Christopher Widmer, a highly respected former army surgeon, J. W. Macaulay, a higher court judge, and Grant Powell, a non-practising doctor and magistrate, assisted by an assortment of 52 other practitioners of di-
verse political and educational backgrounds. The presence of judicial representatives on the Board derived from its formal structure, which was both medical and legal in nature. Board members included tories as well as reformers. At their biannual and then quarterly meetings, usually held at York but sometimes in other district capitals, they examined candidates; and once “satisfied” with the candidate’s “loyalty, integrity, and good morals,” they recommended to the Lieutenant Governor that he issue the candidate a license.

The Board’s examination of the medical applicant included a loyalty and character check, as stipulated under the law. An example is the case of Abraham Pruyn, a graduate of the College of New York. Pruyn had had “an excellent examination,” but the Board knew “nothing” of him. Consequently, while Widmer recognized that the letter of the law was satisfied in the examination, he called upon the Lieutenant Governor “[t]o require some further proof of the ‘Loyalty Integrity & good morals’” of the candidate. Additional supporting letters traced Pruyn’s family background. One confirmed that his family had been Loyalists during the Revolutionary War and that he was “a young man of unblemished character, correct habits and... useful in his Profession and a good loyal subject.” Finally, Pruyn received his license.

While all successful candidates received such scrutiny, there exists only one case among the medical examinations conducted by the Board where the issue of political leanings played a dominant though not a decisive role. A British applicant and pro-republican, Edward J. Barker of Kingston, was formerly an acting assistant surgeon in the British forces during 1818 and 1819, and a graduate of the London College of Medicine, a non-accredited school attached to London University. Barker succeeded in convincing a local magistrate that his qualifications entitled him to an exemption from the Medical Board’s examination, and he was administered the obligatory loyalty oath. Barker was well-known to local doctors, who considered him unqualified. When notified of Barker’s licensing, Dr. James Sampson, a pro-tory Kingston physician, quickly contacted the Lieutenant Governor’s secretary in order to have the magistrate’s actions overturned. Sampson claimed that none of the local practitioners wanted Barker to join the field. In outlining his fervent objections, Sampson noted that Barker, editor of the local newspaper British Whig, was “a factious low radical.”

Nevertheless, if Barker had possessed proper qualifications, his political predilections would probably not have prevented a license being issued. Sampson succeeded in blocking Barker’s admission to the profession by reminding the civil secretary Colonel Rowan that the law limited the issuing of a license without the Board’s formal approval only to
military surgeons, graduates of British universities or holders of diplomas from the London Royal College of Surgeons. Barker had been only an assistant surgeon, and his alma mater had no such charter or privileges: it was self-constituted, "consisting of the lowest and most unqualified of our fraternity." In England, Sampson added, it was considered "discreditable" to have graduated from the London College of Medicine.24

There was no arbitrary refusal of Barker's application. The matter was referred to Attorney General Robert Jameson, who subsequently decided that under 8 George IV, chap. 3, s.2, Barker's diploma was ineligible; it did not come from a "university" as defined in the legislation.25 Barker's only recourse, if he wanted a medical license, was then to present himself for examination before the Medical Board; there is no record that he ever did so successfully. In the end, Barker's loyalty, character, and politics appear to have had little bearing on the outcome of this exceptional case in which a license had been inadvertently issued. Though no records remain, similar factors may well have contributed or led to rejections of other applicants whom the Board considered unsuitable.

The powers of the Medical Board appear to have been considerable. Between 1819 and 1829 it had rejected candidates on 42 occasions, some of whom appeared for examination more than once. In the period 1830 to 1837, the Board granted 100 licenses, having failed candidates 73 times, six of whom had appeared twice, and one person on three occasions. In total, 64 persons had been refused at least once. On three previous occasions, in the years 1819, 1820, and 1825, eight had been turned back in one year. In the early 1830s, however, the number of rejections in any one year ranged from a low of six in 1831 to a high of 19 in 1834. The reason most commonly cited was professional ignorance, and occasionally infirmity or incapacity. Persons who could not read Latin, for example, meaning that they presumably could not read a prescription, ancient texts, or medical theses, failed. The Board restricted a handful of applicants to practising one or two of physic, surgery, and midwifery, but not all three. Properly licensed individuals by statute were automatically licensed in all three categories. Overall, despite growing complaints from members of the profession and rejected applicants, there is no indication that the Board acted arbitrarily or irresponsibly.

THE POLITICS OF MEDICAL EDUCATION

In the late 1820s, some candidates rejected by the Board began to complain publicly against its excessive powers and exclusiveness. Other detractors—who were, however, successful candidates—objected to being forced to appear before the Board because they considered their
qualifications more than adequate and resented having to justify them. Still others believed that the legislation of 1827 was inadequate and improperly enforced, allowing incompetent practitioners—but those who held acceptable official credentials—into the field. In particular, recent immigrant doctors trained in the mother country resented the Board members’ control over them and questioned their professional qualifications to judge new graduates; the Board’s most active members had joined the profession in a bygone frontier era, as products of the Napoleonic period; they were also becoming elderly. Yet the issue of the Board’s powers went beyond the make-up and background of its members to encompass international rivalry among medical schools and associations.

The issue of medical education and regulation became a focus of Lieutenant Governor Colborne’s attention in 1832 when three recently arrived practitioners of Scottish background to Niagara, Drs. Muirhead, Telfer, and Porter, wrote critical letters to Attorney General Boulton and Dr. Widmer, President of the Medical Board. The trio had been “struck” by the lack of “liberal information” and “respectable attainments that characterize(d) members of a learned body... absolutely necessary to inspire the people with confidence in the healing art.” Their primary complaint was the general quality of practitioners, especially the “ignorant pretenders of science, who, besides practising Physic in open defiance of the law, bring an obloquy on the profession.” In their view, those doctors with “proper attainments” were few, “being thinly scattered about the country surrounded by empirics (licensed or not) who generally succeeded better than the former in obtaining practice, because they would adopt habit and cunning that respectable men could not think of.” They suggested organizing the profession into a body comparable to the self-regulating law society with the authority to admit, suspend, and remove doctors from practice.26

Attorney General Boulton reacted favorably though he advocated seeking the opinion of the profession throughout the province. But Widmer and the Medical Board, obviously sensitive to this indirect attack on their activities, defended existing legislation as satisfactory in providing legal protection to both the public and the profession. More laws, in Widmer’s opinion, were not the answer, though effective and impartial enforcement was. Moreover, at this stage in the development of the colony Widmer resisted the idea of incorporating the profession—a “dangerous tendency.” He instead preferred to depend on the power of executive authority to fulfil the will of the legislature in regulating the profession. As to how to deal with licensed practitioners who were “unworthy,” Widmer was convinced that, in Upper Canada as elsewhere, “the corrective influence of public opinion” addressed this problem. In
other words, the public soon learned by word of mouth who was incompetent. His own remedy for improving professional standards was to provide “suitable opportunities of medical education.”

This divided opinion reflects a lack of organization and cohesion within the Upper Canadian medical profession in the early 1830s. One might attribute these deficiencies to the colony’s social and economic state as a hinterland and cultural backwater. But this lack of consensus on how to address the problem of unqualified, or worse incompetent practitioners, was little different from the experiences of Great Britain or the United States. It reflected a broadly based ongoing debate about the state of the medical profession and what to do about it.

During the 1830s, the vast majority of immigrant doctors to the Canadas came from Great Britain. A handful were graduates of Oxford and Cambridge. The large majority of non-apprenticed practitioners had attended Scottish universities which produced roughly 90 percent of all medical graduates in the British empire. Some members of the British medical profession had begun to aspire to establish a national organization to improve medical knowledge and the status of its members. The profession had been rocked by body-snatching scandals. Also, in this period, private medical schools came under attack, and government enquired extensively into the state of medical education, signalling the demise of the apprenticeship tradition in favor of university and college training. Despite an interest in reforming medical knowledge and education, there was no single voice in this transitionary period. The British profession, according to Robert Gray, was plagued by “the incoherence of medical men as an interest group, their dependence on competing networks of ‘lay’ patronage and power and the involvement of more fully organized interests.” This was the climate of discussion and debate over medical knowledge, education, and jurisdiction inherited by British practitioners who now carried this baggage to the Canadas.

Early in 1834 some vocal Irish immigrant doctors fired further salvos at the Medical Board of Upper Canada. They had obviously entreated the Royal College of Surgeons in Ireland to intervene, for the Irish College publicly repudiated the Board’s pretended powers over foreign graduates and practitioners. The Colonial Secretary was drawn into the matter, and he sent a despatch to Lieutenant Governor John Colborne in which he confirmed many recent Irish graduates had embarked in recent years for North America to practise their profession. Facing diminishing opportunities and competition at home, yet armed with credentials accepted in many British quarters, these doctors objected to the critical gaze of the Medical Board of Upper Canada. The Irish College, through the Colonial Secretary, protested specifically though incor-
rectly that, under Upper Canadian law, those who possessed London or Scottish diplomas in medicine and surgery were exempted, but doctors graduating from the university in Dublin or members of the Irish College of Physicians and Surgeons had to submit to an examination. Claiming superiority of their program of medical education to any British counterpart, the College complained that the Medical Board’s powers were “not only derogatory to their character, and injurious to their interests” but that an “unfair and invidious distinction” had been made against Irish graduates. Imposing a need to curtail the powers of the Board, the College therefore had called upon the Colonial Secretary to confer equal status to Irish graduates within all British colonies. The issue of the Medical Board’s powers had thus now become a matter of jurisdiction, of imperial versus colonial law.

Lieutenant Governor Colborne responded by forwarding a copy of the Medical Act of 1827, under which the Medical Board was constituted. He also attached the observations of its President, Dr. Christopher Widmer. In a lengthy but revealing rebuttal, Widmer countered the Irish College’s assertion that the Board’s powers were arrogated, arbitrary and discriminatory. He reviewed the provincial statutes since 1818 which outlined the Board’s right to examine candidates and the Lieutenant Governor’s right to satisfy himself as to their loyalty, integrity, and good morals. He pointed out that the Board had been legally established by the Executive Government and approved by the Home government. Consequently, the College’s charges against the Board of “usurpation and exaction” had been levied without “that just circumstance comporting with their known dignity and professional urbanity.”

Further in his reply, Widmer noted that, under Upper Canadian law, graduates of the Royal College of Surgeons in Edinburgh were treated in much the same manner as Dublin’s licentiates. He also reminded the College that neither the professional body in Scotland nor in Ireland had the right to interfere “with the domestic affairs of the province.” Yet Widmer could only speculate as to why Upper Canadian legislators had distinguished in the statute among graduates from various countries. He thought this had been an attempt to reduce competition, not to create “invidious” distinctions as asserted by the Dublin College. Commonly, Upper Canadian students had been forced to go abroad to medical school, an inconvenient and expensive process, and so the policy of placing restrictions on some foreign graduates was a privilege designed to compensate them for their sacrifices. He also explained that it was necessary to examine candidates to prove their professional competency since some imposters had exhibited diplomas, affidavits, and false credentials, even swearing falsely their identity. Security against
imposters and confidence in licensed doctors was a matter of deep and vital public interest to Upper Canada. Somewhat caustically, Widmer concluded, "if they intend to intimate, that it is an indignity for any stranger entering to command the professional confidence of this community to satisfy a legally constituted tribunal of his competency, the Board are at a loss to know of what that indignity consists, either as it regards the candidate or the Dublin College of Surgeons."^^

Why was the Irish College upset by discrimination against its graduates? One probable source of tension was the unusual case of Irish physician and surgeon, Dr. James Egan, a graduate in 1826 of Trinity College, Dublin, who had come to Upper Canada. Egan had been robbed of his diploma which by law he had to supply to the Medical Board in order to qualify for a license. Trinity College's policy, however, was never to issue replacements, only certificates. In light of his misfortune, Egan applied to the Lieutenant Governor for special consideration, submitting proof of his credentials in the form of a certificate from his Regius Professor of Physic who confirmed his graduation. He also informed the governor that in Great Britain, Trinity College was accorded equal status with Oxford, Cambridge, and London, whereas the University of Edinburgh was not. Yet, in contrast to British legislation, Upper Canadian law discriminated against Trinity College graduates. The matter was referred to Attorney General Jameson, who decided in favor of the applicant. Then Lieutenant Governor Colborne agreed to issue the license, but only on the basis of the Attorney General's discretionary powers; he was, however, averse to setting a precedent by undermining existing colonial law.37

The question of jurisdiction over Irish graduates arose again in 1836 when Dr William Charles Gwynne, a graduate of Dublin and a licentiate of the Royal College of Surgeons in Ireland, complained that the Toronto General Hospital was the exclusive preserve of a few city physicians, and that this deprived him and others of an opportunity to develop their craft.38 Gwynne followed up this letter to complain that Irish doctors were not represented on the Medical Board of Upper Canada, though Irish universities were "equal, in respectability, if not superior to any." Moreover, a large proportion of Upper Canada's population was Irish in origin.39 Initially, the Board managed to stave off these attacks and defend its integrity and prerogatives. Significantly, however, Gwynne's reference to lack of hospital access represented another wedge. It related not only to the power of the Medical Board but also to the state of medical education in the colony.

Provisions for taking medical education out of the hands of the military and away from the apprenticeship system originated in the mid-1820s, when John Rolph40 and Charles Duncombe41 launched a short-
lived, philanthropic, private medical school, the Talbot Dispensary. These two doctors, who openly supported political reform, had planned for a projected enrollment of 12 medical students. In this same period, the executive government, the Anglican Church, and Archdeacon Strachan envisaged placing medical education within the confines of the elitist, Anglican-dominated, politically tory edifice of the proposed King's College, the colony's anticipated university to be funded by the government through land endowments.

The issue of how medical education should be offered and by whom was exacerbated in the face of the dismal and interrelated social and medical conditions found especially among destitute immigrants in the early 1830s. Political measures to meet this challenge included various institutional means, including temporary Boards of health and emigrant hospitals. Yet the executive also resisted handing over permanent regulatory powers to local Boards of health to contain epidemic and contagious diseases. The extent of government financial support and involvement for the Toronto General Hospital, a planned lunatic asylum, and various Medical Board and Toronto Board of Health activities during the cholera epidemics of 1832 and 1834 increasingly pitted ultra-tories against a wide and diverse array of medical practitioners, who sought social and institutional reforms through political intervention. The reform group included physicians such as Widmer, but also John Rolph, Charles Duncombe, and T. D. Morrison, all associated rightly or wrongly with the rebellion of 1837-38.

Not even the loyal Dr. Widmer, a veteran of the War of 1812 and a respected leader of the profession, could bridge these growing divisions within the profession and the ultra-tory tide. Importantly, Widmer had previously won the respect of Lieutenant Governor John Colborne, who was also a strong proponent of institutional reform as evidenced by his support of the Kingston Penitentiary and the York General Hospital. When Francis Bond Head succeeded Colborne in late 1835, however, Widmer fell out of favor. Though President of the Medical Board of Upper Canada, Widmer was entirely ignored when Bond Head and Strachan reached an agreement on the future nature of King's College and its faculty of medicine.

The growing rift was sizeable in the months preceding the outbreak of the rebellion. Writing on behalf of the Medical Board in August 1837, Widmer explained to the pricklish and hard-line anti-democrat Bond Head, that its members had passed a resolution requesting information from the government on the intentions of King's College to organize a Medical Department. Referring to the "anxiety" of the profession in waiting for "an effective plan of medical instruction," Widmer informed the Lieutenant Governor that his predecessor, Sir John Col-
borne, had been "strongly impressed with the imperious necessity of preventing so many of the youths of the province from resorting to a foreign country for the means of instruction, where their early political principles were exposed to an influence not likely to prove advantageous to themselves or their country." Moreover, the profession which Widmer claimed to represent felt that the plan for King's College should attract not only Canadian students but others from the North American provinces, and even those from the United States where "no university enjoying a desirable celebrity for medical education" existed north of Philadelphia.

In approaching Bond Head, Widmer pointed out diplomatically that he was merely asking for information "to correct, if necessary, any erroneous views that may be taken by those, whose official duty it is become, to make the arrangements for the Medical Department of King's College." But Bond Head decided to delay replying to Widmer's address, and a few months later Widmer and the Board were again brushed off by him. This time the governor decided to reply, but only indirectly and somewhat imperiously through his secretary and through a favorite, Dr. King. Bond Head let the Board know that, "if the Medical Board could make out a case sufficiently strong to convince him of the necessity of establishing at once a medical faculty in King's College," he would give it "his serious consideration."

The Medical Board then immediately forwarded a lengthy justification for being consulted on King's College. Appealing to "deep public interest" and its public duty, as "the guardianship of the medical profession and practice," Widmer called upon the Lieutenant Governor to consider appointing some of the Board's members as professors. Widmer explained what Bond Head already knew, that its membership included individuals of education, professional reputation, and "worthy testimonials of public gratitude," who had engaged with little remuneration in "minute scientific and practical examination of medical candidates" and who had "humanely and gratuitously attended" patients at the Toronto General Hospital. Widmer also described the Board's "degree of surprise" that they would have to justify their case of immediately establishing a medical faculty, "as if private interests alone dictated their interference," when this matter was of interest to the colony as a whole.

The source of friction between the two camps is readily evident. The Board's most fundamental disagreement with Bond Head, Strachan, and other advocates of King's College was rooted in the inclusion of moral and religious education (read Anglican) in the proposed medical curriculum at King's College. Its supporters called instead for a wholly secular and popular rather than an elitist education. Such a curriculum
would meet "the public interests of the community throughout the Province without exception of persons, place, condition of life, religion or politics." In defense of the Board's ideological position in promoting a more egalitarian approach to medical education and practice, Widmer argued:

The people of the Province, like mankind generally, are subject to all the variety of disease, accident and their consequences; all in their turn receive their share of pain and anguish, to assuage or remove which is the object of the physician's and surgeon's united science and skill, and thus it is that if there be any one object of human knowledge of more importance to society than another, it is that of the healing art.

Widmer believed that "morals, religion, literature and law" were already adequately provided for in the proposed undergraduate university curriculum at King's College, but medical education was not.

Further, Widmer informed Bond Head that Upper Canadian parents wanted their children to have the choice of being able to study within the province. Lack of educational facilities in the colony, he argued, often resulted in students being unnecessarily rejected upon examination by the Board, an "unjustice." He also contended that the availability of university education in the province would allow graduates later to spend more time in foreign universities and hospitals in advancing their knowledge.

Bond Head took Widmer's letter as a personal slight. He was offended at the apparent misinterpretation of his true intentions. Bond Head said that he had previously assured Widmer in conversation of his immediate support and the encouragement of medical science. He countered that it was "questionable" to open a medical faculty without the support of additional disciplinary branches within the university. And he retorted that if the Medical Board's revised report would concentrate on "scientific matter" and divest itself of "the uncalled-for observations," he would forward the Board's recommendations to the "immediate consideration" of King's College Council.

Not surprisingly caught aback, at the next meeting the Medical Board resolved to deny that it was their intention to imply "animadversions on His Excellency's intentions" and they hoped that public interest would thereby not suffer because of this misunderstanding.

The nature of the Board's appeal to Lieutenant Governor Bond Head and his reaction reflect the splits within Upper Canadian society in the mid-1830s. It is quite evident that the Medical Board was never consulted in the process which led the Lieutenant Governor to print plans for the organization of King's College. In particular Widmer, always one to speak his mind, also objected that medicine was listed in this proposal as the last of six departments, and that the chair was to be filled by
a professor of chemistry with several “out-door servants under the appellation of lecturers.” He protested and inquired, “how does it happen that thus in Upper Canada, Medical Science, of such universal interest that every individual of the community must experience its bane or blessing according to its barbarism or culture, should be so degraded, and the tenderest sympathies of human nature so outraged; a Professor of Chemistry forsooth!!! with out-door lectures in medicine, surgery and anatomy.” He blamed the adoption of this structure on that composition of the College Council, “of men altogether ignorant of medicine and its manifold scientific sub-divisions” and “ignorant of the work in their servants’ hands,” and he offered suggestions on how the medical school and King’s College might be better organized.

Bond Head’s attitude was symptomatic of the chasm which politically divided the colony. Initially welcomed as a conciliator and reformer by the colony’s reformers, he had quickly and bitterly disappointed those individuals who had been calling for social, economic, or political change to resolve very real problems. His conflict with the Medical Board was perceived as yet another example of the imperial government trodding on the legitimate wishes of Upper Canadians. One can assume that Bond Head’s self-avowed elitism and his paternalistic response to the Board accomplished little except to further alienate reformers of every persuasion.

Yet, with some notable exceptions, these ideological differences were insufficient to prompt the medical profession, as a group, to rebel two weeks later against legally constituted authority. Indeed, far more practitioners remained loyal and served as surgeons to the colonial militia than sided with the rebels. Nevertheless, at least twenty licensed practitioners can be identified as holding strong reform views and some doctors, like Rolph and Duncombe, became implicated in the rebel cause. While it is the case that, on the basis of surviving documents, doctors (excluding “quacks” and “empirics”) were proportionately overrepresented among the rebels, they still represented a small minority of the whole contingent.

Still, despite the tensions and divisions exacerbated by the rebellion, there remained a collective consensus among the profession that medical reform was incumbent. The convulsive events had barely ended when, on 25 September 1838, following the arrival of Bond Head’s successor, Sir George Arthur, the Medical Board was reconstituted. Its membership included an array of old reformers: Drs. Baldwin, Hornby, King, and Morrison. The latter had all been active political as well as medical reformers, though Baldwin, Hornby, and King had openly distanced themselves from the radicalism typified by William Lyon Mackenzie. Widmer and Deihl, who were also members of this board—cer-
tainly strong advocates of health reform—were politically moderate in orientation, perhaps even conservative.

In late 1838 the Medical Board led by Widmer attempted to take a major step towards improving colonial medical standards, regulation, and education. Suggesting that unlicensed empirics (or quacks) were more susceptible to immorality and political radicalism—a conclusion perhaps based on their unwillingness to submit to proper authority—the Board demanded new legislation to govern medical practice. They now considered the existing legislation of 1827 to be "very inadequate for the purpose for which it was enacted; particularly for the suppression of empiricism, so baneful to the health and morals of the community and injurious to the medical profession."

A government committee was struck to look into this matter. In reporting to the House of Assembly, it claimed "that of late years the number of persons practising without license or qualification has much increased, chiefly by the influx of empirics from the neighbouring States, causing great danger to the health of the community, and in some instances the loss of valuable lives; being alike detrimental to the peace and tranquility of the country, and degrading and humiliating to the honourable and useful profession of medicine."

Familiar comments about the state of medicine as a science and the lack of representation by medical practitioners on Council of King's College were also included in a petition which circulated following the committee's report.

To gain more control over medical licensing and practice, the Medical Board had finally decided to form its own College of Physicians and Surgeons of Upper Canada. This statute, supported by government and passed in 1839, permitted the College to regulate the entire colonial profession. Its incorporation was, however, formally disallowed on 29 December 1841 by a Queen-in-Council Proclamation in England. Ostensibly, this statute was rejected because nowhere in the Empire was any College handed such wide-reaching powers and such a wide-ranging monopoly to license medical practitioners, including the London College of Physicians and Surgeons, upon whose rights and privileges this legislation encroached. In its dying moments, the College reiterated the call for an "efficient" medical school which included an "ample" library and museum. Its demands were soon acted upon, though probably not in the way its members had envisaged.

**EPILOGUE**

In the year that the College of Physicians and Surgeons of Upper Canada was dismantled, Upper and Lower Canada joined into a legislative union. The concerns of the profession were, however, not forgotten. In
1842 the Montreal physician Archibald Hall praised the new Provincial Legislature of Canada because its members had addressed at length the topic of education, including medical education, giving it "that attention which its extreme importance demanded." The Assembly understood "that knowledge is power, and that for elevating and dignifying the character of a nation, all that is requisite is to cultivate the moral attributes and mental faculties of the rising generation, as the foundation of a moral and intellectual superstructure."\(^{56}\)

Despite this continuing appreciation of the importance of medical education to the social fabric, the medical profession remained markedly divided. The divisions which had surfaced in the 1830s persisted into the 1840s. In 1841 there still existed no formal contact between the profession and the creators of King's College, notably Bishop Strachan. In an apparent concession, however, Widmer was appointed in May 1842 as a member of the College Council. But old wounds did not heal, and this decade witnessed the emergence of several rival medical schools.

The disputes and lessons of the previous decade were reflected, for example, in the nature of the appointments to the Medical Faculty of King’s College. The faculty included Dr. Nicol, professor of materia medica, Dr. Gwynne, professor of anatomy and physiology, Dr. King, professor of medicine, and Dr. Sullivan, professor of surgery. The committee for establishing the medical school included Drs. Potter, Croft and Gwynne who were expected to consult with Drs. King, Beaumont, and Sullivan. Subsequently, Dr. George Herrick was granted a professorship in midwifery and diseases of women and children, Dr. Nicol taught materia medica, and Henry Sullivan was made professor of practical anatomy medica, and Henry Sullivan was made professor of practical anatomy and curator of the anatomical and pathological museum.

Their common background is particularly noteworthy. The English-born Nicol, a graduate of Cambridge, began his Upper Canadian practice in 1836 and served as a militia surgeon in the rebellion. The Irish-born Gwynne, a former ship's surgeon, who was hostile to the practice of heroic medicine (i.e., bloodletting) arrived in 1832 and later played a role as a surgeon to the Queen's Rangers. King, also Irish-born, was a graduate of Trinity College, Dublin, and the University of Edinburgh. Sullivan, whose tory brother was mayor of Toronto in 1835, had been a medical student in Dublin and London and had served as surgeon to the Royal Foresters during the rebellion. Another Irish-born practitioner was Herrick, who had studied at Trinity College, Dublin, and at Edinburgh; he arrived only in 1838. Clearly, this neo-loyalist group was distinguishable from the practitioners who had earlier dominated the
Boards of Health and the Medical Board of Upper Canada. It shared a demonstrated loyalty during the rebellion, a common Irish and English university background, medically related military appointments, and relatively recent arrival in Upper Canada. These men were therefore distinct by virtue of their political, educational, ethnic, and generational nature.

The populist, reform-minded doctors of the 1830s continued to remain out of political favor but were not without influence. Widmer’s former associate John Rolph, who returned from exile in 1843, established a separate medical school, initially known as the “Rolph School.” Like King’s College, it was also based on the McGill model. Incorporated eight years later as the Toronto School of Medicine, it eventually became Victoria College. Rolph’s lecturers included the McGill graduate, Joseph Workman, who had written his medical dissertation on the Montreal cholera epidemic of 1834 and who was licensed in Upper Canada in 1837. He was joined by T. D. Morrison, former Toronto mayor who had been unsuccessfully tried as a rebel. Workman, a Unitarian and liberal in orientation, had found little work as a practitioner in the mid-1830s upon graduation, and he had become a businessman, a local political and educational reformer, and the first President of the Toronto Board of Trade, before returning to medicine as a lecturer.57

While this split between this reform group and the King’s College faculty ensured that the Upper Canadian medical profession remained divided until after Confederation, some evidence suggests that there was also a middle ground. In 1844 Widmer, King, Grasett, Telfer, Burnside and several others were together instrumental in establishing the Toronto Medico-Chirurgical Society and library at Toronto, for “the dissemination and improvement of the various branches of Medicine and the collateral Sciences.” Its activities included the presentation of medical papers before this society of licensed practitioners.58 More typically, an intense and sometimes acrimonious rivalry between King’s College and the Toronto School of Medicine continued.

The Rolph faction finally exacted its own revenge when, in the late 1840s, Workman was appointed government’s commissioner to enquire into the affairs of King’s College. He subsequently filed a devastating report revealing gross mismanagement at King’s College, leading to the demise of Strachan’s dream.59 In 1853 the reform premier Francis Hinck sponsored a University Bill to abolish the Faculties of Law and Medicine at King’s College; he based his decision, in part, on Workman’s report. The University of Toronto, a loose affiliation of several colleges, now replaced King’s College. Workman’s reward was to be appointed medical superintendent of the Toronto Lunatic Asylum, while a candidate recommended by Bishop Strachan was turned down.
The matter of closing King’s College’s medical department was thus naturally shaped by factors such as personality and politics. But this rift was also fundamentally ideological in nature. Marian Patterson has pointed out that the issue for ex-rebel John Rolph, who had become a minister in Hincks’ government in 1853, was state funding for medical education. The liberal Rolph firmly believed that monies should be distributed to a variety of institutions, not to a single “mammoth college,” let alone one which was self-serving and elitist. He saw such an institution as devouring funds, centralizing authority, undermining competition, and risking the creation of despotic power. Moreover, Rolph claimed that many individuals questioned whether state institutions should train students “for the lucrative professions, law and medicine, at the public expense.” He clearly believed that such professional training should be the preserve of private enterprise and self-supporting institutions, much like his own school.60 In effect, the emerging liberalism of the mid-nineteenth century, together with the ethos of private enterprise, equality of opportunity, competition, individual merit, and freedom of choice shared by Rolph and his followers made it impossible in this historical context to justify the creation of a single, monopolizing medical regulatory body or school.

In conclusion, this phase of the history of medicine in Ontario centred on an unresolved struggle for power and monopoly over the nature and dissemination of medical knowledge. But also, the profession lacked the constitutional and legal powers to become a unified, self-regulating medical body. In light of these obstacles, it should surprise no one that the medical profession in Upper Canada remained sharply divided.

NOTES

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There are only scattered references to quackery in Upper Canada, with the important exceptions of Jennifer J. Connor and J. T. H. Connor, ‘Thomsonian Medical Literature and Reformist Discourse in Upper Canada,’ Canadian Literature, 131 (Winter 1991):

10 “An Act to amend the Laws regulating the Practice of Physic, Surgery, and Midwifery in this Province,” Upper Canada, Statutes, 1827, 8 Geo. IV, c. 3, s.1-2.


13 J. B. Robinson to Major Hillier, 5 December 1827, Civil Secretary’s Correspondence, NAC, R G5 B28, Vol. 61, p. 128.

14 For example, the candidate Iabez P. Powers was “well known” to his memorialists “as a young gentleman of a good moral character, and would consider him a very fit person to practise physics in this province” (Upper Canada, NAC, R G5, B9, Vol. 62, p. 318).


19 Civil Secretary’s Correspondence, 5 April 1831, NAC, R G5 B9, Vol. 62, p. 338-39.

20 Arent Van Dyck and Thomas Dorland, J. P. to Z. Mudge, Fredericksburgh, 9 May 1831, Civil Secretary’s Correspondence, NAC, R G5, B9, Vol. 62, p. 340.

21 H. Larkin to Z. Mudge, Bath, 14 May 1831, Civil Secretary’s Correspondence, NAC, R G5, B9, Vol. 62, p. 346.

22 Edward J. Barker, M.D. to Lt.-Col. Rowan, Kingston, 7 August 1834, Civil Secretary’s Correspondence, NAC, R G5 B9, Vol. 62, p. 619.


25 Robert Jameson to Lt.-Col. Rowan, 18 September 1834, Civil Secretary’s Correspondence, NAC, R G5 B9, Vol. 62, p. 628.

26 Minutes of the Medical Board, 22 October 1832, p. 114-16, Thomas Fisher Rare Book Library (TFRBL), University of Toronto.

27 Reply of the Medical Board to Drs. Muirhead, Telfer, and Porter’s communication to the Attorney General through Dr. Widmer, 10 November 1832, Minutes of the Medical Board, TFRBL, p. 119-22.


29 Little, History of the British Medical Association, p. 6.


33 Royal College of Surgeons in Ireland to John Littleton, 27 January 1834, Original Correspondence, 42/424, NAC, Colonial Office (C.O.), p. 181; and John Littleton to Secretary of State for the Colonies, 3 February 1834, C.O. 42/424, p. 183.

34 Colbome to Stanley, 7 May 1834, NAC, C.O. 42/419, p. 33.
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35 Widmer to Colborne, 4 May 1834, NAC, C.O. 42/419, p. 33-41.
37 Robert Jameson to Col. Rowan, Civil Secretary’s Correspondence, 2 July 1835, NAC, RG 59, Vol. 63, p. 659-60.
38 William Gwynne to Sir Francis Bond Head, 29 January 1836, Civil Secretary’s Correspondence, NAC, RG 5, A1, Vol. 163, p. 88183-85.
48 Civil Secretary’s Correspondence, vol. 177, NAC, RG 5, A1, p. 97767-69.
49 Widmer to Joseph, 7 October, 1837, Minutes of the Medical Board, 12 November 1837, TFRBL. Also cited in Canniff, Medical Profession, p. 95.
50 Widmer to Head, Civil Secretary’s Correspondence, NAC, RG 5, A1, Vol. 179, p. 98715-25; also RG 5 A1, Vol. 218, p. 120034-50.
52 Minutes of the Medical Board, 24 November 1837, TFRBL.
53 Canniff, Medical Profession, p. 106-108.
54 Canniff, Medical Profession, p. 106-108.
55 The colonial legislation was "An Act to Incorporate certain persons under the style and title of the College of Physicians and Surgeons of Upper Canada," 1839, 2 Vic., c. 38. The proclamation disallowing this statute, following consultation with the legal officers of the Colonial Office was published in the Upper Canada Gazette, 7 January 1841. The rights and privileges of the London College of Physicians and Surgeons under Great Britain, Statutes, 18 Geo. 3, c. 15 were reaffirmed. Discussions by the College regarding this matter are chronicled in Canniff, The Medical Profession of Upper Canada, p. 150-66.
56 Archibald Hall, "Medical Education: Letter I," *Letters on Medical Education* (Originally Published In The Montreal Gazette,) Addressed to the Members of the Provincial Legislature of Canada (Montreal and Kingston: n. p., 1842), p. 3.


58 See *Laws of the Toronto Medico-Chirurgical Society Together with a Catalogue of Books in its Library* (Toronto: 1845), Baldwin Room (BR), Metropolitan Toronto Regional Library.
