Vaccination and the Law in Ontario and Nova Scotia (1800 – 1924)

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Juridical Science

Faculty of Law

University of Toronto

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Abstract

Since the discovery of smallpox vaccination in the late eighteenth century, Western societies have often confronted the question of whether the state can justifiably impose the procedure on its citizens in the interest of safeguarding general public health. This question is at the heart of ongoing controversies regarding whether to require mandatory vaccination to check a resurgence of childhood diseases such as measles. While there are social and medical histories of the application of vaccination to the problem of infectious diseases in Canada, much remains unknown about the legal history of the procedure, including, specifically, the nature and scope of legal mechanisms used to enforce vaccinations and the factors — legal, social or otherwise — that account for the effectiveness, success or failure of these mechanisms.

This dissertation addresses this gap through the lens of the legal history of smallpox vaccination in Ontario and Nova Scotia in the nineteenth and early twentieth century. It provides an original, comprehensive account of vaccination law and policy in nineteenth century Canada, encompassing the factors and ideologies that triggered and shaped the legal regulation of
smallpox vaccination, the processes, design, content and outcomes of legal regulation, challenges associated with the implementation and enforcement of vaccination laws, and the influence or impact of broader social and political arrangements and norms. It also provides a firsthand account of why and to what extent mandatory approaches to vaccination were utilized in preventing the introduction and spread of smallpox, how such approaches were fashioned, and the reasons why they succeeded or failed to achieve stated regulatory aims.

The study shows that approaches to vaccination varied between Ontario and Nova Scotia, and that the effectiveness of vaccination policies depended on the design of legal measures utilized, strong and responsive (local) government, holistic approaches that eschew a singular focus on vaccination over other methods of fighting infectious diseases, the absence of ideological contests over the legitimacy of mandatory vaccination, availability of financial resources to support the administration of vaccination, heightened and sustained threats of infectious diseases, and a population that is generally supportive of public health interventions.
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CHAPTER ONE – INTRODUCTION

If we are to believe that the ruling of the ‘vaccine court’ in these cases mean that all vaccines are safe, then we must also consider the rulings of that same court [that] vaccines were the cause of autism and therefore assume that all vaccines are unsafe. Clearly both are irresponsible assumptions, and neither option is prudent – Jim Carrey, Actor.

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1.1 Background and Aims

In the fall of 2013, a measles outbreak occurred in British Columbia’s Fraser Valley.¹ In a matter of days, over three hundred individuals contracted the disease.² The outbreak was considered a very serious public health event, as measles is a highly contagious viral infection that spreads easily through the air. Infected persons typically develop a host of medical complications, including high fevers, respiratory problems, infections, and a red blotchy rash that begins on the face and spreads to cover the entire body.³ While most


² See ibid; Allan Maki & Adriana Barton, “A dying disease makes rousing comeback; Doctor points to cultural dynamics that fuel anti-vaccination beliefs in small centres”, Globe and Mail (26 March 2014) A5.

measles victims generally recover, some cases result in brain infection and permanent brain damage.⁴ The disease affects all age groups, but is a leading cause of death among young children worldwide.⁵ Among diseases endemic to North America, it is one of the most feared.

Similar outbreaks soon followed. In October 2013, it was reported that eighteen middle school students in Lethbridge, Alberta, had contracted the disease, most likely through a student who picked up the infection while vacationing in the Netherlands.⁶ Outbreaks affecting a significant number of persons were also reported in various locations in the neighbouring United States.⁷ Between January and March 2014, several cases were reported in Saskatchewan, Manitoba and Ontario,⁸ and in April, the disease struck again

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⁴ See ibid.
⁵ See ibid.
in Edmonton and Calgary. The latest outbreaks affected a number of infants, who are most vulnerable to the disease because they are not eligible for immunization or vaccination against the disease before twelve months of age.

Measles is a vaccine-preventable disease. This means that the disease would not exist if every individual in a community receives the measles vaccine, a medicinal preparation containing a live, attenuated form of the virus that causes the disease, and which confers immunity from the disease on the vaccinated person. Even if measles is imported into a fully vaccinated community, further spread is not possible because vaccinated persons are fully protected from the disease. Due to vaccines, measles and other vaccine-preventable
diseases, such as mumps,\textsuperscript{14} rubella,\textsuperscript{15} varicella (chicken pox),\textsuperscript{16} and smallpox\textsuperscript{17} have been eradicated or lowered in incidence worldwide.\textsuperscript{18} There have been no indigenous cases of measles in Canada since 1997, and prior to the recent outbreaks, imported outbreaks occurred in 2002 and 2011.\textsuperscript{19} Smallpox, the disease that triggered the invention of the first vaccine,\textsuperscript{20} and the subject of this study, was eradicated in 1977 following a worldwide vaccination campaign.\textsuperscript{21}

In Canada, the measles vaccine is available, at no cost, to infants as early as 12 months of age.\textsuperscript{22} It is offered as part of a combination prophylactic therapy that includes the mumps and rubella vaccines. To ensure full protection from measles and to address the possibility of vaccine failure,\textsuperscript{23} repeated doses are required at eighteen months\textsuperscript{24} or between the ages of four and six.\textsuperscript{25} Two doses of the vaccine are ninety-eight percent

\begin{footnotesize}
\textsuperscript{14} Mumps is an acute infectious disease caused by the mumps virus. See “Mumps”, online: Public Health Agency of Canada <http://www.phac-aspc.gc.ca/im/vpd-mev/mumps-eng.php>.
\textsuperscript{15} Also known as German measles. See “Rubella”, online: Public Health Agency of Canada <http://www.phac-aspc.gc.ca/im/vpd-mev/rubella-eng.php>.
\textsuperscript{17} See Part 1.6, below, for more on this topic; “Smallpox”, online: Public Health Agency of Canada <http://www.phac-aspc.gc.ca/publicat/cig-gci/p04-spox-vari-eng.php>.
\textsuperscript{18} See supra note 3.
\textsuperscript{19} See ibid.
\textsuperscript{20} See Part 1.7, below, for more on this topic.
\textsuperscript{21} See supra note 17.
\textsuperscript{22} See supra note 11.
\textsuperscript{25} In British Columbia, Alberta, Manitoba, Nova Scotia and Yukon. See ibid.
\end{footnotesize}
effective in preventing measles, while one dose confers ninety-five percent immunity. The vaccine is also freely available to adolescents and adults. Given the availability of the measles vaccine, and its near complete prophylactic effects, one can safely assume that the recent outbreaks in Canada resulted from failure to obtain vaccination for the disease.

In the wake of the latest outbreaks, public health officials and pundits have blamed the resurgence of measles on declining vaccination rates resulting from the neglect or refusal of vaccination, particularly by “anti-vaccinationist” parents who refuse to vaccinate their children. Refusals of vaccination have been linked to two main reasons. The first is religious or conscientious objections to the procedure. As noted by the Public Health


Agency of Canada, “[t]he largest outbreaks [in Canada] have occurred in isolated groups that are philosophically opposed to immunization.” The second reason is fear regarding the safety or efficacy of the measles, mumps and rubella (MMR) combination vaccine. This fear derives mainly from a discredited and retracted study led by a British physician named Andrew Wakefield, which associated the MMR vaccine with inflammatory bowel disease and autism spectrum disorder. Despite the retraction of the study and overwhelming scientific evidence disproving a causal link between the MMR vaccine and both illnesses, Wakefield’s claims have fueled an unfortunate but effective public misinformation campaign mostly led by alternative medicine practitioners.


33 See Paul A Offit, Autism’s False Prophets: Bad Science, Risky Medicine, and the Search for a Cure (New York: Columbia University Press, 2010); “MMR scare legacy: measles at 18-year high”, The Telegraph (8 February 2013) online: The Telegraph
Vaccination refusals have also prompted questions about whether individuals should be allowed to refuse essential public health interventions based on personal beliefs, especially when such beliefs create or pose considerable risk to societal health or wellbeing. Other recent high profile vaccination controversies highlight this tension
between personal beliefs and public health, as well as ongoing disputes regarding the
evidentiary basis for required or recommended vaccines. In August 2012, for example,
health authorities in British Columbia announced a policy requiring health care workers
in publicly funded health care facilities to obtain the influenza vaccine or wear a mask
during flu season. The policy, which was primarily intended to increase historically low
rates of vaccination among health care workers, was vehemently opposed by some,
including health care workers’ unions, who viewed it as a serious and illegitimate
violation of human rights. Critics further contended that there was a lack of scientific
evidence to support mandatory vaccination of health care workers, and that the
effectiveness rate of the current flu vaccine was not high enough to justify such a policy.

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40 See Branswell, *ibid*; Ikura, Doig & Laupacis, *ibid*. 
Legal challenges and protests against the policy ensued, and the provincial health authorities eventually capitulated by opting to focus on education rather than enforcement of the controversial policy.\textsuperscript{41}

In another example, it was reported that parents would opt not to vaccinate their teenage daughters against the human papillomavirus—a sexually transmitted infection that is the primary cause of cervical cancer—due to the belief that vaccine promotes promiscuity by removing a deterrent to sexual relations.\textsuperscript{42}


These controversies, and the resurgence of vaccine-preventable diseases, have made vaccination one of the most socially divisive health policy issues in Canada today. A primary point of controversy and debate is the question of whether governments in a liberal democratic state, such as Canada, should require mandatory vaccination to safeguard public health without violating constitutionally guaranteed human rights and freedoms.43

Presently, there are no mandatory vaccination laws in Canada. Two provinces — Ontario, and New Brunswick — require children enrolling in school for the first time to provide proof of vaccination for measles and other childhood infectious diseases, or be excluded

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from attending school. However, parents can claim an exemption from the requirements on medical or religious grounds, or simply based on conscientious beliefs. While exemptions claimed are historically low as a proportion of vaccination rates (typically between two and five percent), a significant number of children remain unvaccinated due to parental objections based on non-medical reasons. Provincial health authorities,

44 See Immunization of School Pupils Act, RSO 1990, c I.1, ss 1-3, 6-8, 11, 17; New Brunswick, Department of Education and Early Childhood Development, Policy 706 – Proof of Immunization, online: Government of New Brunswick <http://www.gnb.ca/0000/pol/e/706a.pdf>; Erin Walkinshaw, “Mandatory Vaccinations: The Canadian Picture” (2011) 183:16 Canadian Medical Association Journal E1165. Parents in British Columbia recently urged the government of that province to consider a similar measure to prevent further spread or recurrence of measles in the province. Lazaruk, ibid. Under the common law, the doctrine of “best interests of the child” may be applied to justify vaccination of minors, if permitted by legislation. Di Serio v Di Serio (2002), 27 RFL (5th) 38, 2002 CanLII 49568 (Ont SC) [Di Serio]. However, the state cannot impose vaccination on a child against the parents’ religious objections unless such forced intervention is supported by medical evidence showing that the parental objections are harmful. B (CR) v Newfoundland (Director of Child Welfare) (1995), 137 Nfld & PEIR 1, 428 APR 1 (NL SC (TD)).


47 Approximately 23,000 to 24,500 students in Ontario, and over 90000 kindergartners in the U.S. CDC, ibid. Vaccination rates are also disproportionately lower in some schools. See Chai & Cain, supra note 45. In one “alternative” school in Toronto, vaccination rates for childhood vaccines, including the MMR vaccine, is a mere 45% compared with the provincial average of 95%. See ibid.
acting pursuant to provincial public health statutes, can also exclude students who are unvaccinated or have been exposed to measles from attending school during a disease outbreak. Both approaches operate as forms of isolation or quarantine, and do not impose a requirement to be vaccinated.

Another strategy used to promote vaccination is education. While most educational initiatives are government-run, some jurisdictions mandate parents who register non-medical exemptions to vaccination to attend and complete an educational session or to speak with a healthcare provider. However, a recent research study that assessed outcomes of educational initiatives aimed at promoting vaccines found that parents who object to vaccines are less likely to change their minds after receiving educational information, and that their opposition to vaccines might even become more entrenched. The study also found that educational strategies typically employed by public health

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48 See e.g. Public Health Act, RSA 2000, c P-37, s 29; Health Protection and Promotion Act, RSO 1990, c H.7, ss 22 & 77.1; Health Protection Act, SNS 2004, c 4, s 32.
agencies, including “information about disease risks, a dramatic narrative and images of sick children” are largely ineffective, and hardly change behaviour or beliefs.

To address the shortcomings of existing approaches, proponents of vaccination have called for laws requiring mandatory vaccination and disallowing exemptions for non-medical reasons. This approach, they argue, is consistent with social contract theory, and with liberal democratic norms grounded in shared responsibility and suppression of individual choice for the sake of public welfare. They also contend that the approach would guarantee optimal vaccine coverage and parental compliance. These arguments, and the underlying approach, are not new. Mandatory vaccination, sans exemptions, was the legal norm in most of the Western world throughout the nineteenth and early twentieth century. But was it effective, and what factors accounted for its successes or failures?

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52 Nyhan, ibid.
53 Ibid.
This dissertation seeks to address the latter question, and mandatory vaccination laws in general, through the lens of the legal history of smallpox vaccination in Ontario (formerly Upper Canada up until 1841 and Canada West 1841 to 1867) and Nova Scotia in the nineteenth and early twentieth century. The overarching aim of the dissertation is to answer this question by exploring the role of law and legal institutions within the context of the earliest application and implementation of vaccination in Canada.\textsuperscript{56}

\subsection*{1.2 Why Smallpox Vaccination?}

As previously stated, smallpox was the first disease for which a vaccine was developed.\textsuperscript{57} Although vaccines were developed for other infectious diseases in the nineteenth century,\textsuperscript{58} none was as widely promoted or administered as the smallpox vaccine.

Smallpox vaccination was also the only legally required form of vaccination in many jurisdictions during the period under study, and as this dissertation will show, the procedure generated significantly more social and legal controversy compared with other forms of vaccination (and other methods of preventing and managing infectious diseases).

\textsuperscript{56} While this project relies on contemporary events to formulate and set out the research question and aims, there is no discussion beyond this introduction of contemporary aspects of vaccination or other matters covered in the study. The project is entirely historical, and the findings and conclusions are meant to be understood and interpreted within the context of the historical period covered. While the study may yield some insights that are relevant or applicable to contemporary matters, no attempts will be made to offer direct lessons for or solutions to contemporary issues and problems.

\textsuperscript{57} See supra note 20 and accompanying text. See also Part 1.7, below, for more on the topic.

Furthermore, the use of law to implement smallpox vaccination constituted a novel form of state intervention in public health. Unlike other measures aimed at preventing and controlling the spread of infectious and contagious diseases, such as quarantine and sanitation, smallpox vaccination laws were uniquely characterized by state-imposed application of a biomedical product against a public health problem and the subjection of healthy individuals to a medical procedure for the sake of protecting public or collective welfare. This unique aspect occurred against a backdrop of widespread social resistance to the procedure, scientific uncertainty surrounding the vaccine, and polarizing public disputes about the safety and efficacy of the smallpox vaccine.

59 See Anthony S Wohl, *Endangered Lives: Public Health in Victorian Britain* (London: J.M. Dent & Sons Ltd., 1983) 132 (compulsory vaccination laws “brought the state into public health in the most direct and…most dictatorial fashion” at 132); Nadja Durbach, *Bodily Matters: The Anti-Vaccination Movement in England, 1853-1907* (Durham, NC: Duke University Press, 2005) (“vaccination, a technology of orthodox medicine, was the first medical intervention to be enforced by British law” and vaccination laws were “crucial to the development of the field of state medicine, and…to the rise of medical authority” at 30); Dorothy Porter & Roy Porter, “The Politics of Prevention: Anti-Vaccinationism and Public Health in Nineteenth-Century England” (1988) 32:3 Medical History 231 (“The coming of compulsory health legislation in mid-nineteenth-century England was a political innovation that extended the powers of the state effectively for the first time over areas of traditional civil liberties in the name of public health. This development appears most strikingly in two fields of legislation. One instituted compulsory vaccination against smallpox” at 231).

Although legal rules pertaining to vaccination are referenced in the historiography of smallpox vaccination in Canada, there are no comprehensive accounts of the role of law and institutions of law in the adoption and implementation of vaccination, or of approaches to and outcomes of legal regulation of vaccination. This gap leaves unexplored the critical factor that triggered social resistance to vaccination, as well as the contentious public and political debates that preceded and attended legal developments relating to vaccination, including mandatory vaccination laws. There are also no accounts that place vaccination law and policy within the context of general (other) measures aimed at preventing and managing infectious diseases during this period, and more broadly, within the context of legal developments relating to public health.

This dissertation aims to fill these gaps, and in particular, to investigate the adoption and implementation of smallpox vaccination laws in early Canadian society. The study also seeks to establish the role and contribution of vaccination laws to the development of public health law in Canada, and to illuminate and further our understanding of how early Canadian governments dealt with issues and controversies at the intersection of law, medicine, scientific innovation, and public health. The project serves more broadly as a legal history of an early medical and public health intervention in Canada.

1.3 Why Ontario and Nova Scotia?

Every research study must have and embrace certain limits. Thus, an exhaustive review of the Canadian historical landscape is simply beyond the scope of this work. However,
there are other specific reasons for focusing on Ontario and Nova Scotia. As two of Canada’s founding socio-political units, both (along with Lower Canada62) had well-established legal systems by the time other provinces joined confederation, including laws dealing with vaccination and many other aspects of public health. As a result, public health and infectious disease legislation in the post-confederation provinces appear to have been modeled on or influenced by earlier legal developments in the founding provinces. For example, Manitoba, on joining Canada, enacted a vaccination statute similar in every respect to extant statutes in Nova Scotia and the Province of Canada.63 Likewise, Alberta’s first public health statute arrived “fully-formed”, and without the social and political influences and debates that characterized corresponding legal developments in the founding provinces.64

Another reason is that both jurisdictions, as the chapters that follow will show, present two contrasting approaches of the matters explored in this study. In Ontario, the legal regulation or management of vaccination, infectious diseases and public health was slow and beset with systemic challenges. It was also characterized by disputes and tensions between proponents of vaccination, mainly medical doctors, and opponents, including local government officials, alternative health practitioners, and antivaccinationists, regarding the scope, legitimacy and purposes of legal intervention. By contrast, Nova Scotia was more responsive to public health matters, and the implementation of

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62 Present day Quebec. I have excluded Lower Canada from the analysis because archival sources are mostly recorded in French, a language I am not fluent in.
63 See An Act Respecting Inoculation and Vaccination, SM 1877 (40 Vict) c 24. A public health legislation was also enacted in the same year. See An Act Respecting the Preservation of the Public Health, SM 1877 (40 Vict) c 1). The latter statute dealt mainly with infectious diseases.
64 See An Act Respecting Public Health, SA 1907, c 12.
vaccination and allied public health measures was less chaotic and less controversy-laden. The Nova Scotia experience, as we shall see, is attributable, broadly speaking, to geographical, social and political factors that made legal regulation both necessary and socially acceptable. The principal issues in the Nova Scotia context were operational in nature, chiefly the question of the responsibility for paying for expenses incurred in implementing vaccination and other public health measures.

1.4 Contribution and Thesis

This study makes two main contributions to the academic literature. First, it provides an original, comprehensive account of vaccination law and policy in nineteenth century Canada. This account encompasses factors — social, political, economic, medical or otherwise — that triggered and shaped the legal regulation of smallpox vaccination, the processes, design, content and outcomes of legal regulation, and issues and challenges to implementation and enforcement of vaccination laws. In particular, the study provides a firsthand account of why and to what extent mandatory approaches to vaccination were utilized in preventing the introduction and spread of smallpox, how such approaches were fashioned, and the reasons why they succeeded or failed to achieve stated regulatory aims. Given that law does not operate in a vacuum, the study will seek to situate vaccination law and policy within the context of broader legal developments relating to public health and infectious diseases, and broader and relevant aspects of nineteenth century legal, social, political and medical culture. The latter contribution seeks to illuminate and amplify our understanding of the role and significance of vaccination law and policy within the context of Canadian public health law.
Second, the study builds on and adds to the historiography of nineteenth century Anglo North American legal culture by highlighting, in less directed terms, how certain associated elements or doctrines shaped or influenced vaccination and public health law in early Canadian society. Specifically, the study highlights and discusses how two such elements or doctrines, namely “localized law” or “low law” and salus populi suprema lex esto (“the welfare of the people is the highest law”), helped to shape reflection, debate and action in relation to vaccination laws and other public health strategies used in managing infectious diseases. The discussion aims, in particular, to relate and explore the relevance of both concepts to historical debates and controversies regarding the philosophical basis for state intervention in vaccination and public health matters and the locus of authority to regulate these matters within the state.

Localized law, or ‘low law’\(^\text{65}\), refers to the mostly informal and loosely structured “body of ideas, customs and practices” that provided the basis for the maintenance of public peace and order and the administration of justice in nineteenth century Britain and its

colonies. Both terms denote a body of law issued and/or administered by local officials, as well as the diverse means through which formal legal rules and social order were maintained and implemented at the grassroots level. In the broadest sense, localized law consists of “ideas, customs and practices that guide the determination of justice” as well as “institutional mechanisms, formal and informal…through which decisions were made about legal cases and public issues.” Compared with ‘high’ or state law (statutes and decisions of high courts), localized law was practiced and administered by local level officials with no formal legal training, including justices of the peace and local boards of health. As Douglas Hay has observed, “the vast amount of the law imposed and suffered, used and resisted [in eighteenth to nineteenth century Britain and its empire], was low law, in the hands of laymen…often hardly touched by high law, although the courts of high law could not have operated in its absence.”

As we shall see in the chapters that follow, these local officials were instrumental to the implementation and enforcement of vaccination and other public health statutes during the period covered in this study. However, generally speaking, the role of localized law and its practitioners in the context of infectious diseases and public health is not

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67 Edwards, ibid at 3.
68 For more on the distinctions between “high” and “low” law, see Stokes, supra note 64 at 1-2; Hay, supra note 65 at 60-61; Douglas Hay & Paul Craven, “Introduction” in Douglas Hay & Paul Craven, eds, Masters, Servants, and Magistrates in Britain and the Empire, 1562-1955 (Chapel Hill: University of North Carolina Press, 2004) 1; Donald Fyson, Magistrates, Police and People: Everyday Criminal Justice in Quebec and Lower Canada (Toronto: University of Toronto Press, 2006).
69 Hay, supra note 65 at 60.
70 See David Lemmings, “Introduction” in Lemmings, ed, supra note 65 at 1 (“magistrates were certainly instruments of a statutory legal regime, rather than the common law world of judges and high courts” at 16); Hay, supra note 65.
addressed in relevant historiographies. While not the main focus of this work, the study will highlight the role and influence of localized law in the introduction and implementation of vaccination and other infectious disease laws and policies during the period of this study.

The meaning and relevance of the salus populi suprema lex esto doctrine in Canadian legal history (and in particular, the history of public health law) has also received no attention from legal historians or public health scholars. By contrast, its place within nineteenth century British and American public health law and the general legal culture is better established. The leading account on the American context is by William J

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71 Or at all. See Stokes, supra note 65 (law is an “aspect of socio-legal experience that has tended to escape the scrutiny of legal historians, whose tendency to see only the ‘high’ forms of legal ritual and culture when describing and explaining legal norms or expressions has skewed our understanding of what is and was ‘law’ in a particular time and place” at 538).

72 The phrase was first attributed to Cicero. See Marcus Tullius Cicero, The Treatises of M.T. Cicero: On the Nature of the Gods; On Divination; On Fate; On the Republic; On the Laws; and On Standing for the Consulship, translated by CD Yonge (London: Henry G Bohn, 1853) 464 (“Let two magistrates be invested with sovereign authority; from their presiding, judging, and counselling, let them be called praetors, judges, or consuls. Let them have supreme authority over the army, and let them be subject to none; for the safety of the people is the supreme law; and no one should succeed to this magistracy till it has been held ten years — regulating the duration by an annual law” at ibid [emphasis added]). It was quoted by John Locke in the epigraph to his second treatise on government. See John Locke, Two Treatises of Government, ed by Thomas Hollis (London: A. Millar et al, 1689).

Novak.\textsuperscript{74} According to Novak, governments and civil society in nineteenth century America were committed to the ideal of a ‘well-regulated society,’ one in which private interest was subordinate to public welfare, and in which law, together with public spirit, local self-governance, and civil liberty, served as vehicles for achieving and implementing a prevalent vision of \textit{salus populi}, or the people’s welfare. The main features of this vision of society include its shared heritage with transatlantic, colonial and/or imperial customs and traditions, its distinctive legal and political order based on positive governance, communitarian ideology and pervasive legal regulation and enforcement, and its “powerfully anti-individualistic sentiments about social duties, public obligations, and restraints on private rights and interests.”\textsuperscript{75}

Furthermore, \textit{salus populi} was not an abstract ideal, but rather, a tradition manifested and embedded in statutory rules, judicial doctrine and the “practices of local institutions.”\textsuperscript{76} Novak and others have shown that public health law was one of the main areas where the tradition prevailed, and mainly through legal rules that emphasized the primacy of the public’s health and welfare over matters of individual welfare or freedoms.\textsuperscript{77} This study will explore the extent to which the \textit{salus populi} ideal, if it all existed in the Canadian context, prevailed, shaped or influenced vaccination and public health law and policy. It will also examine and highlight the influence of the concept on the implementation and enforcement of vaccination laws and on social attitudes to government intervention in public health in the period covered by this study.

\textsuperscript{74} Novak, \textit{People’s Welfare}, \textit{ibid}.
\textsuperscript{75} \textit{Ibid} at 6.
\textsuperscript{76} \textit{Ibid} at 10.
\textsuperscript{77} See Novak, \textit{People’s Welfare}, \textit{supra} note 73 at 192-233.
Considered together, the localized law and \textit{salus populi} concepts suggest the hypothesis that Anglo North American legal norms and culture in the nineteenth century were profoundly local, civic and communitarian. This dissertation will investigate the presence of this hypothesis within the context of the legal history of vaccination, infectious diseases and public health in Ontario and Nova Scotia, and highlight any impacts or influences on legal developments in these areas.\footnote{The project lends itself to one more general contribution: to challenge and revise the claim in current medical and social histories of vaccination in Canada that vaccination laws were never enforced, and that such laws amounted to dead letters. See e.g. Keelan, \textit{supra} note 60 at 273. Keelan contends, incorrectly, that “[n]othing resembling the British \textit{Vaccination Acts} was ever passed in Canada” (\textit{ibid}) and that the “downloading” of power from the federal government to the provinces, and from the provinces to the municipal governments, hampered effective and ongoing enforcement. The study offers historical evidence to the contrary.}

Given the various contributions contemplated in this work, a central organizing thesis will be difficult to sustain. However, the project seeks to establish, primarily, that mandatory vaccination laws, \textit{sans} exemptions, were historically applied to the prevention and management of infectious diseases, and that such laws were more likely to be socially accepted and effective in achieving desired outcomes when, (a) promoted as part of broader public health strategies, (b) promoted in a non-politicized fashion by persons and institutions seeking to advance the public interest (rather than particular personal or professional interests), (c) social and geographical factors that heighten the threat and impacts of infectious diseases are present and pressing, and (d) systemic and structural barriers to implementation, such as costs and lack of effective communication in government, are eliminated or kept at a minimum.
1.5 **Approach and Outline**

The rest of this introductory chapter provides the necessary background for what follows, including brief historical overviews of smallpox and vaccination, and the Canadian historiographies on both subjects. The next two chapters, which constitute the principal parts of this study, are focused on Ontario and Nova Scotia respectively. Both chapters explore the matters set out earlier in the aims and contributions of this study, and cover the period between 1800 and 1924. The latter date represents, roughly, the time of creation of or vesting of authority over all aspects of public health in centralized, bureaucratized ministries of health. Where necessary to provide context for the discussion, reference will be made to dates outside of the primary time span of the study. The final chapter concludes the study. Where relevant to the discussion, I will point out comparisons between certain matters discussed in the two main chapters.

The study has one general limitation. The discussion in the two main chapters rely mainly on available historical records, which contain numerous gaps. As a result, the narrative is not necessarily chronological, and may appear less robust in some areas (where possible, I have attempted to fill gaps with information from secondary sources). However, my aim is to identify trends in the legal history, and to argue that these trends reflect the thesis outlined above.

1.6 **A Brief History and Historiography of Smallpox in Canada**

Smallpox is an acute and highly contagious infectious disease caused by *variola*, a virus belonging to the *orthopoxvirus* species, which also includes the *vaccinia, cowpox* and
monkeypox viruses. In humans, variola and monkeypox produce severe infectious diseases, while vaccinia and cowpox produce much milder diseases that confer immunity against the former two. Smallpox is transmitted through inhalation of air contaminated with viral droplets from the respiratory tract of an infected person, or by direct or indirect contact with infected persons or objects. Symptoms manifest following an incubation period of seven to nineteen days, and the clinical onset of the disease is characterized by high fever, malaise, headache, fatigue, abdominal pain and vomiting, and an unsightly rash that starts on the face, palms and soles and soon covers the body. The rash forms pustules and lasts for three to four weeks, often leaving its victims permanently pockmarked, scarred, and sometimes, disfigured. The disease exists in two distinct variants: a severe form of the disease called variola major, and a milder form called variola minor. The mortality rate of the disease ranges between fifteen and forty-five percent, with higher fatality rates among children and pregnant women.

There is no known cure for smallpox, and once a person becomes infected, the disease typically runs its full course. However, similar to measles, smallpox is a vaccine-preventable disease. Indeed, smallpox was the disease for which the first vaccine was

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80 See ibid.
81 See ibid.
82 See ibid.
83 See “Smallpox”, supra note 17; Dixon, supra note 79 at 1. Other classifications exist in the medical literature. For example, Rao uses “haemorrhagic” and “non-haemorrhagic”. Supra note 79 at 6. Dixon identifies nine clinical types. Ibid at 5-56.
84 See “Smallpox”, ibid.
developed.\textsuperscript{85} The smallpox vaccine is a medicinal preparation containing live, attenuated, \textit{vaccinia} virus (the original vaccine was prepared from the \textit{cowpox} virus),\textsuperscript{86} and it confers complete immunity against \textit{variola} (smallpox) and other \textit{orthopoxviruses}. As a result of the vaccine, smallpox is now a historical disease; the last known case of natural smallpox occurred in Somalia in 1977,\textsuperscript{87} and the disease was declared to be eradicated, following a global vaccination program, in 1979.\textsuperscript{88} In Canada, the disease was eliminated much earlier, in 1946, through nationwide intensive vaccination programs.\textsuperscript{89} The re-emergence of smallpox anywhere in the world would be considered a global health emergency.

In unvaccinated persons, contracting and surviving smallpox also confers permanent, natural immunity from future occurrences.\textsuperscript{90} Before the discovery of the smallpox vaccine in the eighteenth century,\textsuperscript{91} it was common practice to induce immunity by injecting healthy persons with fluid extracted from smallpox pustules on the bodies of infected persons. This practice, known as \textit{inoculation} or \textit{variolation}, produced the natural and dangerous form of the disease in persons who received it, in the hopes that they would

\textsuperscript{85} See Part 1.7, below, for more on this topic.
\textsuperscript{86} See “Smallpox”, supra note 17; Rao, \textit{supra} note 79 at 157-8; Dixon, \textit{supra} note 79 at 118-169.
\textsuperscript{88} See generally \textit{ibid}; \textit{“Smallpox”, supra} note 17.
\textsuperscript{90} See Rao, \textit{supra} note 79 at 130; Fenn, \textit{supra} note 79 at 20.
\textsuperscript{91} See Part 1.7, below, for more on this topic.
survive the attack and gain natural immunity as a result. Other methods used historically in the management and control of smallpox include removal, isolation, and quarantine of infected persons or objects, general sanitation and disinfection of contaminated objects, and notification measures such as the placarding of infected locations.

Of these methods, vaccination is generally viewed as the most advantageous; unlike inoculation, it conferred immunity to smallpox without contributing to the spread of smallpox or causing the disease in those who received it, and unlike other methods, it was a prophylactic remedy that prevented the occurrence of the disease in vaccinated persons. However, much of what is known about vaccination today was a mystery throughout the nineteenth and early twentieth centuries, and as the chapters which

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93 See Fenn, supra note 79 at 29-31. Two main forms of quarantine were practiced or regulated in the nineteenth century: “immigration quarantine,” which refers to restricting or preventing the entry of vessels, goods and persons arriving from foreign ports, and local or domestic quarantine, which refers to isolation of persons already within the place where the quarantine is carried out. For more on the history of quarantine, see JC McDonald, “The History of Quarantine in Britain During the Nineteenth Century” (1951) 25 Bulletin of the History of Medicine 25; Charles F Mullett, “A Century of English Quarantine (1709-1825)” (1949) 6 Bulletin of the History of Medicine 527; PS Sehdev, “The Origin of Quarantine” (2002) 35(9) Clinical Infectious Diseases 1071; Gian Franco Gesini, Magdi H Yacoub & Andrea A Conti, “The Concept of Quarantine in History: From Plague to SARS” (2004) 49 Journal of Infection 257.

94 Fenn, *ibid* (“[i]noculation was risky business, and many did die from the illness they inevitably (and necessarily) contracted through the procedure” at 33).

95 See e.g. Dixon, *supra* note 79 at 187:

In attempting to trace the history of smallpox, it is necessary to interpret accounts by many writers, who although using well-known terms rarely give sufficient clinical description to allow one to be certain of the real identity of the disease. At all times contemporary writers assumed that their readers would be familiar with the disease they named, but there is no guarantee that such a disease is the same condition in different countries, or at different periods of history. Due to the widespread practice of borrowing medical knowledge, particularly from Arabic sources, it is probable that the name smallpox was applied to a local disease which appeared to best fit it, although it might have been entirely absent from the particular community. Smallpox is particularly difficult to study, due to the confusion with chickenpox, which existed in some parts of the world until the late nineteenth century.
follow will make clear, views regarding the safety and efficacy of the procedure were the source of considerable social and legal controversy.

Prior to the discovery of vaccines and its eradication, smallpox was one of, if not the most feared infectious disease known to man. Its appearance in a community inevitably led to an epidemic, which left most of its victims dead or scarred for life. Throughout its history, smallpox epidemics were “spectacularly destructive” and “catastrophic, affecting grownups as well as children and crippling entire communities.” The disease is generally regarded as the deadliest of Old World diseases, and with the exception of the American Revolution, “the greatest upheaval to afflict the [American] continent in the period immediately before and after the war.” The effects of the disease on pre-colonial and colonial North America is well documented, and include significant depopulation

See also ibid at 193-95.

96 See e.g. Fenn, supra note 79 (smallpox “found countless new hosts…multiplied rapidly…traveled vast distances… With no respect for boundaries of race, class, or nationality, the opportunistic microbe swept an astonishing array of people and events into its maelstrom [and]…reshaped human destinies” at 3); Boyd, supra note 79.


99 Fenn, supra note 79 at 28.

100 Ibid at 9. See also Glynn & Glynn, supra note 87 at 89, where the following quote is attributed to John Adams, second President of the United States: “Our misfortunes in Canada are enough to melt the heart of stone. The smallpox is ten times more terrible than the British, Canadians and Indians together. This was the cause of our precipitate retreat from Quebec.”

of virgin (previously unaffected) communities, and loss or disruption of aboriginal peoples’ cultural beliefs and institutions. For example, the disease caused the Tlingits, a community of indigenous peoples of the Pacific Northwest coast of North America, to lose faith in their shamans, who, “in spite of their guardian spirits, perished together with those who sought their help.”

The mode of transmission of smallpox, by human contact, made its spread easy and inevitable with human migration. According to one historian, the story of smallpox is one “of connections between people,” and the disease “showed that a vast web of human contact that spanned the continent[s].” There are also accounts of the deliberate introduction of the disease by humans, most notably as a biological weapon in various colonial wars. In a famous but contested account, smallpox blankets removed from infected British soldiers at the Siege of Fort Pitt was distributed to indigenous peoples, triggering an epidemic that decimated their population.

102 See generally Gibson, ibid; Boyd, supra note 78; Jody F Decker, “Depopulation of the Northern Plains Natives” (1991) 33:4 Social Science and Medicine 381.


104 Gibson, ibid at 79.

105 Fenn, supra note 78 at 6.

106 Ibid.


108 Ranlet, ibid.

109 In 1763, a collection of Indian tribes led by Pontiac launched an attack on British forces stationed at Fort Pitt. For more on the siege, see Fred Anderson, Crucible of War: The Seven Years’ War and the Fate of Empire in British North America, 1754-1766 (New York: Vintage Books, 2001) 535-46; Fenn, supra note
Smallpox epidemics occurred in Canada as early as the seventeenth century, and had significant demographic effects on pre- and early contact First Nations peoples.\textsuperscript{111} Smallpox was mostly likely introduced to Canada through European contact, and was endemic for most parts of the eighteenth and nineteenth centuries.\textsuperscript{112} Major epidemics occurred among the indigenous peoples of Canada as early as the 1630s,\textsuperscript{113} in Louisbourg, Nova Scotia between 1732 and 1758,\textsuperscript{114} in the Western Plains between 1780-82 and 1837-38,\textsuperscript{115} Prince Edward Island in 1825,\textsuperscript{116} and in Montreal in the 1870s\textsuperscript{117} and 1885.\textsuperscript{118} A Canada-wide epidemic in 1862 took 20,000 lives.\textsuperscript{119}

Histories of smallpox in Canada typically provide regional accounts\textsuperscript{120} of major epidemics, and no attempt has been made to synthesize the fragments or extract unifying

\begin{footnotes}
\item[111] See Brookhiser, supra note 107.
\item[112] See Boyd, supra note 107; Gibson, ibid at 66; John J Heagerty, Four Centuries of Medical History in Canada and a Sketch of the Medical History of Newfoundland, vol 1 (Toronto: MacMillan, 1928) 17-24.
\item[115] See McIntyre & Houston, supra note 89; Decker, supra note 101; Harris, supra note 101; Boyd, supra note 101; Ray, supra note 101; C Stuart Houston & Stan Houston, “The First Smallpox Epidemic on the Canadian Plains: In the Fur-Traders’ Words” (2000) 11:2 The Canadian Journal of Infectious Diseases 112.
\item[118] See Bliss, supra note 101.
\item[120] Provinces covered in the historical literature include Quebec, Ontario, Newfoundland and Labrador, Prince Edward Island and British Columbia. See e.g. Bliss, supra note 101; Allan Everett Marble, Surgeons, Smallpox, and the Poor: A History of Medicine and Social Conditions in Nova Scotia, 1749-
themes. The historiography can be divided into three categories: medical, social and ethnohistorical. The medical histories deal generally with disease etiology, clinical categories and medical management and are commonly written by medical practitioners for their colleagues and medical students.

The leading work in the social history category is Michael Bliss’ novelized account of the smallpox epidemic that hit Montreal in 1885. Bliss’ book covers the socio-political events surrounding the rise and impact of the epidemic, including the deep social and cultural divisions between the predominantly Roman Catholic French majority and the predominantly Protestant English minority, rampant poverty and social malaise, poor sanitation, and a largely inept public health response to the disease. Bliss concludes that the failure of vaccination programs established during the epidemic was attributable to the French peoples’ fatalistic attitude to the disease and their cultural aversion to science and medicine, as well as “doctrinaire vaccinophobia” from a fringe, unscientific and dishonest group of anti-vaccinationist ideologues. Other works in this category focus


121 Some works provide a chronology of smallpox-related events, and few if any themes are discussed. See e.g. Heagerty, supra note 112 at 17-96. Discussions of the history of smallpox appear in histories of poverty relief, sanitation measures, and public health, but are generally limited in scope. See e.g. Relief MacKay, “Poor Relief and Medicine in Nova Scotia, 1749-1783” in Shortt, ed, supra note 101 at 75; Terry Corp, “Public Health in Montreal, 1870-1930” in Shortt, ibid, 395; Heather MacDougall, “Public Health and the “Sanitary Idea” in Toronto, 1866-1890” in Wendy Mitchinson & Janice Dickin McGinnis, eds, Essays in the History of Canadian Medicine (Toronto: McClelland and Stewart, 1988) 62.

122 See e.g. William Osler, The Principles and Practice of Medicine: Designed for the Use of Practitioners and Students of Medicine, 3d ed (New York: D Appleton and Company, 1899) 56-74. Cyril Dixon’s treatise on smallpox is the definitive text on the pathology of smallpox, and includes general discussions of the histories of inoculation and vaccination and associated social and scientific controversies in nineteenth century England. Dixon, supra note 79. Keelan, supra note 60 at 45-99 contains an excellent overview of the medical history of smallpox and vaccination. See also William B Spaulding, “The Ontario Vaccine Farm, 1885-1916” (1989) 6 Canadian Bulletin of Medical History 45.

123 Bliss, supra note 101.
more on the history of vaccination, and contain cursory discussions of societal experiences with smallpox.⁴

Lastly, the ethnohistorical literature deals with the timing, source and impacts of contact-era smallpox epidemics on Native populations, especially in the coastal regions of present day southern British Columbia.⁵ The main claim that emerges from this literature is that smallpox epidemics depopulated native societies, and thus, had much more far-reaching demographic effects than other recognized causes of depopulation such as migration and warfare.⁶ The ravages of smallpox among a Native population that—unlike most European settlers—had no natural immunity to the disease, contributed to the colonization and settlement of their lands. The ethnohistorical literature provides evidence of the far-reaching impact of smallpox on Native populations, including the displacement of cultural systems that could not be preserved in the absence of custodians who lost their lives to the disease, the discrediting of shamans and medicine men who could not provide any effective remedies to the disease, and the imposition of imperialist cultures and religions on significantly weakened Native populations.

The ethnohistories offer little or no material for legal history analysis. There is some historical evidence that Canadian Natives were vaccinated during the major smallpox epidemics of the nineteenth century, and that the procedure was generally well received

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⁴ See e.g. Keelan, supra note 60; Bator, supra note 60; Baldwin, supra note 116.
⁵ See generally Decker, supra note 101; Decker, supra note 102; Harris, supra note 101; Boyd, supra note 101; Ray, supra note 101.
by them.\textsuperscript{127} This may have obviated any need for legal enforcement of vaccination targeted at Native populations. Still, these accounts provide relevant context for understanding the Canadian experience with smallpox, and suggests that vaccination was likely well received by some segments of the Canadian society in the period before statutory intervention.

\section*{1.7 A Brief History of Vaccination}

Sometime around the year 1770, a British doctor and naturalist named Edward Jenner\textsuperscript{128} set out to investigate a country legend about cowpox, a mild bovine disease that caused a mild infection in humans. According to the legend, smallpox was rare among milkmaids, because they were protected from the disease through infection with cowpox, which was common among milkmaids. Jenner had the right credentials to investigate the cowpox lore; as a medical student under the pupilage of John Hunter, a leading surgeon with whom Jenner shared an interest in natural history, Jenner received training in empiricism and experimental research. Before he turned his attention to the cowpox lore, he completed several observational studies of the natural history of the cuckoo and of bird migration, and in 1789, he was elected Fellow of the Royal Society of London in “formal recognition of his scientific ability.”\textsuperscript{129}

\textsuperscript{127} See Heagerty, \textit{ibid} at 49; McIntyre & Houston, \textit{supra} note 89 at 1545.

\textsuperscript{128} For a biography of Jenner, see Thomas Dudley Fosbroke, \textit{Berkeley Manuscripts. Abstracts and Extracts of Smyth’s Lives of the Berkeleys, Illustrative of Ancient Manners and the Constitution; Including All the Pedigrees in That Ancient Manuscript. To Which are Annexed a Copious History of the Castle and Parish of Berkeley, Consisting of Matter Never Before Published; and Biographical Anecdotes of Dr. Jenner, His Interviews with the Emperor of Russia, &c.} (London: John Nichols and Son, 1821) 219.

Jenner was also motivated by a harrowing personal experience. At age eight, Jenner, “a fine ruddy boy”\textsuperscript{130}, along with many others, was sent to a barn to be inoculated with smallpox. The procedure lasted six weeks. During this period, young Jenner was “bled, to ascertain whether his blood was fine…purged repeatedly, till he became emaciated and feeble…kept on a very low diet, small in quantity, and dosed with a diet-drink to sweeten the blood.”\textsuperscript{131} Following his inoculation with the live virus, he was “removed to one of the then usual inoculation stables and haltered up with others in a terrible state of disease.”\textsuperscript{132} The whole procedure left him with a lifelong aversion to inoculation, and produced a desire to find a less abhorrent alternative.\textsuperscript{133} 

Jenner conducted his first vaccination experiments in 1796. On May 14, he obtained lymph from the hand of Sarah Nelmes, a milkmaid infected with cowpox. He then performed the first vaccination on an eight-year-old boy named James Phipps. Jenner cut two small slits on Phipps’s arm and dabbed the wounds with the lymph. To test his hypothesis, he waited a few days, and then deliberately infected the boy with smallpox. The boy never developed the disease.\textsuperscript{134}

\textsuperscript{130} Fosbroke, supra note 128 at 221. 
\textsuperscript{131} Ibid. 
\textsuperscript{132} Ibid. 
\textsuperscript{133} Ibid (“It is, without suspicion, a noticeable incident in a biographical account, that the misery endured in the [s]mall[p]ox process should have laid the foundation for the extermination of the disease” at 222). 
\textsuperscript{134} See Edward Jenner, On the Origin of the Vaccine Inoculation (London: G Elsick, 1863) [Jenner, Origin]; Edward Jenner, An Inquiry into the Causes and Effects of the Variolae Vaccinae, a Disease Discovered in some of the Western Counties Of England, Particularly Gloucestershire, and Known by the Name of the Cow Pox (London: DN Shury, 1801) [Jenner, Inquiry]. The term “vaccine” is not Jenner’s; it was first used in 1800 by Richard Dunning, a British physician and Jenner’s friend, to describe Jenner’s invention. Allen, supra note 92 at 27.
Having confirmed his hypothesis, Jenner conducted more vaccination experiments, including on members of his family. The vaccinations produced the desired immunity, and in 1798, he published a treatise on vaccination, in which he described twenty-three case histories as evidence of the efficacy of vaccination.\textsuperscript{135} Other publications followed with details of successful vaccination experiments.\textsuperscript{136} By the turn of the century, Jenner’s discovery and experiments were replicated and applied in many parts of the world, and he became a worldwide celebrity. He received, among other things, an honorary doctorate from Harvard University and monetary rewards from Parliament. Napoleon, whose troops were protected by the cowpox vaccine, famously granted Jenner’s request for the release of two of his friends imprisoned in France, saying: “Ah Jenner! We can refuse nothing to that man.”\textsuperscript{137}

Vaccination quickly replaced inoculation as the prophylactic of choice. The latter procedure was blamed for furthering the spread of smallpox, and many jurisdictions passed legislation banning or restricting its use.\textsuperscript{138} However, it remained popular among the poor and working class, mainly because it was familiar and accessible.\textsuperscript{139} For example, inoculation was offered in Newark (Niagara-on-the-Lake) by Doctors Kerr and Muirhead in the year following Jenner’s first experiments (see Plate A). By contrast, obtaining and maintaining a safe and accessible supply of Jenner’s vaccine to meet

\textsuperscript{135} Jenner, \textit{Inquiry}, \textit{ibid}.
\textsuperscript{137} MacNalty, \textit{supra} note 129 at 9.
\textsuperscript{138} Inoculation was banned in England in 1840. See \textit{An Act to Extend the Practice of Vaccination}, 1840 (UK), 3 & 4 Vict, c 29, s 8. The Province of Canada banned the procedure in 1859. See \textit{An Act Respecting Inoculation and Vaccination}, SC 1859 (22 Vict), c 39. For a general history of inoculation in colonial North America, see Allen, \textit{supra} note 92 at 25-45.
\textsuperscript{139} See Durbach, \textit{supra} note 59 at 21-26.
overwhelming demand was a problem throughout the nineteenth and early twentieth century.\textsuperscript{140} Two main production techniques were used during this period; extraction of vaccine lymph from livestock specifically reared for vaccine production purposes and deliberately infected with cowpox, and arm-to-arm transfer of pustular material from a previously vaccinated individual to a new recipient.\textsuperscript{141} Both techniques were plagued with issues of contamination from bacteria and other organisms which thrived normally on livestock and humans, resulting in diseases such as syphilis, erysipelas, and hepatitis B.\textsuperscript{142} Preserving the vaccine, in wet or dried form, was also an issue, as both forms were susceptible to destruction by heat.\textsuperscript{143} The use of heat-damaged vaccines, in turn, resulted in vaccine failures.\textsuperscript{144}

Anti-vaccinationists seized upon these issues of contamination, transmission of diseases and vaccine failure as evidence that the vaccine was neither safe nor effective.\textsuperscript{145} Proponents countered by pointing to statistics showing decrease incidence of smallpox and related mortality in vaccinated populations.\textsuperscript{146} As Arthur Allen has observed, there were no licensing boards or government agencies to “test the vaccine or monitor its

\textsuperscript{142} See Henderson, ibid; MacNalty, supra note 129 at 11-12; Allen, supra note 92 at 52-3.
\textsuperscript{143} See Henderson, ibid; Allen, ibid, 53.
\textsuperscript{144} See ibid.
\textsuperscript{146} See generally Fichman & Keelan, supra note 60; Durbach, ibid at 2-3; Allen, supra note 92 at 60.
use,”147 or to provide independent verification of claims. As a result, the “[s]mallpox vaccine, for most of its effective life, remained an empirical remedy—a portion that worked, but as if by magic,”148 as well as a source of disputation regarding the limits of medical and public health intervention.

The contamination problem was resolved in the 1890s, when glycerol, a bactericidal agent, was applied as a preservative and as a disinfectant for the injection site.149 The preservation issue persisted until the invention of refrigeration in the 1930s.150 A stable freeze-dried vaccine was developed in 1955 by L.H. Collier of the Lister Institute of Preventative Medicine in England,151 paving the way for widespread production and eventual eradication of smallpox.

Vaccination was first used in Canada around 1798, when Rev. John Clinch, a medical missionary in Trinity, Newfoundland and a former colleague of Jenner’s, requested and received a supply of vaccine from Jenner.152 Canadian Native tribes also received a supply of the smallpox vaccine from Jenner in the early period of the nineteenth century, and seem to have found the method preferable to forced relocations and quarantine.153 A public vaccination program was established for Lower Canada through successive

147 Allen, ibid at 53.
148 Ibid.
149 See Henderson, supra note 140.
150 See ibid.
153 See Heagerty, supra note 112 at 49.
statutes enacted in 1815, 1817 and 1821, but the program was terminated in 1823 due to lingering political, scientific and professional disputes.\textsuperscript{154}

In general, the use of vaccination was likely influenced by local factors in the various regions that became Canada, and the social and legal response to the technology varied from place to place. For instance, Nova Scotia took steps to limit the spread of smallpox within the colony as early as 1799, by placing restrictions on inoculation.\textsuperscript{155} It was also the first colony in British North America to adopt vaccination by legislation, in 1850.\textsuperscript{156} A decade and a year later, vaccination was made compulsory by law in the Province of Canada.\textsuperscript{157} School vaccination programs were established in Ontario in the last quarter of the nineteenth century.\textsuperscript{158} Resistance to vaccination laws also varied with local circumstances, although popular and organized antivaccinationism produced notable and widespread resistance in Montreal and Toronto.\textsuperscript{159}

1.8 A Brief Historiography of Vaccination and the Law in Canada

The prevention and management of smallpox in nineteenth and twentieth century Anglo-North America was regulated by a variety of statutory and common law rules.\textsuperscript{160}

\textsuperscript{155} See An Act for regulating the practice of inoculating for the small pox, SNS 1799 (39 Geo 3), c 7.
\textsuperscript{156} See An Act to provide for expenses of boards of health and of vaccination, SNS 1850 (13 Vict), c 15.
\textsuperscript{157} See An Act to provide for the more general adoption of the practice of vaccination, S Prov C 1861 (24 Vict), c 24.
\textsuperscript{158} See An Act to Amend the Act Respecting Vaccination and Inoculation, SO 1886, c 43, ss 2-3. The Act permitted school trustees to require proof of vaccination for smallpox as a condition for school attendance.
\textsuperscript{159} See Bliss, \textit{supra} note 101; Keelan, \textit{supra} note 60.
\textsuperscript{160} See e.g. \textit{R v Vantandillo} (1815), (1815) 4 M & S 72, 105 ER 762 KBD (mother of a child infected with smallpox sentenced to three months imprisonment for carrying the child through a public street. The judgment established the common law offence of unlawfully, injuriously, and knowingly exposing a person
However, the historiography of smallpox and vaccination contains very limited discussion on the role of law, and no studies dedicated to the legal aspects of smallpox control in general or vaccination in particular.

There are only two noteworthy discussions of the legal history of vaccination in the literature.\(^{161}\) The first is Jennifer Keelan’s doctoral dissertation on Canadian anti-vaccination groups active in Toronto and Montreal during the last quarter of the nineteenth century, which contains a brief chapter on the large-scale prosecution of Montreal residents for noncompliance with smallpox control measures, including mandatory vaccination laws.\(^{162}\) The prosecutions occurred in 1885/86 when Montreal was hit by a devastating smallpox epidemic. Keelan’s chapter focuses on the role played by Canadian anti-vaccination groups in providing legal and financial assistance to those prosecuted for refusal or failure to comply with compulsory vaccination laws. Keelan reconstructs the prosecutions mainly from newspaper reports and provides only a general overview of the major characters, distribution of offences and arguments. From a legal history perspective, her contribution suggests but sidesteps interesting leads, such as

infected with a contagious disorder in public); \(^{\text{R v Luellin (1701), (1796) 12 Mod 445, 88 ER 1441 KBD}}\) (indictment against an inn-keeper for not receiving a guest infected with smallpox quashed because the guest did not state he was a traveler); \(^{\text{Baines v Baker (1752), Amb 158, 27 E.R. 105 (denial of injunction to stay building of inoculation hospital as there was no common law precedent for holding that the act amounted to a nuisance); R v Sutton (1767), 4 Burr 2116, 98 ER 104 (motion to quash nuisance indictment for erecting and keeping inoculation houses denied); and Municipality of the Village of the Mile End v City of Montreal (1885), 9 LN 235, MLR 2 SC 218 (Que CA) (injunction to prevent provincial government buildings within municipality from being used as a smallpox hospital denied).}\) A comprehensive retrospective bibliography on the history of smallpox in Canada between 1700 and 1945 compiled by medical historians Charles G. Roland and Jacques Bernier lists twenty two titles (five in French) published between 1984 and 1998. Among the listed works, there is little or no discussion of the legal aspects of smallpox control or vaccination, and none cite any studies of the legal aspects. My assessment of the historiography applies only to the English language studies. Charles G. Roland & Jacques Bernier, \(^{\text{Secondary Sources in the History of Canadian Medicine: A Bibliography, vol 2 (Waterloo: Wilfrid Laurier University Press, 2000) 46-47.}}\) See Keelan, \(^{\text{supra}}\) note 60.
discussion and analysis of issues of constitutional law, procedural due process and exclusion of evidence evident from defense arguments and the conduct of the trials.\textsuperscript{163}

The second noteworthy account of the legal history of vaccination is Karen Walloch’s doctoral essay on antivaccinationism in Boston and Cambridge in the first quarter of the twentieth century.\textsuperscript{164} Walloch’s study includes an impressive analysis of \textit{Jacobson v. Massachusetts},\textsuperscript{165} a seminal 1905 decision of the Supreme Court of the United States. The case involved a Lutheran pastor named Henning Jacobson, who was charged, convicted and fined for refusing to be vaccinated as required by a city of Cambridge mandatory vaccination order made pursuant to a state statute. His appeal against the conviction was emphatically rejected by the Supreme Court. The justices ruled that states possess and could apply their “police powers” to enact and enforce reasonable public health laws, including mandatory vaccination laws, even if such laws place “manifold restraints” on personal liberties.\textsuperscript{166} Walloch provides an extensive review of the case history, information on the litigants, and an excellent discussion of the history of the police powers doctrine.\textsuperscript{167} Walloch’s contribution is unquestionably the most authoritative

\textsuperscript{163} Pursuing the gaps in Keelan’s account requires, to some extent, a working knowledge of French, which I am not fluent in. The analysis contemplated in this work, to the extent that it touches on the identified gaps, is limited to English language materials.

\textsuperscript{164} See Walloch, \textit{ supra} note 60. A possible third is John Duffy, “School Vaccination: The Precursor to School Medical Inspection” (1978) 33:3 Journal of the History of Medicine and Allied Sciences 344, which examines the history of school vaccination programs in the U.S. in the nineteenth century. The article mentions various examples of legislative and judicial activity relating to compulsory school vaccination laws, but does not investigate or discuss this in any detail.

\textsuperscript{165} 197 U.S. 11 (1905). See also Phillips, \textit{ supra} note 43.

\textsuperscript{166} See \textit{Jacobson, ibid} at 26.

and most comprehensive historical analysis of case law in the historiography of smallpox vaccination in Anglo-North America. However, it is only a study of a single case and issue.

Another issue that arose in the case, and which has not been addressed in the literature, was the court’s handling of the defendant’s motion seeking to prove that the smallpox vaccine was neither safe nor effective. In rejecting the motion, the court reasoned, correctly, that matters of vaccination theory and policy were beyond its jurisdiction, and best left to the legislature to decide. However the court also held that the theory that vaccines were safe and effective “accords with the common belief and is maintained by high medical authority.” Recent historical studies suggest that the latter opinion overstates the status of vaccination in the nineteenth century. According to these studies, vaccination theory and practice was neither well-established nor well-understood during this period, and accounts that suggest otherwise or present doubts about vaccine safety and efficacy as unpopular and unscientific are historically inaccurate. Some studies also point to a “presentist bias” in historical accounts that portray nineteenth century vaccination as a well-established medical remedy that was widely accepted by


168 See Jacobson, supra note 165 at 30-31.
169 See ibid.
170 Ibid at 30.
171 See e.g. Keelan, supra note 60, Walloch, supra note 59; Durbach, supra note 59; Fichman & Keelan, supra note 60.
172 See e.g. Durbach, ibid, 3-4.
medical experts. This bias, the studies assert, is borne out of the successful eradication of smallpox. 173 I will return to this discussion in my analysis of a legal dispute concerning vaccination in the next chapter.

The neglect of the legal history of vaccination can also be attributed to the limited attention paid to vaccination in histories of smallpox. S.E.D. Shortt, Canada’s preeminent medical historian, has observed, for example, that although “flamboyant” epidemics have been a primary focus of historical study, Canadian medical and social historians have failed to link the subject with “nineteenth-century Canadian social history in general.” 174 His list of neglected topics that “would broaden considerably our understanding of both Canadian medicine and politics” 175 includes “vaccination programs…and quarantine laws.” 176

Shortt is right. Besides brief and rudimentary accounts of vaccination in encyclopedic texts on the history of medicine in Canada, 177 there are very few works dedicated entirely to the history of vaccination, and virtually all are focused on opposition to compulsory vaccination in the nineteenth century. 178 Notable works in the latter category include Jennifer Keelan’s study of Canadian antivaccinationist groups active in Montreal and

173 Keelan, ibid at 17.
175 Ibid at 8.
176 Ibid. See also Brunton, supra note 60 (“[t]he neglect of vaccination within public health history is all the more surprising given that authors…present it as an important innovation, introducing the British population to state medicine” at 2).
177 See e.g. Heagerty, supra note 112.
178 Brunton has observed a similar trend in the UK historiography. Supra note 60 at 1-3.
Toronto in the late nineteenth century, Paul Bator’s essay on the extent of popular resistance to compulsory vaccination and associated health reforms in Toronto and Ontario in the first quarter of the twentieth century, Barbara Lazenby Craig’s essay on the influence of smallpox management on the evolution of public health in Ontario in the last quarter of the nineteenth century.

In general, there are no pan-Canadian accounts on smallpox vaccination, and not much is known about the first three quarters of the nineteenth century. Also, weaving together what is known leaves substantial gaps and paints an overall picture of public vaccination that is fragmented, limited in scope, and possibly incomplete. Some neglected or under-researched areas include the status of Canadian vaccination policies and programs pre- and post-Confederation, the impact of other infectious diseases on the management of smallpox and implementation of vaccination, the link between developments associated with vaccination and the broader historical context in which they occurred, the

179 See supra note 60.
180 See supra note 60.
181 See supra note 60. The essay also contains a very brief discussion on how aggressive control measures (led by reform-minded members of the medical elite) galvanized latent public opposition into widespread active antivaccinationism.
182 Barbara Tunis’ article on political and professional conflicts surrounding the establishment of public vaccination programs in Lower Canada between 1815 and 1823 is the only study of vaccination in this period. Supra note 154.
183 Some themes pursued in this work are examined in Joseph Logan Atkinson’s study of political motivations behind the ineffectual legal response to a cholera epidemic that devastated Upper Canada in 1832. See Joseph Logan Atkinson, The Upper Canadian Legal Response to the Cholera Epidemic of 1832 and 1834 (LLD Thesis, University of Ottawa, 2000) [unpublished]. Atkinson’s study identified a number of reasons for weak response, including the province’s geographical isolation from first contact with disease-bearing immigrants, difficulties encountered by municipal officials in implementing public health measures, and government “reluctance…to embrace a particular vision of the public good…[that] considered community health as worthy of protection at any cost.” Ibid at 14. These reasons resonate throughout this study.
184 It has been established, for instance, that vaccination and other forms of smallpox management were part of poor relief efforts in the nineteenth century. See generally MacKay, supra note 121; Marble, supra note 120; Keelan, supra note 60 at 266; Brunton, supra note 60. Poor and working class citizens were the
influence of imperial vaccination policies and programs, and a systematic examination of the role of law within the context of the Canadian experience with smallpox and public vaccination. This dissertation will touch upon all these areas.

To conclude, this dissertation seeks to augment the historiography in the identified areas, and to offer a historical account of vaccination that is befitting of its status as one of the most important medical and scientific discoveries in human history, and as an intervention that introduced or shaped modern public health law.
Plate A: Advertisement for inoculation services by Doctors Kerr and Muirhead (25 January 1797)

Small-Pox.

As the inoculation for the Small-pox is this day commenced at Queenston, and the season of the year very favorable, the subscribers propose inoculating immediately, in the town of Newark, and throughout the county of Lincoln, on the most reasonable terms.

$$ The poor inoculated gratis. 

ROBERT KERR,
JAMES MUIRHEAD.

Newark, Jan. 25.

ALL persons whom it may concern are hereby cautioned not to purchase from John (Jr.) Dyer, the house wherein he now dwells at the mouth of Chippawa creek, the same being built upon the freehold of the subscriber, and, as yet, not alienated.

THOMAS CUMMINGS.

January 25, 1797.

Lands for Sale.

THREE hundred acres unlocated, for which a good title will be given: also three hundred acres in Stamford, on which are a good dwelling house, barn, out-houses &c. also 77 acres improved, and under good fences and repairs; with which will also be sold, if the purchaser chooses, a number of farming utensils.
CHAPTER TWO – ONTARIO

“Apparently our forefathers (something like ourselves) needed an epidemic of some sort to create an interest in health matters” — John WS McCullough, Chief Officer of Health for Ontario (1920)

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2.1 Slow Starts and Unfulfilled Responsibilities: Smallpox and Infectious Disease Management in Ontario

In 1833, the Upper Canada legislature passed the province’s first public health legislation. The statute represented the first effort to deal with infectious diseases through statutory intervention, but it was not the first application of law to the problem of infectious diseases within the province.

Prior to 1833, responsibility for the management of infectious disease outbreaks and other public health threats lay at the district level with the Courts of General Quarter Sessions of the Peace (henceforth, “Quarter Sessions” or “Sessions”), as part of their jurisdiction over local government. The courts were presided over by appointed justices of the peace (also referred to as magistrates), who met quarterly in the capital town in each district to settle disputes and hear cases relative to conserving the peace, as well as to deal with matters of district administration and local government. The courts “held in

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1 See An Act to establish boards of health, and to guard against the introduction of malignant, contagious and infectious diseases, in this Province, SUC 1833 (4 Will), c 48 [Board of Health and Infectious Diseases Act of 1833].
2 The Court of General Quarter Sessions of the Peace has been described as the “most important institution through which order was maintained and local government conducted in Upper Canada.” James K Wilson, The Court of General Quarter Sessions of the Peace: Local Administration in Pre-Municipal Upper Canada (MA Thesis, McMaster University, 1991) [unpublished] at 1.
unison virtually all economic and political authority exercised at the local level, overseeing local administration and helping maintain local order,” until 1841, when the responsibility for municipal government was transferred to district councils constituted by an appointed warden and elected councillors. The court retained only its judicial function after this time. However, its influence over municipal or local government prior to 1841 was pervasive, and the magistrates have been called “jack of all trades.” The scope of the magistrates’ duties has been described as follows:

[A]dministratively, they controlled the purse of the district, supervising financial matters, assessments and collections, and setting rates for the townships. Further, they licensed inns, taverns and shops selling spirits, appointed such minor officers as constables and road surveyors, heard petitions for the building of roads and bridges and oversaw the construction of those approved. In the field of local government they approved...regulations...and received the reports of the town meetings of the townships.

The magistrates’ duties in relation to public health and other health-related matters were not prescribed by statute, but instead arose from their authority over local government. These duties included the issuance of public health regulations and allocation of public

4 See An Act to provide for the better internal Government of that part of this Province which formerly constituted the Province of Upper Canada, by the establishment of Local or Municipal authorities therein, S Prov C 1841 (4 & 5 Vict), c 10, ss 3 -5, 51-52.
5 Wilson, supra note 2; Frederick H Armstrong, “The Oligarchy of the Western District of Upper Canada, 1788-1841” (1977) 12:1 Historical Papers 86 at 92.
7 Armstrong, supra note 5. Phillips adds: “Although the office [of justice of the peace] was originally concerned with enforcing the peace, as its name suggests, from the fifteenth through the seventeenth centuries JPs acquired vastly increased duties – economic regulation, road maintenance, administering the poor law system, to name but a few.” Ibid.
8 Although they sometimes acted under statutory mandate in relation to health matters. See e.g. An act to authorize the quarter sessions of the Home District to provide for the relief of insane destitute persons in that district, 1830 (11 Geo 4), c 20 [Destitute Relief Act of 1830].
funds to health-related purposes, including management of infectious disease outbreaks. In 1829, for example, the Lincoln County Court of General Sessions of the Peace (in the District of Niagara) ordered an inquiry into steps taken to deal with a smallpox outbreak in the county jail, and authorized payment for medical services provided to prisoners infected with smallpox. Court records also indicate that prior to 1833, the Lincoln County magistrates routinely delegated public health responsibilities to a board of health constituted by their own appointees.

The magistrates sitting in Quarter Sessions could also invoke and apply the common law of nuisance to deal with offences against the public health. In 1832, for example, residents of York who refused or neglected to comply with sanitation and quarantine regulations issued by the Home District Quarter Sessions, which were aimed at containing the spread of a deadly Asiatic cholera epidemic, were charged with public

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10 See Order No. 8 respecting prisoners confined with smallpox (15 January 1829), Toronto, Archives of Ontario (Lincoln County Court of General Sessions of the Peace records, RG 22-372, Box 3, File 8, MS 10148).
11 See Account No. 20 concerning: Catherine Dangerfield’s account for nursing prisoners with small pox (April 1829), Toronto: Archives of Ontario (RG 22-372, Box 3, File 29, MS 10149); Document referencing payment “for medicine & attendance for the prisoners in the goal of said District” (1829), Toronto, Archives of Ontario (Lincoln County Court of General Sessions of the Peace records, RG 22-372, Box 3, File 8, MS 10148).
12 See generally Lincoln County Court of General Sessions of the Peace records, Toronto: Archives of Ontario (RG 22-372, Box 13), which also contains various orders of the court relating to payments issued to the board of health for services performed during the Asiatic cholera epidemic which prevailed in the district from October 1832 to January 1833.
13 See William Conway Keele, The provincial justice, or, Magistrate’s manual being a complete digest of the criminal law of Canada, and a compendious and general view of the provincial law of Upper Canada with practical forms, for the use of the magistracy, 2d ed (Toronto: H & W Rowsell, 1843) sub verbo “Nuisance” at 462.
nuisance. Individual magistrates also performed a wide variety of administrative and judicial functions in their places of residence, some relating to health matters.

During this early period, the Quarter Sessions magistrates performed health-related functions without much formal guidance from the provincial legislature. This was not unusual at a time when strong local government and variant local approaches to governance were the norm; magistrates were overseers and advocates of local interests, and were expected to inject local flavor into a range of matters affecting their municipalities. Public health was a local affair, best left to each municipality to decide what options best worked for their respective health care dilemmas.

This state of affairs is reflected in the few health-related statutes enacted in the pre-union era, which relied on the machinery of local government for implementation. Magistrates often petitioned the provincial legislature for funds and the legal authority to deal with local concerns, such as when the York Board of Health petitioned Lieutenant Governor John Colborne to convene the Legislature to enact provisions to clarify the Board’s authority to issue regulations aimed at controlling the spread of the devastating 1832 cholera epidemic. Similarly, in January 1830, the Home District Grand Jury and the

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14 See Minute Book, vols 4 & 5, Home District / York Court of General Sessions of The Peace (1832), Toronto, Archives of Ontario (MS 251 Reels 1 & 2); Patterson, supra note 9 at 170-71; Firth, supra note 3 at lxiv.
15 See generally Armstrong, supra note 5.
16 See S Morley Wickett, “Editor’s Introduction” in S Morley Wickett ed, Municipal Government in Canada (Toronto: University of Toronto, 1907) vii (“it will be noted…that the municipal machinery is adapted to a modest range of local activity rather than to the heavier duties that already are being thrust upon it by modern demands on municipal government” at viii).
Chairman of the District’s Quarter Sessions successfully procured the passing of legislation authorizing the application of District funds for the purpose of maintaining and supporting insane and destitute persons.\textsuperscript{18} In many respects, the office of magistrate was meant to embody a symbiotic relationship between community and law, or as Katherine Beaty Christe puts it, “a localized web of understandings about social relationships which are linked to, and in fact shape, the law.”\textsuperscript{19}

In reality, however, the magistrates paid little or no attention to public health matters, and appear to have only been active during times when their communities faced a public health crisis. As one commentator observed in 1920, early Ontarians “needed an epidemic of some sort to create interest in health matters.”\textsuperscript{20} An examination of the minutes of proceedings of the various Quarter Sessions in the province indicates that the courts rarely handled cases or discussed matters relating to public health. In York, for instance, the nuisance prosecutions referred to earlier were never pursued beyond the laying of charges, probably due to lack of interest from the magistrates or the passing of time between sittings of the court. As Edith Firth notes in relation to the lack of convictions, the “failure to enforce their [own] sanitary regulations seriously limited the ability of the magistrates to cope with the emergency.”\textsuperscript{21}

\textsuperscript{18} See Recommendations of Grand Jury for Care of Insane (14 January 1830), Ottawa, Library and Archives Canada (Upper Canada Sundries 1766 – 1841, RG5-A1, vol 98); \textit{Destitute Relief Act} of 1830, \textit{supra} note 8.


\textsuperscript{21} Firth, \textit{supra} note 3 at lxiv.
Two successive boards of health established by the Home District Quarter Sessions also failed to accomplish much in tackling the cholera epidemic, hampered in their duties by lack of funds and sustained criticism from the press regarding the poor state of sanitation in the district. An editorial in the Canadian Freeman, states, for example:

> It is really astonishing how the magistrates can allow the horrible nuisance which now appears on the face of [York] Bay. All the filth of the town—dead horses, dogs, cats, manure…heaped up together on the ice, to drop down, in a few days, into the water which is used by almost all the inhabitants of the Bay shore. If they have no regard for the health of their fellow beings, are they not afraid to poison the fish that supply their own tables? We hope that His Excellency will take cognizance of the state of the Bay from the Garrison down, and see the carrion-broth to which the worshipful magistracy are about to treat the inhabitants when the ice dissolves… There is nothing more conducive to health than good water—nothing more destructive than bad—and what ought the authorities to watch over and protect before the health of the community?

The 1832 cholera epidemic highlights, in particular, the weaknesses of the local or municipal government machinery in relation to public health. The epidemic arrived in North America on April 28, 1832 when the Irish ship Constantia docked at the Port of Quebec at Grosse Île with infected passengers on board. The highly contagious plague

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22 See Patterson, supra note 9 at 177; Firth, ibid at lxiv - lxv.
23 “State of York Bay”, Canadian Freeman (5 April 1832). See also Firth, supra note 3 at 236.
24 Cholera is presently known to be a bacterial infection of the small intestine acquired by eating or drinking contaminated food or water. Victims experience watery diarrhea, severe and rapid dehydration, abdominal cramps, and face eventual death if left untreated. The disease is treated with oral rehydration solutions or intravenous administration of fluids to relieve the dehydration symptoms, and a course of antibiotics to address the infection. At the time of its introduction to Canada, its causes, symptoms and pathology were a mystery and matters of much speculation and debate. See generally Robert Nelson, Asiatic Cholera: Its Origin and Spread in Asia, Africa and Europe, Introduction into American through Canada; Remote and Proximate Causes, Symptoms and Pathology, and the Various Modes of Treatment Analyzed (New York: William A Townsend, 1866). Causes attributed to the disease at that time included “a poison generated in a patient…which travels independently of wind, climate and season” (ibid, 33), atmospheric conditions, moisture and “vegetable and other putrefaction exhaled from low places.” Ibid, 38. Prophylactic and therapeutic remedies were also matters of speculation, and included “extreme cleanliness and hygiene” (ibid, 58) and religious observance. Ibid.
25 See generally Firth, supra note 3 at lix-lixvii; Patterson, supra note 9; Atkinson, supra note 17; Geoffrey Bilson, A Darkened House: Cholera in Nineteenth-Century Canada (Toronto: University of Toronto Press, 1980).
“spread with lightning rapidity… [and] struck suddenly and capriciously, leaving only a few brief moments of life to many whom it attacked.”

It soon reached Upper Canada, where it completely overwhelmed the Province’s administrative machinery, which relied on discretionary actions by local government officials in the various municipalities. Province-wide quarantine of infected immigrants arriving via the various entry waterways would have helped to prevent the introduction and spread of the disease, but the provincial legislature failed to enact necessary laws to implement and enforce quarantine measures.

The Home District appears to have been the most active municipality during the prevalence of the cholera epidemic. The District’s Quarter Sessions, sitting in York, passed sanitation and quarantine regulations, and appointed special constables to implement the regulations.

Several municipalities appealed to the provincial government for financial aid. Responding to the appeals, Lieutenant Governor John Colborne advanced a grant of 500 pounds to each district in the Province to help defray the costs of dealing with the epidemic, and directed Quarter Sessions in each district to establish a board of health.

However, the grant proved inadequate, especially in larger districts such as York and Kingston. The district boards of health, which were established without formal legislative sanction, also lacked clear legal authority to enforce public health regulations. The York Board of Health lamented these setbacks in resolutions.

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26 See Patterson, *ibid* at 167.
27 For a detailed analysis of the reasons why the provincial legislature failed to act, see Atkinson, *supra* note 17.
28 See Patterson, *supra* note 9 at 170-72.
29 See Firth, *supra* note 3 at lxiv.
passed on August 8, 1832, which also appeared to suggest the existence of doubts as to whether the magistrates possessed any legal authority to enforce public health regulations. The resolutions read, in part:

Resolved that Information hath been given to this Board, that at the present time several Nuisances exist in various parts of the Town…which nuisances neither this Board nor the Magistrates of the District hath power summarily to abate: nor hath any public body authority to punish the persons guilty thereof —
Resolved that the Board of Health, as at present constituted, has not authority by Law to enforce the carrying into effect, or observance of any sanitary regulations, for preventing the Increase of the Disease, which is now so widely extending its ravages over the whole Province: nor hath any funds at its Disposal, for providing Houses of reception for the Indigent sick, removing Infected persons: from populous and ill Ventilated parts of the Town, nor for performing any Act, which may be beneficial to the public at Large.\footnote{Minutes of the Board of Health (8 August 1832), Toronto, Academy of Medicine (York Board of Health Minute Book). See also Firth, \textit{supra} note 3 at 248.}

Local attitudes towards public health affairs is also attributable to structural shortcomings in the system of local government. The Quarter Sessions courts did not meet regularly (as the name suggests, they met quarterly), and most magistrates resided in the major townships in their districts, away from many of the communities they were charged with governing. The system of appointment of magistrates, which was largely based on privilege and the existence of “The Family Compact,”\footnote{See generally Armstrong, \textit{supra} note 5 at 2-6; Patterson, \textit{supra} note 9 at 166; Adam Shortt, “Municipal Government in Ontario: An Historical Sketch” in Wickett, ed, \textit{supra} note 16, 61 at 66.} also contributed to the “evils of apathy, sloth and backwardness”\footnote{Patterson, \textit{ibid} at 166.} in local government, as appointees obtained their position through patronage rather than by any discernible skill, interest or qualification. The magistrates were chosen “from among those who supported the administration,”\footnote{Firth, \textit{supra} note 3 at lxix.}
mainly wealthy Tories, a system which according to Edith Firth, “was anathema to the radicals, both because the method of appointment made the Quarter Sessions independent of popular opinion and because its members were politically obnoxious to them.”

Frederick Armstrong, in his study of the role of the magistracy in the establishment of oligarchies in the Western District of Upper Canada, elaborates further:

Geographical factors prevent[ed] many magistrates from attending its sittings regularly: bad roads, bad weather, and simply the problem of distance, were endemic in Upper Canada. Others were too old, disinclined, or just too busy with their own affairs.

Marian Patterson notes, similarly:

It was inefficiency in local government that touched the individual settler most closely… The duties of local government were in the hands of the District Courts of Quarter Sessions, an artificial body consisting of the [m]agistrates of the districts who were appointed by the Executive and Governor for life. It was merely an extension of the Family Compact. All public funds available for building roads, bridges, or alleviating disasters, such as the increased immigration and the sudden outbreak of cholera brought to many localities, were in the hands of the magistrates. They were unfit to open up a new country, for they neither knew the needs of the district, nor were they sufficiently anxious to supply them. Many were old army officers, and most of them of sufficient income to render them indifferent to the hardships and needs of the average hard-working settler.

With respect to their judicial duties, a lack of legal training among magistrates and the absence of both public health legislation and informative treatises on relevant common law principles may have contributed to their ineffectiveness in dealing with offences

\[34\] Ibid.
\[35\] Armstrong, supra note 5 at 92.
\[36\] Patterson, supra note 9 at 166.
\[37\] This may have changed with the publication of the first Magistrate’s Manual by William Conway Keele in 1835. The Manual contained summaries of the law on an alphabetically arranged list of topics, such as “nuisance” and “patent rights.” The Manual was intended as a guide for magistrates in the discharge of their judicial and peacekeeping duties. See William Conway Keele, The provincial justice, or, Magistrate’s
against the public health. In addition, the authority of the Quarter Sessions in relation to public health offences (and criminal matters in general) lacked precise definition throughout the history of the court, and could only be inferred from discrete references in various early enactments that many magistrates were probably unaware of.\textsuperscript{38}

Furthermore, as noted earlier, health boards established by the Quarter Sessions to deal specifically with public health threats lacked clear legal authority to enforce public health regulations.\textsuperscript{39} Few if any such regulations existed prior to 1832, when the cholera epidemic forced municipalities to act. By contrast, local regulation and administration of health affairs was well established in Nova Scotia by this time, a fact that, as will be seen in the next chapter, is of some consequence in comparing the influence of localized legal responses to public health matters in both jurisdictions.

Reform of this flawed system began with the enactment of the \textit{Board of Health and Infectious Diseases Act} of 1833.\textsuperscript{40} The purpose of the Act was to “guard against the introduction of [m]alignant, [c]ontagious and [i]nfectious diseases, and for the

\textit{manual being a complete digest of the criminal law, and a compendious and general view of the provincial law; with practical forms, for the use of the magistracy of Upper Canada} (Toronto: Upper Canada Gazette Office, 1835). The topic “public health” was missing from the inaugural edition, but was included in the second edition. See supra note 13. Cf John George Marshall, \textit{The Justice of the Peace and County and Town Officer, in the Province of Nova Scotia, Being a Guide to such Justice and Officers in the Discharge of their Official Duties} (Halifax: Gossip & Coade, 1837) ("[w]ith regard to…magistrates, although in general selected from the most suitable persons, yet the greater number…are but of ordinary education…they have but little leisure for the acquisition of any particular knowledge of the [l]aws" at iv to v). Although Marshall is referring to justices of the peace in Nova Scotia, same is most likely true of their Ontario counterparts. See generally Phillips, supra note 6.

\textsuperscript{38} See generally EJ Senkler, \textit{The Jurisdiction of the Courts of General Sessions of the Peace in the Province of Ontario} (Toronto: Carswell, 1885) 2-4.

\textsuperscript{39} Patterson, supra note 9 at 176. Patterson observes further that “[v]arious forms of quackery were urged upon the public,” especially by the press, which served to undermine the implementation of public health measures. \textit{Ibid} at 177.

\textsuperscript{40} Supra note 1.
preservation of the public health of the Province.”\textsuperscript{41} However, the Act did not make extensive provisions for achieving this purpose, but merely authorized the Governor to appoint three or more persons to serve as health officers in “each and every town”\textsuperscript{42} in the Province, and to enact regulations to govern the entry and departure of watercrafts, passengers and cargo into the Province “as shall be thought best calculated to preserve the public health.”\textsuperscript{43} The powers and duties of the health officers, who also served as the local board of health, were limited merely to sanitary inspections and ordering the cleansing, removal or destruction of public health threats.\textsuperscript{44} However, the health officers could call upon the assistance of constables and peace officers in discharging these responsibilities.\textsuperscript{45} Offences under the Act, such as resisting or obstructing health officers in the performance of their duties, were to be laid before Justices of the Peace for the district where the offender(s) resided.\textsuperscript{46}

It is doubtful that the appointment of health officers and the establishment of local boards of health accomplished much in raising the profile of public health in the province or in facilitating a more efficient response to public health threats and issues. Compared with similar legislation in other jurisdictions, the Act was lacking in several important respects. As we have seen, the responsibilities of the local boards of health were limited to superintending sanitary matters,\textsuperscript{47} and the Act did not provide for various other methods of dealing with infectious disease outbreaks. By comparison, the Nova Scotia

\textsuperscript{41} Ibid, s 1.
\textsuperscript{42} Ibid.
\textsuperscript{43} Ibid, s 3.
\textsuperscript{44} Ibid, s 2.
\textsuperscript{45} Ibid.
\textsuperscript{46} Ibid, s 4.
\textsuperscript{47} See Firth, supra note 3 at 257.
legislature enacted the colony’s first infectious disease legislation in 1761, and by 1800, the colony’s laws had been expanded to provide for smallpox inoculation, quarantine, removal and isolation of infected or exposed persons, notifications regarding the existence of infectious diseases, and placarding of infected houses.

The narrow scope of the health officers’ powers also meant that the ineffective magistrates of Quarter Sessions remained in charge of matters of public health not specifically addressed by the Act. Also, as noted above, the local boards of health seem to have experienced considerable difficulty with obtaining finances to support the discharge of their duties.

The provisions of the 1833 Act appear to have been adopted from earlier Lower Canada quarantine statutes. By 1833, the Province of Lower Canada had a well-established and robust legal framework for public health, management of infectious diseases, and health care in general. Between 1795 and 1833, the Province enacted several health-related statutes that addressed a range of subjects, including quarantine, smallpox vaccination, care of sick immigrants, regulation and licensing of medical practice, public health and

48 See An Act to prevent the spreading of contagious distempers, SNS 1761 (1 Geo 3), c. 6.
49 See An Act in addition to an Act, made in the first year of his present Majesty’s reign, entitled, an Act to prevent the spreading of contagious distempers, SNS 1775 (15 & 16 Geo 3), c 2; An Act in amendment of an Act, passed in the first year of his present Majesty’s reign, entitled, an Act to prevent the spreading of contagious distempers, and also in amendment of an Act, passed in the sixteenth year of the said reign, entitled, an Act in addition to the before recited Act, SNS 1799 (39 Geo 3), c 3. See Chapter 3, below, for more on this topic.
50 See supra note 28 and accompanying text; Atkinson, supra note 17 at 320-331.
51 See An Act to oblige ships and vessels coming from places infected with plague or any pestilential fever or disease, to perform quarantine, and prevent the communication thereof in this Province, SLC 1795 (35 Geo 3), c 5 [Quarantine Act of 1795]; An Act to give further powers to the Executive Government to prevent the introduction or spreading of infectious or contagious diseases in this Province, SLC 1800 (40 Geo 3), c 5 [Quarantine Act of 1800].
infectious diseases, appropriations to healthcare charities, and establishment of hospitals. The earliest statute, enacted in 1795, enjoined the quarantine of all vessels and persons arriving in the Province through the Saint Lawrence River from places infected with the “plague or any pestilential fever or disease.” Three separate pieces of legislation, passed in 1815, 1817 and 1821, authorized appropriations for provision of free optional vaccination in the districts of Quebec, Montreal, Three Rivers and Gaspé. These statutes represent the earliest governmental effort to use vaccination “to check and arrest the progress of…[s]mall-Pox” in British North America. Appropriations authorized by the statutes were used to retain medical practitioners to administer vaccinations, and to keep and transmit to the government a record of information relating to persons vaccinated and the existence of endemic diseases in areas visited. The 1817 statute also authorized the establishment of a “Board of Vaccination” constituted by five “licensed and practicing [p]hysicians or [s]urgeons” resident in Quebec City. The Board was charged with managing vaccination funds and overseeing the implementation of the Act. The Board was the first and only governmental institution dedicated solely to management of smallpox and vaccination in British North America.

52 For a list of statutes, see Ordinances and Acts of Lower Canada before the Union, Consolidated Statutes for Lower Canada 1861, Sch C.
53 See Quarantine Act of 1795, supra note 51, Preamble.
54 See An Act to encourage and diffuse the practice of vaccine inoculation, SLC 1815 (55 Geo 3), c 6.
55 See An Act to appropriate a certain sum of money therein mentioned, for the promotion of vaccine inoculation, SLC 1817 (57 Geo 3), c 15.
56 See An Act to encourage the practice of vaccine inoculation and to appropriate a certain sum of money for that purpose, SLC 1821 (1 Geo 4), c 7.
57 See ibid, s 3; supra note 53, Preamble; supra note 54, s 2.
58 Supra note 55, s 2.
59 See supra note 54, s 3.
60 Ibid.
By contrast, Upper Canada legislation in the same period consisted entirely of statutes dealing with the licensing of medical practice and appropriations for various health-related purposes. The statutes in the latter category were enacted between 1830 and 1833 and provided public funds for the care of insane persons and destitute immigrants and repayment of private monies advanced to local officials by Lieutenant Governor John Colborne for the care of persons affected by the cholera epidemic.

The Lower Canada vaccination program was discontinued around 1823 (appropriations authorized by the 1821 statute ended in the same year, and there is no record of subsequent appropriations for vaccination purposes). Reasons for the discontinuance of the program include disputes surrounding the membership of the Board of Vaccination and between Board members and vaccinators over vaccination directives issued by the Board, disagreements among members of the medical profession over the value of vaccination, and resistance to vaccination by members of the public who preferred inoculation or who did not like the aggressive strategies employed by the Board in promoting vaccination. Following the lapsing of the vaccination program, further enactments provided for the establishment and appropriation of funds to hospitals.

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61 See e.g. *An Act to regulate the practice of physic and surgery*, SUC 1795 (35 Geo 3), c 1.
62 See e.g. *An Act to authorize the Quarter Sessions of the Home district to provide for the relief of insane destitute persons in that district*, SUC 1830 (11 Geo 4), c 20; *An Act granting one hundred pounds in aid of the funds of the Female Benevolent Society of Kingston*, SUC 1830 (11 Geo 4), c 32; *An Act granting a sum of money for the relief of sick and destitute emigrants at Prescott*, SUC 1833 (3 Will 4), c 52.
63 See *An Act to provide for the re-payment of certain sums of money advanced by his Excellency the Lieutenant Governor in the year one thousand eight hundred and thirty-two, during the prevalence of the Asiatic Cholera*, SUC 1833 (3 Will 4), c 54; *An Act granting to his Majesty a certain sum of money to enable His Majesty to defray certain charges incurred during the prevalence of the cholera during the last summer*, SUC 1833 (3 Will 4), c 57.
64 See Barbara Tunis, “Public Vaccination in Lower Canada, 1815-1823: Controversy and a Dilemma” (1982) 9:1/2 Historical Reflections 264.
65 See *ibid* for a full discussion.
receiving and treating immigrants suffering from infectious and contagious diseases.  

Preventing the importation of immigrant diseases remained the sole focus of health legislation prior to union with Upper Canada.

Why was Upper Canada slow to enact public health or infectious disease legislation? Available historical records, consisting mainly of personal correspondence from Ontario residents in the pre-union era, suggest the reason is not an absence of infectious disease outbreaks or other public health threats. For instance, on 19 January 1837, John Macaulay, a businessman, militia officer and member of the Legislative Council of Upper Canada from 1839-1841, wrote to his mother Ann Macaulay in Kingston that “there is continually some epidemic or another prevailing” in Toronto, and that a recent smallpox outbreak had “in one instance...proved fatal.” Similarly, a letter dated 4 July 1838 and addressed to John Strachan, teacher, Anglican Archbishop of York and one-time member of the Legislative and Executive Councils of Upper Canada, recommends the appointment of one Dr. Darling to oversee a possible smallpox outbreak among “Roman Catholic[]” Indian settlers on Manitoulin Island in the Lake Huron region. The letter also expresses regret over “want of proper exertions on the part of the [government]” regarding the matter.

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66 See e.g. An Act to appropriate a certain sum of money there-in mentioned, towards the support of the emigrant hospital established in Quebec, SLC 1829 (9 Geo 4), c 2.
67 See John Macaulay to Ann Macaulay (19 January 1837), Toronto, Archives of Ontario (Macaulay Family fonds, F 32, MS 78, reel 2).
68 Ibid.
69 See TG Anderson to John Strachan (4 July 1838), Toronto, Archives of Ontario (Papers of John Strachan, F 983-1, MS 35 reel 3).
70 Ibid.
Earlier records suggest similar outbreaks. Richard Russell, father of Peter Russell, who was Upper Canada’s first receiver-general and a close friend of Chief Justice William Osgoode,71 lost two daughters to outbreaks of smallpox and tuberculosis in or around 1751 and 1797.72 In 1788, Thomas Ridout, an Upper Canada politician, wrote to his son Samuel advising him to seek inoculation for smallpox.73 Archbishop Strachan, in a letter to Ann Macaulay dated 15 August 1804,74 wrote about an epidemic affecting the health of his pupils in Kingston.75 In August 1822, a smallpox epidemic was reported “in the vicinity of the [army] Garrison” stationed at York.76 Isabel Mackenzie, the 19-month infant daughter of William Lyon Mackenzie — Toronto’s first mayor, member of the Legislative Assembly of Upper Canada, and a leader of the Rebellion of 1837 in Upper Canada — died of smallpox on December 23, 1824, during an outbreak that began in the fall of 1824 and persisted till around late January 1825.77 As previously noted, a smallpox

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73 See Thomas Ridout to Samuel Smith Ridout (24 February 1788), Toronto, Archives of Ontario (Thomas Ridout family fonds, F 43-1-10, MS 537, reel 1).
74 John Strachan to Ann Macaulay (15 August 1804), Toronto, Archives of Ontario (Macaulay family fonds, F 32, MS 78, reel 1).
76 See Major Harry Powell to Hillier (2 August 1822), Ottawa, Library and Archives Canada (Upper Canada Sundries, vol 57, RG 5, A1); Dr. Duncanson to Major Powell (2 August 1822), Ottawa, Library and Archives Canada (Upper Canada Sundries, vol 57, RG 5, A1).
77 See Firth, supra note 3 at 230; Peter Paterson to William Lyon Mackenzie (8 January 1825), Toronto, Archives of Ontario (Mackenzie - Lindsey family fonds, F 37, MS 516, reel 1); Matthew Crooks to William Lyon Mackenzie (11 January 1825), Toronto, Archives of Ontario (Mackenzie - Lindsey family fonds, F 37, MS 516, reel 1); Thomas Fyfe to William Lyon Mackenzie (3 January 1825), Toronto, Archives of Ontario (Mackenzie - Lindsey family fonds, F 37, MS 516, reel 1).
outbreak among prisoners in the Lincoln County jail in January 1829 provoked an inquiry by the county Quarter Sessions.  

The availability and use of vaccination during this period also suggests the presence of smallpox, as well as the early adoption of the procedure in Upper Canada. A letter from Ann to John Macaulay, dated 3 April 1838, states, for example:

William writes me that Ann[e] before she was married was vaccinated for the kine pock and it took. The small pox being in the place he sent for the doctor to vaccinate the little girl who lives with them and they thought they would try if there was any truth in the report of losing its effect in preventing its taking the small pox or being liable to take it again so she was vaccinated, took it and was doing very well.

The procedure also received the endorsement of high ranking government officials such as Samuel P. Jarvis, a lawyer who held various positions in the civil service, including Clerk of the Crown in Chancery, Assistant Secretary and Registrar of the Province of Upper Canada, Sheriff of the Home District, and Chief Superintendent of Indian Affairs.

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78 See supra note 10. See also James R Armstrong to Margaret (Rogers) Greeley (21 October 1807), Toronto: Archives of Ontario (F 533-2, container B230681, File F 533-2-0-69) stating that a fellow named Edmund had just recovered from smallpox.
80 Anne Catherine Geddes, William Macaulay’s first wife. They married in 1829; Anne died 20 April 1849. William remarried in 1852, to Charlotte Sarah Vesconte. See ibid.
81 See Ann Macaulay to John Macaulay (3 April 1838), Toronto, Archives of Ontario (Macaulay family fonds, F 32, MS 78, reel 3).
82 See Samuel P Jarvis to Mary Jarvis (9 Dec 1842), Toronto, Archives of Ontario (Samuel Peters Jarvis and William Dummer Powell collection, F 31, MS 787, reel 2, file 318).
Infectious diseases other than smallpox are also mentioned in correspondence from this period.\textsuperscript{83} Between 1831 and 1832, just before the arrival of cholera, various diseases prevailed in the town of York, including measles, scarlet fever and croup.\textsuperscript{84} The period in York’s history was described in a letter addressed to John Macaulay, as follows:

\begin{quote}
[T]his is an afflicted town at the moment—scarce a family without sickness or death in their dwellings. I have not left the house for a week confined by illness, & once only the last ten days, when I mustered strength and resolution to follow one of my dear little ones aged 5—to his grave—another lies very ill, & one of my household a bound girl rather dangerous—Col Wells poor man has two now lying in his house to be consigned to the [t]omb tomorrow I believe—[m]easles with inflammation, [s]carlet fever, and croup among the [c]hildren, & inflammatory attacks from violent colds & coughs among the adults—‘tis altogether a most distressing time, & our medical men are nearly won out.\textsuperscript{85}
\end{quote}

Government officials in Upper Canada were also likely to have been aware of the prevalence of infectious disease epidemics and legal developments directed at preventing the spread of such diseases in nearby jurisdictions. As noted in the introductory chapter, smallpox and other infectious diseases were endemic to the entire continent of North America throughout the eighteenth and nineteenth centuries, and Nova Scotia, Western Canada and Prince Edward Island suffered several major disease epidemics between 1732 and 1838.\textsuperscript{86} Smallpox was a major cause of death in Nova Scotia in the later half of

\textsuperscript{83} See Firth, \emph{supra} note 3 at lxiii.
\textsuperscript{84} See R Stanton to John Macaulay (21 December 1831), Toronto, Archives of Ontario (Macaulay family fonds, F 32, MS 78, reel 2); John Kirby to John Macaulay (21 December 1831), Toronto, Archives of Ontario (Macaulay family fonds, F 32, MS 78, reel 2).
\textsuperscript{85} \emph{Ibid}.
the eighteenth century, surpassed only by drowning, and “the disease that...surgeons were most frequently asked to treat.” Infectious disease epidemics were also common and widespread in the U.S. and Britain, two countries from which immigrants to British North America originated. In neighbouring New York for example, smallpox was the leading cause of disease related mortality, with 3313 deaths between 1805 and 1840, and the highest number of deaths per year, surpassed only by cholera in 1832 and 1834.

A series of legislation dealing with smallpox and vaccination also emerged in nearby jurisdictions during this period. In addition to the Lower Canada vaccination statutes discussed earlier, concerns over the introduction and spread of smallpox triggered the enactment of various infectious disease statutes in Nova Scotia, including a 1761 statute that established measures for preventing the importation of smallpox or other contagious distemper into the colony, a 1775 statute that provided for the quarantine and flagging of houses where persons inoculated with smallpox were residing out of concern that
inoculation might be contributing to the spread of smallpox, and another statute in 1799 that limited inoculation with smallpox to specified periods during the year.

In nearby Massachusetts, the state legislature passed a statute to regulate and provide for smallpox vaccination in 1809, and in 1827, Boston became the first North American city to require mandatory vaccination of public school children. In Britain, common law developments had established legal precedents for dealing with the spread of smallpox, and prior to 1815, smallpox and vaccination matters were often on the legislative agenda, either through financial appropriations and awards to Edward Jenner to support his vaccination research, or through legislative bills that variously sought (unsuccessfully) to prevent the establishment of inoculation houses, compel the removal and isolation of persons infected by smallpox, require mandatory notification and certification of inoculations, quarantine of inoculated persons and flagging of their places of abode, and

92 See supra note 49. See also Marble, supra note 86 at 103-107.
93 See An Act for regulating the practice of inoculating for the small pox, SNS 1799 (39 Geo 3), c 7. See also Marble, ibid at 158-9. Further discussion of these statutes will be found in Chapter 3, below.
94 See An Act to diffuse the benefits of inoculation for the cow pox, c 117, 1809 Mass Acts 204.
96 See e.g. R v Vantandillo (1815), (1815) 4 M & S 72, 105 ER 762 KBD (mother of a child infected with smallpox sentenced to three months imprisonment for carrying the child through a public street. The judgment established the common law offence of unlawfully, injuriously, and knowingly exposing a person infected with a contagious disorder in public); R v Burnett (1815), 4 M & S 272, 105 ER 835 KBD (apothecary who inoculated children with smallpox and allowed them to be carried along a public street while suffering from the disease guilty of indictable offence); R v Luellin (1701), (1796) 12 Mod 445, 88 ER 1441 KBD (indictment against an inn-keeper for not receiving a guest infected with smallpox quashed because the guest did not state he was a traveler); Baines v Baker (1752), Amb 158, 27 E.R. 105 (refusal to grant injunction to stay building of inoculation hospital as there was no common law precedent for holding that the act amounted to a nuisance); R v Sutton (1767), (1767) 4 Burr 2116, 98 ER 104 KBD (motion to quash nuisance indictment for erecting and keeping inoculation houses denied).
provide for free vaccination of poor persons through licensed vaccinators working under contracts for services with overseers of the poor.\textsuperscript{97} In both jurisdictions, various existing methods of dealing with smallpox and other infectious diseases, including quarantine of vessels, isolation and removal of infected persons, flagging of infected houses, disinfection, inoculation and vaccination were also incorporated into legislation.\textsuperscript{98}

A compelling explanation for the lag in Upper Canada’s legal response to public health and infectious diseases matters is that prior to 1832, disease outbreaks within the province and in nearby jurisdictions simply did not create as much cause for concern as the 1832 cholera epidemic did. Compared with the province-wide cholera epidemic that persisted from 1832 to 1834, the outbreaks described in the private correspondences discussed earlier were sporadic and isolated to different locations within the province. As one commentator has observed, frequent, sustained or widespread disease outbreaks were uncommon in Upper Canada during this period because the “immense area of the province” was occupied by a “comparatively small and scattered population” of settlers


\textsuperscript{98} See e.g. An Act to prevent the spreading of contagious sickness, c 16, 1797 Mass Acts 356; An Act for, providing hospitals for inoculation, and preventing infection from the small-pox, and for repealing several acts heretofore made for that purpose, c 58, 1792 Mass Acts 85; An Act in addition to an Act, entitled, “An Act to prevent the spreading of contagious sickness”, c 59, 1799 Mass Acts 439; An Act for erecting a lazaret on Chetney Hill, in the County of Kent; and for reducing into one Act the laws relating to quarantine; and for making further provision therein, 1800 (UK), 39 & 40 Geo III, c 80; An Act to establish regulations for preventing contagious diseases in Ireland, 1819 (UK), 59 Geo III, c 41. See generally Brunton, ibid.
who did not often come in contact with one another.\textsuperscript{99} Also, unlike littoral provinces such as Lower Canada and Nova Scotia, inland-located Upper Canada was not a primary entry point for disease-bearing immigrants. Comparatively, Upper Canada experienced fewer immigration-linked outbreaks, and government officials likely did not perceive the province as facing a constant threat from imported diseases.\textsuperscript{100} Upper Canada government officials may have also believed that the province was protected by established and robust disease prevention and management measures at the primary points of entry into British North America.\textsuperscript{101}

The link between immigration and diseases in coastal locations is discussed in government reports from this period. A report issued by the Lower Canada Central Board of Health notes for example:

\begin{quote}
The subject of immigration is one that must be of vital importance to a country which, like Canada, is susceptible of such rapid and immense development. In so rich a field, the value of human labour attains a price to which no parallel can be drawn in other countries, and a due supply of which from without is necessary to the very existence of the Province. It therefore becomes a question of the greatest interest to the politician, as well as the philanthropist, how the health and well-being of those seeking a new home in this Province, may be best cared for in their passages to their various destinations. Many of the thousands, who, year after year, are thronging up the St. Lawrence, probably leave their homes under the pressure of poverty entailing a scanty supply of the necessaries of life, and consequent depression of bodily vigor, if not the first symptoms of disease. Thus situated, they are exposed to the unhealthy influence of a crowded vessel, which all the efforts of an active emigration department must at times fail to prevent. Arrived here, if they have not already succumbed to disease on the voyage, the seeds of which they have brought
\end{quote}

\textsuperscript{99} See supra note 20 at 24.
\textsuperscript{100} See Atkinson, supra note 17 (“another possible explanation for Colborne’s reluctance to implement a general quarantine [during the 1832 cholera epidemic] lies in the relative isolation of Upper Canada” at 94).
\textsuperscript{101} But see Atkinson, supra note 17 at 94-5.
from their native places, they fall too ready victims to epidemic or incidental disease in Canada.\textsuperscript{102}

Statistical accounts also suggest an association between immigrants and disease. For instance, of the 98,106 immigrants that arrived at the port of Quebec in 1847, 8,961 were admitted to Grosse Île Hospital and over 5000 died of typhus fever.\textsuperscript{103} Indeed, the Grosse Île Hospital and human quarantine station were established to prevent disease-bearing immigrants from entering Lower Canada through the busy Port of Quebec.\textsuperscript{104} By 1800, similar measures, including robust immigration restrictions, were in place in Nova Scotia\textsuperscript{105} and New York.\textsuperscript{106}

A related reason for the lag is that public health measures such as quarantine and cleansing of incoming vessels may have been viewed as politically and economically inadvisable at a time when politicians in the Canadian provinces were seeking to “populate and develop the provinces.”\textsuperscript{107} As Robert Bothwell has observed, the government of Upper Canada actively “sought out settlers, either directly or through


\textsuperscript{103} See \textit{supra} note 20.

\textsuperscript{104} See \textit{An Act to establish boards of health within this Province, and to enforce an effectual system of quarantine}, SLC 1832 (2 Will 4), c 16, s 21. See also JD Page, “Grosse Isle Quarantine Station” (1931) 22:9 Canadian Public Health Journal 454; CA Mitchell, “Events Leading up to and the Establishment of the Grosse Isle Quarantine Station” (1967) 23:11 Medical Services Journal, Canada 1436.

\textsuperscript{105} See \textit{supra} note 49 and accompanying text.

\textsuperscript{106} See \textit{supra} note 89 at 40-41.

some intermediary,” and during the 1820s and 1830s the population of Upper…Canada virtually exploded...mainly [as a] result of immigration.” Similarly, Marian Patterson has noted that even when faced with the 1832 cholera epidemic, “[b]usiness interests on both sides of the Atlantic were strongly opposed to [public health] measures which hampered trade and commerce” between Britain and its North American colonies or “unnecessarily hindered emigration” to the colonies. Thus, for example, an Order in Council issued by the Privy Council on March 27, 1832 requiring British ships sailing to North America to have a surgeon and medical chest on Board and the daily airing of passenger bedding during the voyage was vehemently opposed in Parliament and ultimately rescinded. Atkinson’s examination of the historical evidence on government decision-making during the 1832 cholera epidemic further suggests that the provincial government was worried that establishing quarantine measures would pose a threat to “continued high levels of immigration” and commercial activity in the province. To sum up, concern over the impact of restrictive quarantine policies on immigration to the province, coupled with reliance on protective measures at primary points of entry, most likely served to delay the establishment of public health measures in Upper Canada.

108 Ibid.
109 Ibid at 167.
110 Patterson, supra note 9 at 169.
111 Ibid.
112 See ibid at 168-69.
113 Atkinson, supra note 17 at 98.
114 See ibid. Vaccination policies attracted similar concerns about impacts on business interests in the first quarter of the twentieth century. See e.g. “Soo Perry ties up”, The Globe (17 December 1919)2 (vaccination regulations requiring travellers from Canada to the US to be vaccinated “resulted in serious loss of business to the ferry service,” causing it to become grounded); “Getting less strict over vaccination”, The Globe (9 February, 1920) 4 (US officials to vacate ban on travel from Canada without proof of vaccination after “[m]erchants over the river…complained bitterly of the loss of Canadian trade owing to smallpox regulations”).
Another likely reason for the delay in implementing public health measures is low levels of public support for public health causes. Enacting public health legislation would have necessitated allocating public funds to support implementation of measures that many considered “a useless expenditure of money.” Adam Shortt has noted, for example, that successive assessment statutes passed by the Upper Canada legislature between 1793 and 1840 made appropriations to the Quarter Sessions to support various local causes, but never included any objects relating directly to health care or public health. Although municipalities were authorized to levy taxes, the amount they could spend was capped, and it was common for the legislature to impose a duty on municipalities to fund new services from the limited funds made available to them. The latter issue is addressed in a report presented on March 9, 1836 by D. Boulton, chairman of the Home District Quarter Sessions, to the Upper Canada House of Assembly. The report states:

[W]ith an increased population the amount of rates must also have experienced a somewhat proportionate degree of increase, yet that the funds arising from this source have at the same time been rendered applicable to other purposes than those previously contemplated, leaving them chargeable, not only with those ordinary items of district expenditure which the law in the first place had in view but rendering them by subsequent statutes, chargeable with the payment of other and new services without providing any additional means for meeting them… The result of the operation of the law as it now stands, is to entail on the district funds [expenses], which independent of the increased expenditures which have been imposed upon them without any extra means for defraying the additional charges, cannot fail of impressing upon the magistrates the conviction, that unless a remedy is applied in the proper

115 See supra note 20 at 8.
117 See ibid at 75; Firth, supra note 3 at lxix.
quarter it will not be in their power to meet these increasing demands with the degree of punctuality so desirable in the conduct of public affairs.\textsuperscript{119}

Furthermore, without formal legislative enactments authorizing appropriation of public funds for public health purposes, it is doubtful that municipalities generated enough funds for or voted to apply limited funds to public health matters. During the 1832 cholera outbreak, York magistrates ignored or refused to grant an application from their own Board of Health for funds to purchase a wagon for removing infected persons to the hospital and to increase the wages of the Health Officer.\textsuperscript{120} Efforts by the Board to raise money through “[i]mperative [c]alls on the public benevolence [on] behalf of the numerous [w]idows & [o]rphans left [d]estitute”\textsuperscript{121} by cholera proved unfruitful. The Board dissolved shortly after, citing “want of legal authority and of funds [to] mitigate the evils of the dreadful pestilence…raging in” York.\textsuperscript{122} With these constraints on local government funds, municipal officials were therefore “not likely to indulge extravagant conceptions of civic improvement,”\textsuperscript{123} including preventative public health measures.

\textsuperscript{119} Ibid at 11-12.
\textsuperscript{120} See Minutes of the Board of Health (22 June 1832), Toronto, Academy of Medicine (York Board of Health Minute Book); Minutes of the Board of Health (8 August 1832), ibid. See also Firth, supra note 3 at 246, 249.
\textsuperscript{121} See Minutes of the Board of Health (8 August 1832), ibid.
\textsuperscript{122} “Dissolution of Board of Health”, Courier of Upper Canada (15 August 1832).
\textsuperscript{123} Shortt, supra note 31 at 75. Municipal funding issues persisted well into the twentieth century, and were, in particular, a source of legal disputes between municipalities and medical doctors over unpaid bills for attending to smallpox patients. See e.g. Bogart v Corporation of Seymour, (1885), 10 OR 322 (Ch) (plaintiff physician sued the municipality of Seymour for unpaid bills for vaccination services rendered by order of the board of health); Johnston v The Municipality of the County of Halifax (1913), 9 DLR 220, 46 NSR 474 (NS SC) (claim for payment for services rendered in connection with suppression of infectious diseases); Bibby v Davies (1902), 1 OWR 189, 1902 CarswellOnt 147 (plaintiff physician successfully recovered partial costs of attending to smallpox patient and the monetary value of clothing and other items destroyed by order of the board of health of the township of Euphrasia).
The *Board of Health and Infectious Diseases Act* of 1833 expired at the end of the next legislative session, about a year from when it came into force. A new public health statute followed in 1835.\(^\text{124}\) However, other than a provision empowering boards of health or the majority of inhabitants of any town or city to compel the removal and isolation of persons infected with malignant diseases, it did not address or rectify many of the gaps in the 1833 Act. The 1835 Act also expired after one year, was continued in 1837,\(^\text{125}\) and ultimately made perpetual in 1839.\(^\text{126}\) The 1839 Act was the last major piece of legislation dealing with public health and infectious diseases in Upper Canada prior to union with Lower Canada. It remained in force in the Province following union by virtue of section 46 of the *Act of Union*,\(^\text{127}\) which provided for the continuance solely within each province of laws enacted by the respective provincial legislatures prior to union.\(^\text{128}\)

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\(^{124}\) See *An Act to promote the public health, and to guard against infectious diseases in this Province*, SUC 1835 (5 Will 4), c 10.

\(^{125}\) See *An Act to continue for a limited time an act entitled, "An Act to promote the public health, and to guard against infectious disease in this Province*, SUC 1837 (7 Will 4), c 26.

\(^{126}\) See *An Act to continue and make perpetual an Act passed in the fifth year of the reign of King William the Fourth, entitled “An Act to promote the public health, and to guard against infectious diseases in this Province*, SUC 1839 (2 Vict), c 21 [Board of Health and Infectious Diseases Act of 1839].

\(^{127}\) See *An Act to re-unite the Provinces of Upper and Lower Canada, and for the Government of Canada*, S Prov C 1840 (3 & 4 Vict), c 35.

\(^{128}\) See *ibid*, s 46.
2.2 Smallpox, Vaccination and the Law: From Union to Centralized Governance of Public Health

2.2.1 Legislative Developments in the Union Era

In 1849, following the union of Upper and Lower Canada, the Province of Canada legislature enacted three public health statutes relating to public health emergencies,\(^{129}\) quarantine\(^{130}\) and immigration\(^{131}\) respectively.

Although the statutes applied to the entire union, the latter two dealt with matters relating to ports of entry into the Province of Canada, all of which were located in Lower Canada. The quarantine statute was a minor amendment of earlier Lower Canada quarantine legislation, and the immigration law, which repealed a number of existing statutes dealing with immigration matters, aimed to encourage the introduction of a “healthy and useful class” of immigrants into the Province, and to prevent indigent persons “labouring under disease” from immigrating into the United Province.\(^{132}\) To achieve these aims, the statute made provisions for the levying and collection of duties from vessels arriving at the Ports of Quebec and Montreal for the purpose of defraying expenses incurred for medical examination and care of destitute immigrants.\(^{133}\)

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\(^{129}\) See *An Act to make provision for the preservation of the public health in certain emergencies*, S Prov C 1849 (12 Vict), c 8 [*Public Health Emergencies Act of 1849*].

\(^{130}\) See *An Act to amend the Quarantine Act*, S Prov C 1849 (12 Vict), c 7.

\(^{131}\) See *An Act to repeal certain Acts therein mentioned, and to make further provision respecting emigrants*, S Prov C 1849 (12 Vict), c 6.


\(^{133}\) *Ibid*, s 2.
In 1852, all Province of Canada statutes relating to immigration and quarantine were consolidated, with amendments, under one Act. A major amendment empowered the Governor in Council to make regulations for quarantine and to establish measures for preventing the introduction of diseases into the Province. This change is significant for two reasons. Firstly, it marked a formal separation of quarantine and immigration matters from public health and health care, which remained largely under the jurisdiction of municipal officials. Secondly, the change made quarantine and immigration — formerly subjects governed exclusively by each constituent colony — matters of common interest to the union. The latter reason likely set the wheels in motion for the inclusion of quarantine and immigration under the legislative authority of the Dominion Parliament at the time of confederation.

The third statute, relating to public health emergencies, made provisions for the management of emergencies caused by infectious disease outbreaks or epidemics. The statute authorized the Governor to issue a proclamation declaring a public health emergency and outlining measures for dealing with such emergency whenever the Province or any part of it was threatened “with any formidable epidemic, endemic or

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134 See *An Act to amend and consolidate the laws relative to emigrants and quarantine*, S Prov C 1853 (16 Vict), c 85. The Act received royal assent on 22 April 1852.

135 Support for this view is suggested in resolutions passed by the committee of the Legislative Assembly charged with reviewing the consolidated bill. See *Journal of the Legislative Assembly of the Province of Canada*, 4th Parl, 1st Sess, vol 2 (15 March 1853) at 587. The resolutions cite the following justifications for the consolidation: the prevention of importation of contagious or infectious diseases into the united Province, authorizing the Governor in Council to make permanent regulations for quarantine, and establishment of duty rates for both arriving immigrants and those transiting through Canada to the United States. *Ibid*.

136 See *British North America Act*, 1867 (UK), 30 & 31 Vict, c 3, s 91, 95. The power to legislate on immigration is concurrent. See *ibid*, s 95.
contagious disease.” Proclamations were to remain in effect for six months, unless revoked earlier by the Governor. This meant that the Act simply authorized temporary measures for managing infectious disease threats and outbreaks. While the Act did not repeal extant public health statutes in the constituent provinces, it suspended the operation of parts of Upper Canada’s *Board of Health and Infectious Diseases Act* of 1839, as well as all local by-laws on the subject of health, but only for the period during which the emergency proclamation was in effect.

A major feature of the *Public Health Emergencies Act* of 1849 was the creation of temporary boards of health to serve for the duration of the emergency proclamation. The Act empowered the Governor to appoint five or more persons to serve on a provincial board known as the Central Board of Health. Municipal mayors (or the chief municipal officer in places without mayors) were similarly empowered to appoint temporary local boards of health. Municipalities that failed to appoint a board of health would have one appointed for them by the Governor.

Under the Act, the Central Board was vested with wide powers to “issue such directions or regulations as they shall think fit” and to adopt any measure for the “prevention...or

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137 *Supra* note 129, Preamble.
141 See generally *ibid*, ss 3-4.
mitigation of epidemic, endemic or contagious diseases.” The Central Board could also assign duties to local officials and supervise local implementation of emergency measures. However, although serious disease outbreaks occurred during the period when the emergency statute was in force, none was considered serious enough to trigger the establishment of a Central Board of Health.

Except for emergencies, the management of public health and infectious diseases remained within the jurisdiction of the constituent provinces in United Canada. However, the Upper Canada legislature did not enact any new public health or infectious disease statutes prior to confederation. Post-confederation, the Ontario legislature passed the province’s first public health statute in 1873. The latter statute was essentially a consolidation of the Board of Health and Infectious Diseases Act of 1839 and the Public Health Emergencies Act of 1849, and did not introduce any new provisions. Moreover, prior to 1873, there appears to have been no attempts to bolster implementation of the Board of Health and Infectious Diseases Act of 1839, whether through authorizing increased appropriations for public health work or by expanding the authority of local boards of health. By contrast, Lower Canada entered the union with a very robust public health system.

Ibid.

The Act remained in force past confederation. A revised version was passed by the Dominion Parliament in 1868. See An Act relating to quarantine and public health, SC 1868 (32 Vict), c 63, ss 7-15. On disease incidence during this period, see F Marson, “Analytical Examination of all Cases Admitted, During Sixteen Years, at the Smallpox and Vaccination Hospital, London, with a View to Illustrate the Pathology of Small-pox, and the Protective Influence of Vaccination” (1854) 4 Upper Canada Journal of Medical, Surgical and Physical Science 236 [Marson 1854]; JF Marson, “On Small Pox and Vaccination: Analytical Examination of all the Cases Admitted During Sixteen Years, at the Small Pox and Vaccination Hospital, London; With a View to Illustrate the Pathology of Small Pox, and the Protective Influence of Vaccination, in Degrees Varying According as the Vaccination Has Been Perfectly or Imperfectly Performed” (1853) 36 Medico-Chirurgical Transactions 359 [Marson 1853].

See An Act respecting the public health, SO 1873, c 63.

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health governance framework, including a number of statutes dealing with various aspects of public health.\footnote{See e.g. supra notes 51 and 54-56; An Act to appropriate a sum of money to facilitate the execution of an Act therein-mentioned, commonly called the Quarantine Act, and for other purposes, SLC 1823 (3 Geo 4), c 20; An Act to appropriate a certain sum of money therein-mentioned, towards the support of the Emigrant Hospital, established in Quebec, SLC 1824 (4 Geo 4), c 32; An Act for the establishment of a temporary fever hospital for the reception of persons infected with contagious diseases, SLC 1830 (10 & 11 Geo 4), c 18; An Act to make further provision for preventing the introduction of contagious and pestilential diseases into this Province, SLC 1831 (1 Will 4), c 25; An Act to appropriate certain sums of money for the support of the Emigrant Hospital at Quebec and of the Fever Hospital at Point Levi, and for other purposes therein mentioned, SLC 1832 (2 Will 4), c 15; An Act to establish boards of health within this Province, and to enforce an effectual system of Quarantine, SLC 1832 (2 Will 4), c 16.}

It appears, therefore, that the amalgamation of Upper and Lower Canada did not cure the defects in or improve public health governance and infectious disease management in Upper Canada. While the pre-union era was marked by inertia and apathy in matters of public health, the remainder of the century can be characterized as involving a gradual shift toward centralized governance of public health, and to a lesser extent, socialized medicine. Smallpox vaccination played a pivotal role in the process of this shift, and associated legal developments produced ideas, arguments and arrangements that affected and influenced eventual outcomes. In the next section of this chapter, I trace and analyze the main elements of this shift, principally the role and impact of legal developments relating to vaccination and public health more broadly, and the relationship between smallpox vaccination, medical practitioners’ agitation for professional autonomy and centralization administration of public health, and the emergence of a communitarian ethos in public health governance.
2.2.2 Smallpox, Vaccination and the Path to Legal Management of Infectious Diseases

Besides cholera, smallpox was the only disease that consistently triggered legislative intervention in Ontario throughout the nineteenth century. After 1832, cholera also faded as a trigger for infectious disease legislation. There are three main reasons for the legislative attention paid to smallpox. First, smallpox was a constant threat and “a loathed and dreaded disease.” This point is captured in an 1853 editorial in the Medical Chronicle, a leading medical journal published in Montreal, as follows:

The hideous disfigurement of the features which is present during the different stages of the eruption, and the heavy, disagreeable odour which emanates from the person of the patient, particularly during the periods of maturation and desiccation, render him, for the time, an object of disgust even to those most nearly related to him by ties of consanguinity or affection. The deep pits and seams, moreover, the results of the cicatrization of the pustules, which too often remain after the subsidence of the eruption, is not less distressing to friends than to the person affected, from the great and permanent alteration which they make in the personal appearance of the individual. Since its first outbreak in Arabia...it has been distinguished, in its different epidemic visitations, by a rate of mortality greater than obtains in many other diseases. This, in conjunction with its repulsive character, sufficiently accounts for the manifestation of dread which is usually exhibited by the great majority of persons as it approaches a place, or makes its appearance among a community.

Mortality from the disease was also very high compared to other diseases. For example, between 1838 and 1851, Ontario experienced four severe smallpox epidemics, with a

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150 See A Von Iffland, “Observations on Small-Pox in the Rural Districts of Canada East” (1846) 1:10 British American Journal of Medical and Physical Science 257 (“[o]ne of the most destructive scourges in human society, the [s]mall-[p]ox...has within two years (and particularly the present one), exerted its direful influence in several sections of Lower Canada, and been attended with the most calamitous consequences and destruction of human existence” at 257-58).

151 “Compulsory Vaccination” (1853) 1:2 Medical Chronicle 57 at 57.

152 The Medical Chronicle was one of six medical journals in circulation in the Province of Canada during this period. Others include the Canadian Medical Journal and Monthly Record (1852-53), Montreal Medical Gazette (1844-45), Upper Canada Journal of Medical, Surgical and Physical Science (1851-54), British American Medical and Physical Journal (1850-52) and the British American Journal of Medical & Physical Science (1845-1850).

153 Supra note 151.
mortality rate of one third of those who contracted the disease.\textsuperscript{154} According to one account of a serious outbreak in Kingston in 1847, “funerals [from smallpox-related deaths] average[d] daily five or six” and in the hospital, there were over 200 sick persons with “sheds full to excess [with] small pox” victims.\textsuperscript{155} A similar rate of mortality was observed in an epidemic that ravaged Montreal in 1852-3. According to one description of the epidemic:

For the last year [1852] small pox has been epidemic in Montreal. The only source from which we could obtain information regarding its fatality was the register of deaths kept in the Seminary. The books were kindly placed at our disposal by Mr. Sancer. This gentleman, who makes the entries, stated that he feels convinced that many children who are entered without the name of the disease being appended, died from small pox. Those which we have selected were in every instance marked distinctly as having died of “Variola”. There were, from 2nd November, 1852, to the 1st January, 1853, 286 persons interred in the Roman Catholic burial places in the city. Of these 286, eleven died of small pox, the proportion to 1000 being 31.1. From the 1st January to the 30th June, 1853, the number of interments were 1065, of which 58 died from small pox. The mortality rising in those eight months to the high ratio of 54.4 in every 1000 deaths from all causes. We are certain that, were it possible to obtain correct information as to the number of deaths which have occurred from variola during each year, for the last five years, throughout Canada, the ratio in which they would stand to all deaths that have occurred during each year for the same period, would vary between 15 and 60 in the 1000.\textsuperscript{156}

Second, the political debates and legal reforms surrounding smallpox and vaccination in England attracted similar but much more muted reforms in Canada. Third, smallpox vaccination was a unique remedy that presented medical practitioners with the perfect tool to advocate for public health law reforms aimed at improving the social and

\textsuperscript{154} See Marson 1854, supra note 147. One of the outbreaks occurred in Toronto in 1842. See Samuel P Jarvis to Mary Jarvis (9 December 1842), Toronto: Archives of Ontario (MS 787, reel 2, file 318).
\textsuperscript{155} Rev W Herchmer to John Macaulay (9 July 1847), Toronto: Archives of Ontario (Macaulay Family fonds, F 32, MS 78, reel 5). The outbreak also reached the town of York. See George M Murray to Miss Eliza Powell (13 January 1847), Toronto: Archives of Ontario (MS 787 reel 2, file 437).
\textsuperscript{156} Supra note 151 at 61-2.
economic status of their profession. I expand on the latter two reasons in the next two sections.

2.2.3 Britain’s influence on the legal adoption of vaccination in Canada

In 1853, the Province of Canada legislature passed a statute titled *An Act to restrain the injurious practice of inoculating with smallpox* (hereafter, *Smallpox Inoculation Prevention Act of 1853*).\(^{157}\) This was the first piece of legislation that dealt specifically with smallpox in United Canada. The main intent of the Act was to ban inoculation with natural smallpox, a practice which, though widely used, had fallen into disfavour—especially among members of the medical profession\(^ {158} \)—largely due to the fact that it contributed to the spread of smallpox and the slow uptake of vaccination. A commentary published in a leading medical journal stated, for example:

> [W]e ought not to overlook the calamitous consequences now before us, from the inoculation with [s]mall-[p]ox, lamentably affording a constant source of infection... It is...a subject, which, from its bearing so intimate a relation with the preservation of public health, and, as embracing in its extent, the whole of society, ought to fall within the province of Government, whose bounden duty is, at all times, to remove or diminish, through the most vigorous and effective means of its legislative authority, whatever evils result from the social state itself.\(^ {159} \)

Under the Act, persons practicing inoculation with smallpox were liable, upon summary conviction, to face a term of imprisonment not exceeding one month, and offenders who were medical professionals would have their license to practice permanently revoked.\(^ {160} \)

\(^{157}\) *S Prov C 1853 (16 Vict), c 170.*  
\(^{158}\) See e.g. *supra* note 151 (“[t]o those two causes then—prejudice against vaccination, and the practice of inoculation—we are, in great measure, indebted for the continual presence of smallpox amongst us” at 61).  
\(^{159}\) *Supra* note 150 at 259.  
\(^{160}\) *Supra* note 157, Preamble and s 2.
The Smallpox Inoculation Prevention Act of 1853 arrived decades later than similar bans on inoculation in England, the New England colonies, and several European states. In England, the first vaccination legislation, passed in 1840, imposed a total ban on inoculation, with a penalty of up to one month imprisonment. The Act also made provisions for free optional vaccination. However, the Act was not the first attempt to prohibit or restrict inoculation with smallpox in England. Earlier on, in 1813, a bill put before Parliament unsuccessfully sought to ban public exposure of inoculated persons prior to complete recovery from smallpox. Members of Parliament (MPs) roundly

161 The practice was banned in England in 1840. See An Act to extend the practice of vaccination, 1840 (UK) 3 & 4 Vict, c 29 [British Vaccination Act of 1840]; supra note 97.
164 Supra note 161, s 8.
165 Ibid, Preamble, ss 2-7.
166 See UK, HL, “A Bill Intituled an Act for the more Effectual Prevention of the Spreading of the Infection of the Small Pox”, Cmd 99 in Sessional Papers, vol. 59 (1812-13) 581 [Cmd 99]; UK, HL, Journals of the House of Lords, vol 49 (21 June 1813) at 517. The 1813 bill also included a provision requiring the owner or occupier of a house in which an infected or inoculated person resides to display “from some visible or public front part of the house...a red flag, or piece of red cloth, stuff, or linen, being not less than three feet long, and one foot and a half broad.” See Cmd 99, ibid at 583; UK, HL, Parliamentary Debates, vol 31, col 0-1121 (5 July 1815) [HL Debates 0-1121]. This was not first bill to address measures aimed at combating smallpox. In 1808, Mr. John Fuller, a member of the House of Commons, introduced a bill that made it illegal to operate inoculation centres within three miles of any town or settlement. See UK, HC, “Bill (as Amended by the Committee) to Prevent the Spreading of the Infection of the Small Pox”, Cmd 287 in Sessional Papers, (1808) 645. The bill was never debated, and was abandoned in favour of a resolution for the establishment of a central institution to promote vaccination, which resulted in the founding of the National Vaccine Establishment. See UK, HC, Parliamentary Debates, vol 11, col 841-44 (9 June 1808). For more on the National Vaccine Establishment, see Brunton, supra note 97 at 5, 11, 15-16, 41; Arthur Salusbury MacNalty, “The Prevention of Smallpox: From Edward Jenner to Monckton
criticized the bill as amounting to illegitimate state interference with the individual freedom to choose among available medical options, and rejected arguments by the sponsors of the bill stating that state intervention and restrictions on individual liberties were necessary to protect public welfare and prevent the spread of communicable diseases.\textsuperscript{167} A similar bill proposed in 1815 also met the same fate.\textsuperscript{168} However, by 1840, state intervention in matters of social welfare had gained political acceptance in Britain, as Parliament passed a variety of legal reforms “aimed at protecting the lives and interests of poorer sections of society.”\textsuperscript{169}

The provisions of the \textit{Smallpox Inoculation Prevention Act} of 1853 were very similar in wording to \textit{British Vaccination Act} of 1840, which suggests that the drafters drew inspiration for the Canadian law directly from the earlier British Act. However, unlike the British law, the 1853 Act did not mention vaccination, despite the fact that the method was gaining popularity as the preferred method of smallpox prevention, especially among members of the medical profession.\textsuperscript{170} For instance, in 1845, the editors of the British American Journal of Medical and Physical Science praised a Norwegian vaccination bill

\begin{footnotesize}
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\item \textsuperscript{167} See UK, HC, \textit{Parliamentary Debates}, vol 9, col 1007-15 (29 July 1807).
\item \textsuperscript{168} See HL Debates 0-1121, supra note 166; UK, HL, \textit{Parliamentary Debates}, vol 31, col 1088 (4 July 1815).
\item \textsuperscript{169} See Brunton, supra note 97 at 20.
\item \textsuperscript{170} Medical doctors frequently expressed support for vaccination in practice notes and comments published in medical journals. See e.g. Dr. Koesch, “Variola, Vaccinia, Varioloid, and Varicella” (1847) 3:7 British American Journal of Medical and Physical Science 179 (“vaccination is the only mode of exterminating small-pox” at 179); Marson 1854, supra note 147 (“vaccination performed in infancy afforded almost complete protection against the fatality of small-pox, to period of puberty” at 238); G Gregory, “Lectures on the Eruptive Fevers” (1851) 7:3 British American Medical and Physical Journal 120 at 122; supra note 151 (1853).
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drawn up by “two medical gentlemen in that kingdom,”¹⁷¹ which made it unlawful for an unvaccinated person to be married, employed as a scholar in a public school or to undergo the Catholic rite of confirmation.¹⁷² In their opinion, the “close system of medical surveillance...provided for in the [b]ill, is somewhat remarkable [and]… productive of the most beneficial consequences.”¹⁷³ The editorial also called for establishment of similar measures in the Province of Canada.¹⁷⁴ Responding to reports of resistance to vaccination by inhabitants of the Indian village of St. Regis “in consequence of the representations of a schoolmaster, who has contrived to imbue them with his own silly prejudices,”¹⁷⁵ another editorial called upon “the interference of the Government in some shape or way, for relieving present, or future, distress”¹⁷⁶ from smallpox.

Likewise, shortly after the Smallpox Inoculation Prevention Act of 1853 became law, the Medical Chronicle published a lengthy editorial in support of compulsory vaccination measures.¹⁷⁷ Citing the success of vaccination in combating smallpox in many countries, the editorial urged the Province of Canada legislature to enact a similar measure:

We have no hesitation in asserting...that it is the manifest duty of the Legislature of every country, showing a ratio of 10 deaths from smallpox to every 1000 deaths from all diseases, to protect the citizens, in like manner, from this loathsome and fatal disease... There are few countries where compulsory measures, to ensure general vaccination, are more imperatively demanded than in our own. Smallpox is constantly in our midst. Sometimes occurring sporadically; at other times, as during the last

¹⁷¹ “The Medical Bill”, Editorial, (1845) 1:1 British American Journal of Medical and Physical Science 27 at 27.
¹⁷² Ibid at 27-28.
¹⁷³ Ibid at 28.
¹⁷⁴ See ibid at 27-28.
¹⁷⁵ “Small Pox at Regis”, Editorial, (1849) 5:8 British American Journal of Medical and Physical Science 223 at 223.
¹⁷⁶ Ibid.
¹⁷⁷ Supra note 151.
winter, prevailing epidemically... *Vaccination must be made compulsory by legislative enactment, if we are ever to rid the country of this repulsive disease.*\(^{178}\)

Support for vaccination was, however, not universal among doctors.\(^{179}\) A comment from the editorial board of the British American Journal of Medical and Physical Science (comprised of doctors) in response to an article in the journal promoting vaccination, states, for example:

> We take occasion to differ from our [c]orrespondent on the value to be attached to the act of vaccination. We think that it is commonly a modifier of the type of a subsequent attack of [s]mall-[p]ox, by no means a preventative. As for the propriety of some legislative interference in preventing *inoculation*, we heartily concur with Dr. Von Iffland.\(^{180}\)

In one emblematic case,\(^{181}\) doctors advised the prosecution of one Dr. B, a “young German physician and surgeon,”\(^{182}\) for medical malpractice, on the charge that he communicated smallpox and some “unknown animal poison”\(^{183}\) to two girls who were vaccinated by him during a smallpox outbreak. Following vaccination, one of the girls suffered “a very bad case of confluent disease,”\(^{184}\) while the other’s arm became very much inflamed. As a result, Dr. B was subjected to “a great deal of guerrilla prosecution,

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\(^{178}\) *Ibid* at 60-61 (emphasis in original).

\(^{179}\) See e.g. *supra* note 150 (“there are, however, several respectable practitioners who assert, that many who have been vaccinated, and who then appeared to have gone through all the characteristic stages of the Vaccina, have some years subsequently, taken the [s]mall-[p]ox” at 258).

\(^{180}\) See *ibid* at 258 (emphasis in original).

\(^{181}\) See William M Wood, “Thoughts on Suits for Malpractice, Suggested by Certain Judicial Proceedings, in Erie County, Pennsylvania” (1849) 5:8 British American Journal of Medical and Physical Science 216. Although the case occurred in Erie County, Pennsylvania, its inclusion in an article published in a Province of Canada medical journal suggests interest among readers in issues relating to the safety and efficacy of smallpox vaccination.

\(^{182}\) *Ibid* at 217.

\(^{183}\) *Ibid*.

\(^{184}\) *Ibid*. 
professional and lay,” and the payment of his bill was resisted “upon the defence of malpractice.” Likewise, reports published in medical journals suggest that in combating smallpox, some medical practitioners were more interested in experimenting with known treatments than with prophylactic remedies such as vaccination. The reason for the preference is most likely pecuniary and/or due to difficulties with procuring good but scarce vaccine lymph; doctors would have found it easier to administer and receive payment for familiar procedures such as puncturing diseased pocks and applying poultries, leeching and “tincture of iodine.”

Furthermore, given that the U.K. Parliament enacted Britain’s first compulsory vaccination statute only two months after the *Smallpox Inoculation Prevention Act* of 1853 passed, it is surprising that the latter Act did not feature compulsory vaccination measures. The British law mandated the vaccination of infants within three months of birth and provided for free optional vaccination for the rest of the population.

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186 *Ibid* at 218.
188 See Pasquin, *ibid* (“[a]fter mature deliberation upon the treatment of small-pox, Mr. Pasquin arrived at the conclusion that the pitting and disfigurement of the face was dependent upon the confinement of the matter too long in the pocks, causing a slough thereby to form in the cellular tissue lying between the cuticle and the facia of the face...[t]o obviate this, Mr. Pasquin determined to puncture each pock previous to its striving at perfection, and apply a common poultice”) at 477-478).
189 See *ibid* (“I had three more with affection of the larynx, the respiration being so difficult that I expected asphyxia would come in a few hours. To these I applied leeches over the region of the larynx” at 478).
191 See *An Act further to extend and make compulsory the Practice of Vaccination*, 1853 (UK) 16 & 17 Vict, c 100 [British Compulsory Vaccination Act of 1853].
compulsory vaccination requirement was controversial forthwith, and triggered the birth of the British anti-vaccinationist movement. While it is possible that Canadian legislators were not aware of the British Act prior to when it passed—there is no record or mention of the British Act or the preceding bill in the legislative journals, and the parliamentary debates preceding the British Act were largely uneventful—the omission more likely reflects reluctance to resort to measures that interfere with the liberties of individual citizens. Indeed, during the legislative debates on the Canadian bill, a less intrusive amendment, which required the flagging of residences with active smallpox infestation, was withdrawn to appease critics who felt it amounted to unwarranted interference with individual freedoms. Also, there was a great deal of resistance to vaccination during this period, especially in Lower Canada, where, despite a legal ban, “[i]noculation [was] regarded by many with more favour.” Another likely reason is that the Province did not want to shoulder the considerable financial burden of requiring compulsory vaccination, or to impose same on municipalities. In England, the provision of vaccination was financed through rates collected for poverty relief. A similar system of rate collection for poverty relief did not exist in the Province of Canada at the time.

The absence of vaccination provisions in the Smallpox Inoculation Prevention Act of 1853 further suggests another important distinction between the British and Canadian

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193 See Brunton, ibid at 44 ("[n]o MP argued that compulsory vaccination was unacceptable" at 44); Ogbogu, supra note 97 at 4-10.
195 See supra note 151 at 61.
196 See Brunton, supra note 97 at 166.
contexts, namely the level of involvement of the medical elite in securing vaccination reforms. While Canadian medical doctors favoured vaccination as a means of preventing smallpox they had no discernible involvement or role in the process that produced the Act. By contrast, their British counterparts mounted a prolonged and successful campaign in support of the *British Compulsory Vaccination Act* of 1853. As Brunton has observed in relation to the role of the British medical profession:

The most consistent influence on public vaccination legislation was exerted by medical practitioners. They lobbied for legislation, drew up bills, and campaigned for amendments to measures... Practitioners’ vision for public vaccination was shaped by their wider vision for the medical profession and its relationship with the state. The vision was extraordinarily powerful and pervasive, influencing practitioners’ views on many aspects of public medicine, not just vaccination.

As we shall see in the next section, Ontario medical practitioners adopted vaccination for similar purposes later in the century, chiefly to attain professional recognition and gain control of state-supported health care. However, during the union era, the level of professional organization and commitment to public vaccination displayed by British doctors was simply not present in Canada.

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197 See *supra* notes 150, 151, 171 and 175.
198 Brunton, *supra* note 97 at 164. Brunton identifies three main ways in which practitioners influenced vaccination matters in the period leading up to the passage of the 1853 Vaccination Act: (1) through medical organizations such as the Epidemiological Society; (2) through powerful political leaders and civil servants such as John Simon, Henry Rumsey, Edwin Chadwick, Sir Benjamin Hall and William Cowper; and (3) through individual and disparate efforts of rank-and-file practitioners. See generally Brunton, *ibid* at 39-90.
199 There were, however, rumblings of a desire among medical practitioners for formal state recognition of their professional status during this period. For example, Upper Canada medical doctors voiced this desire in editorials calling for legislation to grant the profession with the power to “to regulate [its] own affairs [and] to manage [its] own concerns” and to protect the profession “from the intrusion of uneducated, unlicensed and pretending impostors...and unworthy members.” Editorial, (1851-52) 1 Upper Canada Journal of Medical, Surgical and Physical Science 25 at 28.
Support for vaccination increased over time, and by 1858, the Province of Canada Legislature passed into law the first statute to exclusively regulate vaccination in United Canada (henceforth, the “Vaccination Extension Act of 1858”). The Act did not establish compulsory measures, but rather provided for a system of vaccination similar to that put in place by the British Vaccination Act of 1840. The Act’s principal provision required hospitals receiving public funds to keep an adequate supply of vaccine matter at all times for the purpose of providing free vaccination to paupers or paid vaccination to non-paupers, and for supply to the Superintendent General of Indian Affairs for the use and benefit of Indian settlements. Hospitals were required to submit a statement of compliance with the Act to the Crown Lands Department based in Toronto, and non-complying hospitals were denied access to public funds. While hospitals generally complied with the law, it appears the Act did not really increase vaccination rates.

There is also some evidence of support for compulsory measures during this period. While such measures had long had the support of the medical community, ordinary citizens also petitioned the legislature to enact compulsory vaccination measures. In 1859, for example, Robin Charles and Company, a fish, fur and timber trading business domiciled in Bonaventure, a county on the Gaspé Peninsula (along the south shore of the

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200 See e.g. F Marson, supra note 147.
201 See An Act to encourage, and to provide for the extension of the practice of Vaccination, S Prov C 1858 (22 Vict), c 89 [Vaccination Extension Act of 1858].
202 Ibid, s 1.
203 See ibid, s 2; Province of Canada, Legislative Assembly, Journals of the Legislative Assembly of the Province of Canada, 6th Parl, 2nd Sess, vol 17 (16 February 1859) at 66-67.
204 A letter dated 1 February 1959, from C Fremont, a medical doctor employed at Hôtel-Dieu Hospital in Montreal, to the Crown Lands Department, states, for example, that while the hospital was prepared to comply with the requirements of the Act, “none had presented themselves for [v]accination.” Journals, ibid.
205 See supra notes 151, 171 and 175.
St. Lawrence River), along with others in the county, twice petitioned the Legislative Council to introduce compulsory vaccination, presumably hoping that the remedy would help reduce the impact of smallpox on the company’s business.206 Another group of merchants, led by one Philip Vibert, sent similar petitions to the Legislative Assembly.207

Such support for coercive measures was by no means universal. Despite lacking compulsory measures, the Vaccination Extension Act of 1858 was criticized by some as being unnecessary and interventionist. For instance, an editorial in the Upper Canada Law Journal and Municipal and Local Courts’ Gazette argued that the Act was “more allied with the science of medicine than of law,”208 and contained provisions which both “overstep[] the necessity of the case [and] partak[e] of unnecessary cruelty.”209 The editorial also criticized the Province of Canada Legislature for undertaking unnecessary legal reforms, noting that:

More members of Parliament during the present Session appear anxious to distinguish themselves as law reformers than ever we remember during any previous session. Of this the result is an abundance of bills upon every conceivable subject, ranking from the sublime to the ridiculous.210

In 1861, the Legislature, most likely influenced by the increased support for vaccination, and by the success of the British Compulsory Vaccination Act of 1853 (which, though controversial, had gone through successive amendments without defeat or repeal),211 passed into law the first compulsory vaccination statute in United Canada (henceforth,  

206 See Journals, supra note 203 at 207-8.  
207 See ibid at 319.  
208 See supra note 194.  
209 Ibid.  
211 See generally Brunton, supra note 97.
the “Compulsory Vaccination Act of 1861”).212 The Act’s principal provisions were modeled after the British statute, and similarly required the mandatory vaccination of all infants born after January 1, 1862213 within three months of birth (or four months, if the parents are unable to do so and the child is under the care or custody of a third party).214 The Act also made provisions for free optional vaccination of the poor, but non-paupers could opt for the procedure at their own expense.215 Procedures mandated by the Act were also similar to the British law: parents were legally obligated to present their children for vaccination three months after birth,216 and to return eight days following the operation for inspection and confirmation that the operation was successful.217

Following confirmation, the medical practitioner who performed the operation was required to deliver a “certificate of successful vaccination” to the parents, and to transmit a duplicate to the city clerk for the purpose of maintaining statistical records.218 Infants who were insusceptible to smallpox (by virtue of having survived a prior smallpox attack) or unfit for vaccination (for medical reasons) were to receive certificates from the vaccinator reflecting the corresponding condition.219 The certificates were the only proof of successful vaccination admissible in any prosecution or complaint laid against the parents under the Act.220 The penalty for contravention of the mandatory vaccination

212 See An Act to provide for the more general adoption of the practice of Vaccination, S Prov C 1861 (24 Vic), c 24 [Compulsory Vaccination Act of 1861].
213 Ibid, s 4.
214 Ibid.
215 Ibid, s 2.
216 Ibid, s 4.
217 Ibid, s 5.
218 Ibid, s 6.
219 Ibid, s 7.
220 Ibid, ss 6-7.
requirement was a fine not exceeding five dollars recoverable on summary conviction before a police magistrate, the inspector and superintendent of police, a Stipendiary magistrate, or two justices of the peace. The Act also contained a provision denying public funds to hospitals that did not have a “distinct and separate ward set apart for the exclusive accommodation of patients afflicted with Small Pox.”

Though clearly influenced by the British Compulsory Vaccination Act of 1853, the Canadian statute differed from it in several important respects. Firstly, the Act did not apply to the whole Province, but only in the major cities, including Quebec, Three-Rivers, St. Hyacinth, Montreal, Ottawa, Kingston, Toronto, Hamilton, London and Sherbrooke. The rationale for this selective application is unclear from the legislative or historical record, but is most likely a cautionary move aimed at mitigating resistance to the highly controversial measure by focusing only on heavily populated areas where smallpox outbreaks were most likely to occur or have the most impact. The application of the Act could also have been a response to pressure from businesses.

\footnote{Ibid, s 10.}
\footnote{Ibid, s 1.}
\footnote{Ibid, ss 2-4.}
\footnote{The mayor of Sorel, a town situated east of Montreal, at the confluence of the St. Lawrence and Richelieu Rivers, petitioned the Province of Canada Legislature to extend the provision of the Act to their township. See Province of Canada, Legislative Assembly, Journals of the Legislative Assembly of the Province of Canada, 7th Parl, 1st Sess, vol 20 (2 May 1862) at 149. A bill that would have made the law applicable throughout the Province never passed. See Province of Canada, Bill 41, An Act to extend, and in certain cases to make compulsory, the practice of vaccination, 1863 (sponsored by Mr Cowan; first reading 6 May 1862).}
\footnote{See supra notes 206 & 207 and accompanying text.}
Secondly, unlike the British Act, which placed responsibility for administering vaccination on the poor law authorities,\textsuperscript{226} vaccination measures in the Canadian law were to be administered by city councils. The reason for this difference is that a poor law system did not exist in Canada at the time. City councils were enjoined to retain legally qualified medical practitioners to serve as vaccinators, and to set up vaccination centres in their respective localities.\textsuperscript{227}

Thirdly, the \textit{Compulsory Vaccination Act} of 1861 contained a provision that specifically addressed a loophole in the British law relating to the common law plea of \textit{autrefois convict}. Translated as “formerly convicted,” the plea bars the indictment of a person for an offence for which s/he has been formerly convicted.\textsuperscript{228} To circumvent this plea, the Act provided that contravention of the compulsory vaccination provisions two months following a previous conviction would attract fresh prosecution and repeat conviction.\textsuperscript{229} The British Act lacked a similar provision when it was passed. The omission proved to be a major trigger of legal challenges against the British Act, as repeat offenders claimed the law did not authorize multiple convictions, and that even if it did, a repeat conviction for the same offence would violate the \textit{autrefois convict} rule.\textsuperscript{230}

\textsuperscript{226} See Brunton, \textit{supra} note 97 at 22-23. This responsibility was transferred to local government boards in 1871. See \textit{An Act to amend the Vaccination Act}, 1871 (UK), 34 & 35 Vict, c 98, s 16.
\textsuperscript{227} See \textit{supra} note 212, s 2.
\textsuperscript{228} See Black’s Law Dictionary, 2d ed, sub verbo “Autrefois convict”: “Formerly convicted...A plea by a criminal in bar to an indictment that he has been formerly convicted of the same identical crime.”
\textsuperscript{229} See \textit{supra} note 212, s 11. The section reads, in part:
After the expiration of two months from the conviction of any person for an offence against this Act, in respect of any child, no plea of such conviction shall be sufficient defence against any complaint which may then be brought against the same or any other person for non-compliance with the provisions of this Act in respect of the same child.
\textsuperscript{230} English anti-vaccinationists often attacked this provision. See Williamson, \textit{supra} note 163 at 157-162, 233.
The issue first arose in the 1864 English case of *Pilcher v. Stafford*,\(^{231}\) where defendant William George Stafford faced prosecution for neglecting to vaccinate his infant son as mandated by law, an offence for which he had been previously convicted. In his defence, he pleaded *autrefois convict*, and argued that enforcement of the law would subject him to being punished twice for the same offence. The trial court agreed, holding that in the absence of an express statutory provision, a second conviction would offend the common law plea. The Court of Queen’s Bench affirmed on appeal, noting that “nothing will meet [the issue] but fresh legislation.”\(^{232}\)

The challenge issued by the Court of Queen’s Bench in *Pilcher* was taken up by Parliament in an 1867 amendment of Britain’s vaccination law.\(^{233}\) The amendment created a summary offence punishable by a maximum fine of twenty shillings for non-compliance with an order to vaccinate issued by a Justice of the Peace.\(^{234}\) A few years later, in 1870, this provision was approved in *Allen v. Worthy*,\(^ {235}\) where the Court of Queen’s Bench held that it could be applied to secure repeat convictions if the offender refused each time to comply with a fresh enforcement order issued by a Justice of the

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\(^{231}\) (1864), 122 ER 651, (1864) 4 B & S 775 QBD [cited to ER].

\(^{232}\) Ibid at 653.

\(^{233}\) See *An Act to consolidate and amend the laws relating to vaccination*, 1867 (UK), 30 & 31 Vict, c 84, s 31.

\(^{234}\) Ibid.

\(^{235}\) (1870), LR 5 QB 163 (*Allen*), aff’d on other grounds *Knight v Halliwell* (1874) LR 9 QB 412 (notice to vaccinate creates a continuing basis for repeat prosecution and conviction for non-compliance with vaccination order, provided that the repeat prosecution is carried out within limitation period).
Peace.\textsuperscript{236} The court distinguished \textit{Allen} from \textit{Pilcher}, noting that the provision affirmed in \textit{Allen} relates to disobedience of a judicial order, to which the \textit{autrefois convict} rule would not apply, rather than to the regulated offence in \textit{Pilcher} (i.e. failure to vaccinate as required by law).\textsuperscript{237} However, \textit{Allen} was reversed and the \textit{autrefois convict} rule restored by the Court of Queen’s Bench in \textit{R v Justices of Portsmouth},\textsuperscript{238} decided in 1892. The provision in the 1867 Act relating to a summary offence for non-compliance with a judicial order to vaccinate was repealed by statute a few years later, in 1898.\textsuperscript{239} By contrast, the repeat conviction rule in the Province of Canada Act was continued in post-confederation Ontario legislation,\textsuperscript{240} and remained in force in the province until repealed in 1964.\textsuperscript{241}

The \textit{Compulsory Vaccination Act} of 1861 was the last pre-confederation legislation that dealt specifically with smallpox and vaccination. Following confederation, an unaltered version of the Act was included, together with \textit{Smallpox Inoculation Prevention Act} of 1853, in a revised consolidation passed by the Ontario Legislature in 1877.\textsuperscript{242} The latter

\textsuperscript{236} \textit{Allen}, \textit{ibid} at 169-72 (“the powers given by s 31 are not confined to one order and one conviction, but that the proceedings may be repeated \textit{toties quoties} so long as disobedience continues” at 170, per Cockburn CJ).
\textsuperscript{237} For more discussion of \textit{Allen}, see Williamson, \textit{supra} note 163 at 163-175.
\textsuperscript{238} \textit{(1892), [1892] 1 QB 491}. See also \textit{R (Vint) v Justices of Donegal}, \textit{(1903), [1904] 2 1R 1 KBD}.
\textsuperscript{239} See \textit{An Act to amend the law with respect to vaccination}, 1898 (UK), 61 & 62 Vict, c 49, s 3 [\textit{British Vaccination Act} of 1898].
\textsuperscript{240} See \textit{An Act respecting vaccination and inoculation}, RSO 1877 (40 Vict), c 191, s 14.
\textsuperscript{241} See \textit{An Act to repeal the Vaccination Act}, SO 1964, c 122, s 1.
\textsuperscript{242} See \textit{supra} note 240.
statute, along with major amendments passed in 1886 and 1912, applied to the whole of Ontario, and not just to select cities.

2.2.4 Legal regulation of vaccination in Ontario: A new era in public health governance emerges, and Britain’s influence wanes

In England, the compulsion rule remained intact through the years, surviving several well-organized anti-vaccinationist campaigns (including repeated attacks on the repeat penalties provision), successive amendments to the vaccination statute (in 1867, 1871, 1874, 1898 and 1907), and the introduction of provisions allowing conscientious objection to vaccination. The resilience of compulsory measures in the English context had an impact on legal developments in Ontario. For example, Ontario pro-vaccinationists, chiefly medical professionals, cited the longevity of compulsory vaccination in England as evidence that vaccination was a legitimate and acceptable form of state intervention in medicine and public health. As expressed in a report issued in 1882 by a provincial health board comprised entirely of medical doctors:

“[A]lthough possessed of the study idea of independence epitomized in the remark of Micawber, when, having slammed the door in the face of the bailiff...exclaimed “[e]very Englishman’s house is his castle… [the

243 See An Act to amend the Act respecting vaccination and inoculation, SO 1886 (49 Vict), c 43 [Vaccination Act of 1886].
244 See An Act respecting vaccination and inoculation, SO 1912 (2 Geo 5), c 59 [Vaccination Act of 1912].
245 See An Act to provide for certain amendments and additions to the statutes of the Province, as consolidated by the commissioners appointed for that purpose, SO 1877 (40 Vict), c 7, sch A, para 203.
246 See generally Williamson, supra note 163; Durbach, supra note 192.
247 See supra note 233.
248 See An Act to amend the Vaccination Act, 1867, 1871 (UK), 34 & 35 Vict, c 98.
249 See An Act to explain the Vaccination Act, 1871, 1874 (UK), 37 & 38 Vict, c 75.
250 See supra note 239.
251 See An Act to substitute a statutory declaration for the certificate required under section two of the Vaccination Act, 1898, of conscientious objection, 1907 (UK), 7 Edw VII, c 31.
252 See ibid, s 1; supra note 239, s 2.
This viewpoint proved influential in a major amendment to Ontario’s vaccination law passed in 1886. The new Act, which did not repeal the 1877 consolidation or the existing system of mandatory infantile vaccination, required the mandatory vaccination of all previously unvaccinated persons resident in a municipality where a smallpox outbreak was present or imminent. The 1886 Act also, for the first time, authorized school trustees to require proof of vaccination or insusceptibility to smallpox as condition precedent to school attendance. However, this provision was a target of anti-vaccinationist campaigns, and proved difficult to implement in practice. In 1907, for instance, a motion put forward by Dr. Ogden, a trustee of the Board of Education, to enforce compulsory vaccination in city schools, was defeated by a vote of seven to one. Several prominent anti-vaccinationists attended the vote, including some members of the Anti-Vaccinationist League of Canada. In 1920, protests from parents and anti-vaccinationists forced the St. Catherines’ Board of Education to lift a ban on school attendance without proof of vaccination ordered by the Board of Health, which affected “nearly 20 per cent” of public school pupils. The following year, the Smith’s Falls Board of Education filed a test case in the Ottawa Supreme Court challenging orders issued by the local board of health requiring compulsory vaccination of school children.

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253 Provincial Board of Health, First Annual Report of the Provincial Board of Health of Ontario being for the year 1882 (Toronto: C Blackett Robinson, 1883) at xxxi [Annual Report, 1882].
254 See supra note 240.
255 See supra note 243, s 4.
256 Ibid, s 2.
258 “Education board lifts the vaccination ban”, Special Dispatch, The Globe (22 March 1920) 3.
but subsequently withdrew the case.  

Finally, in 1922, residents of New Toronto attended a meeting in Orange Hall convened by the Anti-Vaccination League of Canada to protest an order by the Medical Officer of Health requiring vaccination of all children attending school.

Under the 1886 Act, responsibility for implementing vaccination measures remained with municipal councils. However, the Act also contained a provision authorizing local boards of health to contract with medical practitioners to provide vaccination services where municipal councils failed or neglected to do so. Fees for vaccination services ordered by the local board of health were to be charged to the municipality regardless of whether it was party to the contract or not. Municipal councils were also given the discretion to order and implement the mandatory vaccination measures in the Act whenever they felt it was necessary to do so or if notified by provincial authorities or the local board of health that a smallpox outbreak was imminent. A 1912 amendment eliminated the discretionary element and made it mandatory for municipal councils to

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260 “Vaccination order rouses parents’ ire”, The Globe (18 November 1922) 3. See also Clowes v Edmonton School Board, [1915] 25 DLR 449 (Alta SC) [Clowes], where the plaintiff sought an order of mandamus from the court to compel the defendant to admit his son to school contrary to a regulation which provided that no pupil shall be admitted to school unless he produced proof of successful vaccination for smallpox, or a valid medical exemption. Clowes was an anti-vaccinationist, and he refused to vaccinate his son, who, as a result, was refused admission to school. Clowes argued that the regulation was not specifically authorized by statute, but rather, was issued pursuant to the Provincial Board of Health’s general authority over infectious diseases and public health. He contended further that the regulation was in conflict with the Truancy Act, which made school attendance compulsory for children between ages seven and fourteen. Since choosing not to comply with the regulation would result in a violation of the Act, the regulation was therefore void by virtue of the inconsistency. In a unanimous decision rendered in five separate opinions, the court reluctantly found in the plaintiff’s favour. The judges held that although it would serve the public interest to preserve such an important regulation, they had no option but to strike it down due to the irreconcilable conflict with the superior Act.
261 See supra note 243, ss 1 & 4.
262 Ibid, s 1.
263 Ibid.
264 Ibid, s 4.
order vaccination or revaccination of all unvaccinated persons resident within their respective municipalities in the event of a smallpox outbreak or on being notified that an outbreak was imminent by provincial or local health authorities. I have highlighted both provisions—the municipal council’s responsibility for honoring vaccination contracts executed by the local board of health and the obligation to order vaccination upon request by provincial and local health authorities—because, as we shall soon see, each gave rise to legal disputes.

Furthermore, the provision authorizing local boards of health to contract with doctors if municipal councils refused or neglected to do appears to have been inspired by *Bogart v Corporation of Seymour*, an 1885 decision of the Ontario High Court. The plaintiff, a medical doctor and medical health officer for the township of Seymour, instituted a legal action against the defendant municipal council seeking to recover unpaid expenses for “vaccinating a large number of persons in the...township.” In its defence, the municipal council argued that the local board of health, which had procured the plaintiff’s vaccination services, was not properly appointed in accordance with the governing statute, and that the vaccination instructions issued to the plaintiff did not comply with the statute. As such, the Board lacked legal authority to bind the municipality in contract. Rejecting this argument, the trial judge held that the plaintiff, having relied on the

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265 See *supra* note 244, s 12.
266 *Supra* note 123.
267 *Ibid* at 323.
instructions issued by a board of health held out as such by the municipality, was entitled to recover.\textsuperscript{268}

The provision empowering provincial health authorities to request that municipal councils exercise their statutory discretion to order vaccination was most likely intended to appease medical professionals seeking an increased role in vaccination affairs. In the period shortly preceding the passage of the 1886 Act, the profession’s elite members became convinced that municipal management of smallpox was either non-existent or inefficient, and they campaigned tirelessly for measures that would shift responsibility for overseeing vaccination from municipal authorities to a provincial board constituted and run by medical doctors. A year before the Act passed, a group of elite members of the profession wrote in a report to the Legislature that “[t]he Public Vaccination Act…has…proved, though useful in many cases, nevertheless inoperative on the whole.”\textsuperscript{269} They also forwarded a draft bill to the Legislature (which most likely became the 1886 Act) urging reforms aimed at “better fulfilling the wants that recent epidemics of smallpox have so clearly demonstrated.”\textsuperscript{270}

Developments in nearby jurisdictions also influenced vaccination reforms in Ontario during this period. Health reformers in Ontario often praised the interventionist approach to infectious disease management in places like New York, Massachusetts and Michigan, and urged the provincial legislature to emulate public health measures in these

\textsuperscript{268} \textit{Ibid} at 324-5.
\textsuperscript{269} See Provincial Board of Health, \textit{Fourth Annual Report of the Provincial Board of Health of Ontario, 1885} (Toronto: Warwick & Sons, 1886) 2.
\textsuperscript{270} \textit{Ibid}. 

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jurisdictions. A report issued in 1882 by the doctor-controlled Provincial Board of Health\textsuperscript{271} and submitted to the provincial legislature, states for example:

They [people of New York and Michigan] submit to what some people might call an invasion of individual rights, when, in cases of occurrence of infectious disease, they notify the Health Boards of the presence in their families of such disease, and are placed under various degrees of surveillance, according to the danger of contagion with which it may be attended. They admit that it is a mistaken idea of freedom and independence to suppose that the individual should be allowed to follow his own ideas, no matter how unwise, in such cases; and that such freedom degenerated into license. It is indeed a high development of social science which admits that it is better for the individual to submit to a temporary isolation and supervision, than that the body politic of which he is a member should be injured to an indefinite and unknown degree from its absence.\textsuperscript{272}

The constant fear of importation of infectious diseases from these neighbouring jurisdictions also prompted the government of Ontario to bolster vaccination laws and enforcement measures. Indeed, the reforms in the 1886 Act were likely intended to protect the province from the effects of frequent smallpox epidemics in Montreal in the early 1880s, including a devastating outbreak in 1885 that affected over 9000 persons, with over 3000 deaths.\textsuperscript{273} Government reports issued around this time contain instances of actions taken to prevent importation of diseases from nearby places. One report notes, for example:

\begin{quote}
Early in September the epidemic of smallpox in Montreal and the Province of Quebec had assumed such serious proportions, that with the sanction of Government, a staff of medical men were sent down to accompany all trains leaving that city for the west to enforce vaccination
\end{quote}

\textsuperscript{271} See Part 2.2.1.III, below, for more on the Provincial Board of Health.
\textsuperscript{272} \textit{Supra} note 253 at xxxi.

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in transit, or deal with recalcitrants...by either sending them back to Montreal or detaining them until better judgment was arrived at.\textsuperscript{274}

The report also lamented the opposition to smallpox vaccination in Montreal, and urged the introduction of measures to improve vaccination rates in Ontario, as follows:

\begin{quote}
[T]he opposition of a section of the population of Montreal to vaccination, and the existing sentiment amongst them that smallpox was like measles, a something which had to be taken and got over with, made the health authorities reluctant to resort to coercive measures for the suppression of the disease. viz.: vaccination, isolation and disinfection, were either wholly neglected or but imperfectly carried out. A knowledge of the existence of the disease in Montreal...caused...fear that smallpox might extend to this Province from Quebec; and hence it was that at the May meeting of the Board, a report was presented...advocating the establishment by the [g]overnment of a [v]accine [f]arm.\textsuperscript{275}
\end{quote}

The 1886 Act was more stringent and interventionist compared to the British vaccination Acts, which never imposed compulsion on the general population, or as a prerequisite to school attendance. Indeed, both reforms were a departure from regulatory developments that occurred in Britain in the last quarter of the nineteenth century, which focused mainly on a dilution of their mandatory vaccination laws through the repeal of the repeat penalties rule\textsuperscript{276} and the introduction of a conscientious objection exemption.\textsuperscript{277}

The matter of conscientious objection to vaccination first arose around 1878, when a few British MPs, sympathetic towards parents whose objections to vaccination were founded

\textsuperscript{274} Supra note 269 at 1-2.
\textsuperscript{275} Ibid at 4.
\textsuperscript{276} See supra note 239 and accompanying text.
\textsuperscript{277} During the 1885 Montreal smallpox epidemic, a number of individuals were charged with non-compliance with vaccination orders. During their trial before the Montreal Health Court, they argued their objection to the procedure was based on conscientious beliefs. The plea was rejected by the court. See Jennifer E Keelan, The Canadian Anti-Vaccination Leagues, 1878-1892 (PhD Thesis, University of Toronto Institute for the History and Philosophy of Science and Technology, 2004) at 249-50 [unpublished].
upon the belief that it would cause harm to their children, began to inquire into whether such cases ought to necessitate a repeal of compulsion\textsuperscript{278} or, at a minimum, exemptions “founded upon conscientious views.”\textsuperscript{279} These MPs were possibly under the influence of leading anti-vaccinationists, who engaged in successive campaigns to repeal compulsory infantile vaccination. One such campaign forced the government to appoint a Royal Commission in 1889 to investigate, inter alia, “objections made to vaccination on the ground of injurious effects”\textsuperscript{280} and “[w]hether any alterations should be made in the arrangements for securing the performance of vaccination, and, in particular...prosecution for non-compliance with the law.”\textsuperscript{281}

The Commission’s final report, issued in 1896, seven years after it began its investigations, recommended, among other things, the abolition of repeat penalties for non-compliance\textsuperscript{282} and the establishment of “a scheme...which would preclude the attempt (so often a vain one) to compel those who are honestly opposed to the practice to submit their children to vaccination.”\textsuperscript{283} Both recommendations were adopted in the British

\textsuperscript{278} UK, HC, \textit{Parliamentary Debates}, vol. 239, col. 496-7 (3 April 1878) [Sir Thomas Chambers].
\textsuperscript{279} UK, HC, \textit{Parliamentary Debates}, vol. 303, col. 1178 (18 March 1886) [Mr. Thomas Robinson].
\textsuperscript{280} UK, HC, “Final Report of the Royal Commission Appointed to Inquire into the Subject of Vaccination” Cm 8270 in \textit{Sessional Papers} (1896) iii.
\textsuperscript{281} \textit{Ibid}. See also Williamson, \textit{supra} note 163 at 233-37.
\textsuperscript{282} See Royal Commission, \textit{ibid}, para 521:

We do not doubt that the fact that penalties may be repeated secures in some cases the vaccination of children who would otherwise remain unvaccinated, but we believe that the irritation which these repeated prosecutions create, when applied in the case of those who honestly object to have their children vaccinated, and the agitation and active propaganda of antivaccination views which they foster...tend so greatly to a disuse of the practice in the district where such occurrences take place, that in the result the number of children vaccinated is less than it would have been had the power of repeated prosecution never existed or been exercised.

\textsuperscript{283} \textit{Ibid}, para 524.
Vaccination Act of 1898.\textsuperscript{284} Specifically, the conscientious objection exemption stipulated that a parent who “conscientiously believes that vaccination would be prejudicial to the health of the child”\textsuperscript{285} could apply for and obtain a certificate from two justices or a magistrate exempting him/her from penalties for non-compliance with compulsory vaccination requirements. A second provision, relating to repeat penalties, prevented the issuance of an order to vaccinate against a person “who has previously been convicted of non-compliance with a similar order relating to the same child.”\textsuperscript{286}

The Royal Commission report also offered a philosophical view of legal intervention in public health matters that was, as we shall soon see, radically different from views that informed vaccination and other public health interventions in Ontario as the nineteenth century progressed. According to the report:

A law severe in its terms and enforced with great stringency may be less effectual for its purpose than one of less severity, and which is put in force less uncompromisingly. When this is the case it cannot be doubted that the law which appears less severe is really the more effective. The ultimate object of the law must be kept in view... Too blind a confidence is sometimes reposed in the power of an Act of Parliament... When that which the law enjoins runs counter to the convictions or prejudices of many members of the community it is not easy to secure obedience to it.\textsuperscript{287}

A conscience-based exemption to smallpox vaccination was never proposed or legalized in Ontario. It is very likely that such an exemption would have provoked a response from Ontario pro-vaccinationists similar to that of their British counterparts, who claimed the

\textsuperscript{284} See supra note 239.
\textsuperscript{285} Ibid, s 2(1).
\textsuperscript{286} Ibid, s 3.
\textsuperscript{287} Supra note 280, para 521, 527.
exemption “would undermine the whole purpose of the Vaccination Acts.” Also, an exemption would not have appealed to reform-minded medical professionals, who, as chief architects of Ontario’s vaccination reforms, sought harsher, more interventionist policies as part of a portfolio of plans to raise the profile of the medical profession, gain control of vaccination and other public health matters, and implement a vision of public health that placed community interests above individual or personal interests. I expand on these points in the following sections of this chapter.

2.2.5 Vaccination and the professionalization of medicine in Ontario

In British North America and elsewhere, vaccination was one of few, if not the only, preventative for infectious diseases that attracted and maintained specific and sustained government interest throughout the nineteenth century. This was mainly because unlike other methods, such as sanitation and quarantine, it was a costly, physically invasive remedy that required government authority and resources to ensure both its availability and widespread (potentially coercive) implementation. The high political (and legal) profile of vaccination was deeply attractive to medical practitioners, who, working through a few elite members or medical societies, adopted the remedy as a tool to advocate for occupational autonomy, status and identity, and for the establishment of practitioner-run public health and health care. Although acceptance of vaccination was not universal among doctors, many of them endorsed and adopted the remedy as a means of demonstrating specialist knowledge and progressive attitudes to the study of disease

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288 See Williamson, supra note 163 at 236.
289 See Brunton, supra note 97 at 41 (vaccination was “one of the few areas where government had made significant efforts to control disease” at 41).
causality, prevention and treatment. Practitioners also sought to gain a more prominent role in the administration of a potentially lucrative state-backed medical service.

While no Canadian studies have explored the link between vaccination and practitioners’ quest for professional status and advancement, the topic has received some attention in other jurisdictions. A leading example is Deborah Brunton’s political history of vaccination in the United Kingdom,290 which outlines how medical practitioners drew upon social, political and legal events surrounding public vaccination in mid-nineteenth century England to “protect and improve their collective interests”291 and further their professional aspirations.292 Beginning from the 1830s, English practitioners and medical societies sought to use public vaccination to attain or improve certain goals, including professional status and autonomy,293 the social standing of medicine,294 compensation/working conditions of rank-and-file practitioners,295 and control of state provision of medical care. As Brunton observes, “[c]oncerns about status, autonomy, and

290 See supra note 97.
291 Ibid at 25.
292 See generally, ibid.
293 See ibid. Brunton observes that:
 Patients had ceased to give practitioners the respect due to possessors of specialized knowledge and were willing to employ cheaper, less qualified practitioners, such as druggists. As a result, ‘practitioners’ incomes had fallen, making it more difficult to maintain the lifestyle of a professional gentleman… Although members of the House of Lords were apparently uninterested in how or why free vaccination should be provided, ordinary medical practitioners were extremely agitated by the issue. Their concern was not just fired by a desire for the state to control smallpox, but reflected their fears of the impact of a new vaccination service on the medical profession. Ibid at 22-23.

294 See ibid (“[p]ractitioners repeatedly complained that their status in society had declined [and that] medicine no longer received the same regard for the public as other traditional professions—the law and the church” at 25).

295 According to Brunton:
 Practitioners complained that the local agencies—the boards of guardians—did not pay at the level appropriate for skilled professional work. Poor law medical officers were saddled with excessive workloads for low salaries. They also objected to the practice of tendering: this was a system suited to tradesmen not to professional men and tended to push down payments. Ibid.
rights to self-regulation fired practitioners’ interest in public vaccination, which was widely debated in societies and journals representing rank-and-file practitioners.” 296 Practitioners petitioned Parliament in support of state promotion and provision of vaccination 297 and advocated for “responsibility for overall control of public vaccination.” 298

From the perspective of the British doctors, involvement with and control of public vaccination—a remedy that was gaining both scientific and political support—would assure their sought after aims, and “ensure that any new state employment [for the purpose of providing vaccination services] respected their rights as skilled practitioners” 299 possessed of unique specialist knowledge. At the same time, practitioners feared that their professional aspirations and financial security would be jeopardized if the government placed responsibility for the administration of vaccination in the hands of other less-skilled individuals or bureaucrats, especially poor law administrators and the Board of Guardians. 300

Ontario medical practitioners employed similar arguments in the course of similar agitation for professional identity, status and autonomy. However, the Ontario movement occurred late in the nineteenth century, beginning with the establishment of the Provincial Board of Health in 1882. Although arguments for professional status and

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296 Ibid at 26.
297 See ibid at 29-30.
298 Ibid at 27.
299 Ibid at 26.
300 See generally, ibid at 20-31.
autonomy were rehearsed by Upper Canada medical practitioners in earlier agitation for licensing reform and state support for medical education, and despite significant support for vaccination among doctors during this period, no attempts were made to politicize remedies like vaccination for their own ends. Rather, practitioners’ support for vaccination appeared to be grounded in a genuine belief that the remedy was both effective and necessary in the fight against smallpox.\textsuperscript{301}

Likewise, earlier agitation for professional status and autonomy was based on the genuine belief that the profession as a whole\textsuperscript{302} was engaged in unique pursuits, and that its members ought to be distinguished from other providers in a medical marketplace populated by all manner of health care trades, including quacks and charlatans. As Charles Roland has observed, in the 1800s, the “number of charlatans and incompetents practicing medicine…proliferated, partly because the public preferred them, having no social or scientific reason to choose regular doctors.”\textsuperscript{303} This situation shaped doctors’ advocacy for professional reform, and they sought to promote their profession as both uniquely scientific and uniquely qualified to practice science-based medicine. An

\textsuperscript{301} See e.g. supra notes 170 & 171.
\textsuperscript{302} The editors of the Upper Canada Journal of Medical, Surgical and Physical Science wrote that the enactment of a statute that would recognize and regulate the practice of medicine was widely supported by members of the medical profession. See supra note 199 at 28:

\begin{quote}
We have thrown these observations together by way of an introduction to our future remarks on our own [b]ill. The [b]ill we intend to publish in our next number, with, if possible, the amendments which have been effected upon it, by the Medical Committee to which it was referred. We see no reason why, in obtaining an enactment at all, bearing on such important interests as are involved in the study and practice of medicine, it should not be a good one at once—-one which will place such matters here on a level, at least, with those of other enlightened countries. We are satisfied that in this respect we but enunciate the sentiments of the profession generally, and we shall be happy to record the opinions of any individual members of it on our pages.
\end{quote}

editorial in the inaugural issue of the Upper Canada Journal of Medical, Surgical and Physical Science, published in 1852, notes, for example:

There is no subject more appropriate for the first leading article of a journal, about to become, we have every ground for believing, the organ of the Medical Profession of Canada West, than the actual state of medicine as a science, its progress as an art and future prospects of its practitioners as a body in this section of the Province. We have been accustomed from early associations and habits of thinking, as well as by practical experience, to look upon the science of medicine as one not to be acquired by all men indiscriminately, and susceptible of being advanced by only a limited number; while the legitimate practice of the art, although vested in many, is only carried out by a very small number of so called practitioners. Many may be licensed to treat the ills to which flesh is heir, but are they capable of doing so?304

On the unique pursuits of the medical profession, the editorial stated:

Of such various denominations in the medical profession made up...there is here, as elsewhere, a band of individuals, comparatively small it is true, and somewhat scattered, who while they assume Medicine as their profession, as an honourable means of livelihood, cannot be tempted to forego the satisfaction of watching the advance of Science generally...They revel in the strides made by their brethren at home and abroad in the cause of Medicine; they rejoice in proclaiming the results of mental labour in every branch of philosophical [s]cientific research; but they do not do so blindly--they subject them to the searching scrutiny of practical analysis or logical reasoning, and according as the case may turn out, they adopt them as facts, adding these to their already acquired stock of knowledge, or refute them by proofs which they have discovered in the course of their investigation, and which they can satisfactorily sustain.305

304 Supra note 199 at 25-26. The editorial also noted that licensing reform and recognition by the state would “invest [the profession] with powers and privileges...essential to the well-being of the [profession], and with a prestige which without these parliamentary parchments they would not enjoy,” and concluded by calling for meetings to be held by doctors, “before the assembling of Parliament...in each of the sixteen counties of Western Canada” for the purpose of drawing up petitions and chose delegates to present them to the Legislature. Ibid at 28-29.
There are three possible reasons why doctors in Upper Canada failed to see or seek a connection between vaccination (or public health more broadly) and the professionalization of medicine. First, prior to the establishment of the Provincial Board of Health, in 1882, vaccination and public health laws in force in Ontario were essentially dead letters. Implementation and enforcement were sporadic at best, and there was little or no state support for vaccination measures, whether pecuniary or otherwise. Medical practitioners, though the chief advocates of vaccination, had a very limited role—primarily as vaccinators—under successive vaccination statutes, and much of the responsibility for implementation and enforcement devolved upon hospital trustees or management (in the earlier Acts) and municipal councils and local boards of health (in the later Acts). Without a direct implementation role, doctors’ main interest in

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306 See supra note 269 at 94 [emphasis added]:

The difficulty which exists at present is that, while the Vaccination Act is practically a compulsory Act, the municipal authorities in health matters, having hitherto had no proper status, have never in Ontario been in a position to carry the Act into force. By the Health Act of 1884, which has given to each municipality a Local Board, whose special duties refer to all matters affecting the public health, a means has been supplied by which municipalities can with the greatest convenience put in force provisions of the Vaccination Act. An important omission was made in the Health Act when the powers and duties of Local Boards were not extended so as to enable them to carry out this work, and when a clause was not inserted making it one of the duties of the Provincial Board to see that vaccination be everywhere carried out. Experience has proven that the Act which has been on the statute book since 1861...has been practically a dead letter, and that it will continue to be so, unless machinery, other than that hitherto in existence, be set in motion.

See also supra note 20; Samuel B Woodward, “Smallpox in Canada from 1913-1923” (1925), Toronto: Archives of Ontario (RG 10-163, container B254020, file RG 10-163-0-125 [emphasis added]:

The border states report together 168,214 cases of smallpox, the Canadian provinces 37,845; 16,023 of these last reported by the Province of Ontario where vaccination is not a prerequisite to school attendance although attendance itself is compulsory. There is a law requiring the vaccination of all infants under the age of four months but the health officer writes me that for many years it has been a dead letter.

See also Provincial Board of Health, Fifth Annual Report of the Provincial Board of Health of Ontario, 1886 (Toronto: Warwick & Sons, 1887) 65; “Smallpox and Councils”, The Globe (17 December 1908) 5, where Dr. Hodgetts, a member of the Provincial Board of Health, claimed that the Vaccination Act is a dead letter and that “[b]usiness is crippled” in Ontario as a result of the “failure on the part of municipal councils to make the act operative.”
vaccination during the early period focused mainly on seeking financial compensation for vaccination services.  

Second, given the limited application of the first vaccination statute to select cities, doctors in other parts of the province may have less aware of or interested in the political and financial ramifications of the remedy.

Third, the medical profession was not formally incorporated in Ontario until 1869 (by comparison, the profession became incorporated in Lower Canada in 1847). As such, the profession lacked a body or association to represent or articulate its common interests. Matters of interest to or affecting the practice of medicine were taken up, if at all, mainly by individual practitioners, through editorials and commentaries in medical journals and newspapers.

The creation of the Provincial Board of Health radically altered the shape and focus of the quest for professional medicine in Ontario, and provided medical doctors with a platform to advance both their professional interests and the status of the medical profession. The Board also presented the profession’s elite members—consisting of a well-educated group of politically savvy and reform-minded practitioners—the opportunity and resources to test theories and procedures favoured by medical

\[307 \text{ See supra note 123.} \]
\[308 \text{ See supra note 223 and accompanying text.} \]
\[309 \text{ See An Act to amend and consolidate the Acts relating to the profession of medicine and surgery, SO 1869 (32 Vict), c 45; Canniff, supra note 305 at 113-83; Roland, supra note 303.} \]
\[310 \text{ See Roland, ibid.} \]
professionals, including views regarding disease causation and innovative remedies like vaccination. The Board membership was dominated by these elite doctors throughout its history, and they arrived on the scene with the assured awareness that a connection existed between public health and professional advancement. Eager to exploit this connection, they set upon a mission to win political and legal backing for a more prominent role for the profession in public health administration.

The Board came into being by virtue of the *Public Health Act* of 1882, which came into force on March 10, 1882, and held its first meeting in an office located in the Parliament Buildings on May 9, 1882. Although the Act provided that “[a]t least four members of the board shall be duly registered medical practitioners” out of maximum of seven members, the inaugural composition of the Board consisted entirely of medical doctors, including two professors of sanitary science at the University of Toronto, one surgeon and four general practitioners. This composition reflected a high level of interest within the medical profession in having significant representation on the Board. Shortly after the Board’s first meeting, one of its members resigned, “owing to the urgency of other duties,” and was replaced by a Professor of Engineering whose role was to fill a gap in

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311 See *An Act to establish a Provincial Board of Health, and to give increased powers to Local Boards of Health*, SO 1882 (45 Vict), c 29 [*Public Health Act* of 1882].
312 See *supra* note 253 at 4-8; “The Provincial Board of Health” (1882) 7:6 Canadian Journal of Medical Science 211; “Ontario Board of Health” (1882) 14:10 Canada Lancet 296.
313 *Supra* note 311, s 1.
315 *Supra* note 253 at vii.
expertise with respect to “the many details, which arise in connection with questions of sewerage and drainage systems [and] water supplies.”

The doctors on the inaugural Board were also “committed sanitarians” with longstanding interest or careers in public health and the mitigation of infectious diseases. The Board was led by William Oldbright, who obtained his medical degree from the University of Toronto in 1865, and was appointed Professor of Hygiene in the Toronto School of Medicine a few years later. Dr. Oldbright “became interested in public health” early in his career, and he was “an active supporter of the Canadian Medical Association” and local medical societies. At the time he took up the position of Chairman of the Provincial Board of Health, he was considered “one [of the profession’s]… best known members.” A young Peter Henderson Bryce, physician and

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316 Ibid at viii.
319 Ibid.
320 Ibid.
321 Ibid. This assertion is taken from Dr. Oldright’s obituary, which was signed with the initials “W.O.” As obituaries from this period were typically published without author names or initials, the initials suggest that Dr. Oldright prepared his own obituary before his death. See ibid. His appointment as Chairman of the Board divided opinion among his professional colleagues. The editors of the Canada Lancet criticized the appointment, citing lack of practical qualifications and want of “sufficient leisure to do justice to the position” due to numerous other engagements. See “Chairman, Ontario Board of Health” (1882) 14:10 Canada Lancet 313. They also claimed outside of a “charmed circle” of medical men, he was not “the choice of the profession in Toronto,” and berated the editors of the Canadian Journal of Medical Science, a rival publication, for defending Oldright’s appointment “at all hazards” merely because he was a colleague, for daring to criticize the Lancet’s “undoubted right of criticizing the qualifications of the Chairman of the Ontario Board of Health,” and for making unfounded statements in their journal under the nom de plume “Junius” stating that the editor of the Lancet was an applicant for the position. Ibid. It was also clear that the editors of the Lancet did not hold Dr. Oldright in high regard. According to them, when Oldright was asked to “give his views upon the public health question, and the best mode of procedure to induce the Government to provide for the establishment of the Provincial Board of Health, he treated the committee to a long dissertation about the drainage, or something of that sort, of Osgoode Hall, a matter entirely foreign to the subject in hand.” Ibid at 314.
author of a famous report on health conditions in the Canadian residential school
system,\textsuperscript{322} served as the first secretary of the Board. Other medical members were “well-
known practitioners”\textsuperscript{323} and public figures, including Francis Rae, the Mayor of Oshawa,
Charles William Covernton, the President of the Ontario Medical Association,\textsuperscript{324} and John
Joseph Cassidy, the youngest visiting staff surgeon to the Toronto General Hospital and a
medical journalist who served as the editor of the Canadian Journal of Medicine and
Surgery, a prominent medical journal, from 1897 to the time of his death in 1914.\textsuperscript{325}
These doctors were the “first generation of medical bureaucrats in Ontario,”\textsuperscript{326} and they
“used their close ties to the economic and political élites to obtain the legislation which
produced the 20\textsuperscript{th}-century regulatory state.”\textsuperscript{327}

That medical doctors should dominate the Board’s membership was seen as self-evident;
the Board’s first annual report to the Ontario Legislature pronounced that “[a] naturally in
the composition of any [b]oard of [h]ealth the public expects to find the great proportion
of its members medical men.”\textsuperscript{328} An editorial in a leading medical journal proclaimed, in
similar manner, that “[t]he probabilities are, in point of fact, that six out of the seven

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PH Bryce, \textit{The Story of a National Crime} (Ottawa: James Hope, 1922). See also Janice Dickin, “Peter
Henderson Bryce” in \textit{The Canadian Encyclopedia}, online: The Canadian Encyclopedia
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Supra note 253 at viii.
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Supra note 317.
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Ibid.
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Supra note 253 at vii. Doctors also dominated the membership of some local boards of health, despite
being exempted by law from serving on municipal councils or as health officers. See e.g. “Smallpox in
Canada: The Stamping-Out Method in Action” (1924) 2: 3316 British Medical Journal 123 (“[t]he [Essex]
Board of Health is composed wholly of doctors, each of whom had been at some time a medical officer of
health”). For the exemption provisions, see \textit{An Act respecting the Public Health}, SO 1873 (36 Vict), c 43, s
6; \textit{An Act respecting Municipal Institutions in the Province of Ontario}, SO 1873 (36 Vict), c 48, s 76.
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members of the [Provincial] Board [of Health] will be medical men.”

Another lamented the appointment of persons from non-medical professions to the Board, although this view was not universally shared among doctors. Medical professionals continued to dominate the membership of the Board until it was replaced by a ministerial Department of Health in 1924. In 1919, for example, the Board’s membership consisted entirely of medical doctors. Several inaugural members remained or served in leadership positions on the Board for many years.

The cause for the creation of the Provincial Board of Health was taken up by medical doctors in the 1870s—shortly after the profession was incorporated in Ontario—mainly through editorials and comments in prominent medical journals. In 1878, Dr. Joseph Workman, President of the Canadian Medical Association, delivered an annual address to members that was reproduced in full in the Canada Lancet, the most widely read

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330 See “Boards of Health” [1882] Canadian Journal of Medical Science 238: “We would like to direct the attention of our contemporary, the Canada Lancet, to the fact that association in such matters with non-professional persons is quite comme il faut, as the deliberations of [the Provincial Board of Health] in no sense constitute a medical consultation. Our contemporary is guilty, therefore, of an egregious non sequitur when he endeavors either to derive countenance for consultation with homeopaths from the presence of a homoeopathic practitioner on our Provincial Board of Health, or to discredit that Board, with the profession of the Province, by reiterated allusions to the fact. If a disciple of Hahnemann, or any other unprofessional man, can bring any light to bear upon the problems of sanitation which await solution, let him speak, and the true disciples of Hippocrates will be the last to scorn his information, or refuse him audience. Ibid.”
332 For example, in 1884, Dr. Charles William Covernton, inaugural member, Professor of Sanitary Science at Trinity Medical School, and Vice President of the College of Physicians and Surgeons of Ontario from 1870-71, was appointed chairman of the Board. See Provincial Board of Health, Third Annual Report of the Provincial Board of Health of Ontario, being for the year 1884 (Toronto: Grip Printing and Publishing, 1885); “Obituary – Dr. Charles William Covernton” (1901) 1:2106 British Medical Journal 1179. Dr. Bryce served as secretary from 1882 to 1904. See Dickin, supra note 322.
333 See supra note 309 and accompanying text.
334 See “Annual Address” (1878) 11:2 Canada Lancet 33.
medical journal in Canada at the time. The address urged the establishment of a central board of health for Ontario, as follows:

[Ontario is] still without the benefit of a central Board of Health…but as a vigorous committee of the Legislative Assembly, during the last session, devoted much attention to the subject of sanitation, and availed itself of the opinions of numerous experienced physicians, we may reasonably trust that in the next session our expiring Parliament will place on the Statute Book an Act which will prove that they duly value the great national blessing of public health.335

The address also advocated extensive powers for this central board, as well as functions that were likely to improve the economic fortunes of doctors, including:

the direction…of all matters relating to the health of our large public institutions, embracing…the selection of proper sites, the erection of substantial and truly economic buildings, securing our salubrious air and reliable abundant ventilation, adequate sewerage…and advantageous position for the obtainment and delivery of all sorts of supplies.336

In the same vein, J.A. Grant, the President of the Bathurst and Rideau Medical Association, called for a “regulated system, to carry [public hygiene] measures into active operation”337 and for Parliament to provide “more of [its] fostering care”338 to the medical profession by allowing its members to superintend the operation of the system. These early calls for legislation prompted Dr. John Fitzgerald Clarke, a physician who was also the Member of Parliament for Norfolk North, to call for a parliamentary committee to examine the necessity for legislation to better protect public health.339 Following its deliberations, the committee issued a report proposing a bill to establish, inter alia, “a

335 Ibid at 34.
336 Ibid [emphasis added].
337 See “Annual Address Delivered Before the Bathurst and Rideau Medical Association” (1877) 9:6 Canada Lancet 163 at 166.
338 Ibid.
339 See “And to Charitable Institutions” (1872) 4:7 Canada Lancet 342.
permanent Provincial Sanitary Board or board of health, to which all reports on epidemic
and other diseases shall be referred.” However, the proposed bill was never drawn up.

Some members of the inaugural Provincial Board of Health were also involved in the
agitation for the establishment of a central board. At a meeting of a newly-formed
Ontario Medical Association held in June 1881, Dr. Oldright championed a resolution
calling on doctors to “urge as strongly as possible upon the [g]overnment…the
desirability of early legislation which shall make provision for the formation of a
Provincial or Central Board of Health.” Two future members of the Board—Drs.
Covernton and Horace Yeomans—were in attendance at the meeting. The resolution was
unanimously carried. In a bid to be appointed the Chairman of the Board, Dr. Oldright
also reportedly “forced himself upon the attention of the House and the Government, by
most persistent lobbying, and the presentation of petitions which he carried about the city
for signatures.”

340 Ibid.
342 Ibid.
343 “Chairman, Ontario Board of Health” (1882) 14:10 Canada Lancet 313 at 313. In a very public row with
the Canada Lancet, Oldright denied this version of events. He wrote a letter to the Lancet to ask that they
publish his “distinct and emphatic denial of the statement” that he “carried about the city petitions for
signatures.” According to him, the “document in favor of [his] appointment was drawn up by one
influential friend in the House at the suggestion of another, and was signed by all the medical members of
the House, except one.” See “Correspondence” (1882) 14:12 Canada Lancet 362. The Lancet published his
letter, but with an editorial note reiterating their claim. The note stated that the journal “took pains to make
due enquiry on every point” and that “[a] medical gentleman in th[e] city, whose veracity has never yet
been called in question, told [the journal] that Dr. Oldright personally asked him to sign a petition
recommending him to the Government for the chairmanship of the Board.” Ibid at 363. The position of
Chairman of the Provincial Board of Health was coveted by medical professionals. Doctors in various parts
of the province expressed their interest in the position to the Premier, who was responsible for making the
appointment. See e.g. Dr. TE Kaiser to JP Whitney (26 May 1906), Toronto, Archives of Ontario
(Correspondence of Sir James Whitney, F 5-1, container B273266); A Broder to JP Whitney (5 October
1906), Toronto, Archives of Ontario (Correspondence of Sir James Whitney, F 5-1, container B273267);
JC Milligan to JP Whitney (22 July 1908), Toronto, Archives of Ontario (Correspondence of Sir James
Whitney, F 5-1, container B273271).
Other members of the profession carried on similar campaigns in support of legislation to establish a provincial board of health. As reported by the Canada Lancet, an “influential deputation of medical men…waited upon the Attorney-General of Ontario…to urge upon the Government the necessity of establishing a Provincial Board of Health to promote the interests of sanitary science, and especially to aid in preventing the spread of contagious and infectious diseases.” 344 The deputation also presented a draft bill to achieve this purpose to the Attorney General. The bill laid out extensive powers for the proposed board of health, including the power “to adopt prompt measures for the stamping out of [infectious] diseases” throughout the province, and “to issue such regulations regarding the prevention of disease as might be approved of.” 345

While the doctors may have sought the creation of a central board of health out of a genuine interest in advancing the state of public health in the province, there is evidence to suggest that they viewed the proposed board of health as a means of advancing certain professional interests and aspirations, including centralization and control of public health affairs, increasing their incomes, and procuring government support for public health and sanitary reforms that would place doctors in prime position to improve both their professional fortunes and public image. These aspirations were summed up in a lengthy editorial in the Canada Lancet calling for the establishment of a central board to manage sanitary reform.” 346 The editorial stated:

345 Ibid.
346 “Sanitary Reform” (1881) 14:4 Canada Lancet 123.
The subject of public health and sanitary reform is one which requires to be kept constantly before the profession and the public, until some efficient legislative measures are secured from the government. It is a question of such vital interest to the welfare of the people and the prosperity of the nation, that it should take precedence of every other consideration. All merely political questions should be laid aside, in view of the great and inestimable importance of a question which has for its objects the life and health of the people. It is clearly one of the first duties of a government to provide the means, wherever practicable, for the amelioration of the condition of the people... The members of the medical profession have been...almost the only individuals who have interested themselves in the matter of public health. They have...from time to time, and in various ways, urged upon the government, federal and provincial, the importance of preventive measures... We do not believe it would be in the least degree inimical to the interest of the profession in this country, if there were established upon a proper basis, a well-organized sanitary system...such a system would add materially to the value of professional services, and place the profession itself on a higher level in public estimation than it occupies at present. It would be infinitely better in more respects than one, for municipalities and governments to employ medical men to give a portion of their time to the prevention of disease, than for the public to employ them for the cure of diseases which have for the most part been caused by the neglect of the simplest laws of health... We trust that the profession will lose no opportunity of urging upon the various governments of the day, the very great necessity of thoroughly organized sanitary boards, including...a Provincial Board in each of the Provinces... With the view of bringing this matter again under the notice of the Ontario Government, we have been solicited to enclose blank petitions to avail our subscribers, with a request that they will not only sign the petitions, themselves, but obtain as many signatures as they conveniently can, of prominent public men and others who may sympathize with the movement.347

Regarding the relation between the proposed board and improvements in doctors’ economic fortunes, another editorial criticized the provision in the Act limiting remuneration to only two out of a possible four medical doctors on the Board.349

According to the editorial:

347 Ibid [emphasis added].
348 See supra note 311, s 2.
349 See supra note 329.
The Medical Profession has been appropriately termed the GREAT UNPAID; for indubitably no other class of the community expends so large a portion of its substance, strength…time, and mind gratuitously for the service and relief of others… We do not…grudge the many acts of private charity in a professional way which every physician freely dispenses, to the world unknown. Nor yet do we object to much of the gratuitous service rendered in dispensaries and hospitals, for here there is in a certain sense a sort of quid pro quo, an opportunity of partly satisfying the inexorable thirst for knowledge by study and experiment. But surely the expectation of its extent must attain finality in the case of the public service. The people…can afford to…pay well and fairly for the benefits they derive from the service of the individual in all ranks and classes of the community. We can conceive of no reasonable or equitable grounds why an exception should be made of members of the medical profession. It is with considerable surprise and disappointment, therefore, that we find the Ontario Public Health Bill passing its third reading and becoming law, providing that the Provincial Board of Health shall consist of seven members, of whom at least four are to be medical practitioners, and two only (the chairman and secretary) are to receive remuneration… We had fondly hoped that the utmost limits of unpaid service would fall far short of the public service… [W]e…hold most strongly that the least that could be done would be to pay these gentlemen at consultation rates for their loss of time whenever they are called upon to meet in consultation on the public health. It is inexplicable to us how this piece of simple justice to the profession could have been omitted in a House numbering amongst its members so many doctors as does the Provincial Legislature of Ontario.350

Pressure from doctors finally led the government to introduce a bill to establish a Provincial Board of Health on February 23, 1882.351 The bill moved quickly through the House, and passed on March 7,352 with overwhelming support from physician MPs.353

350 Ibid. Another editorial argued it would be difficult to attract a worthy candidate to fill the position of secretary if the position was not well remunerated:

The success of the newly-appointed Provincial Board of Health will doubtless depend in large measure upon the zeal and capacity of its Secretary, upon whom will devolve the lion’s share of the labour, and no slight responsibility. We think, therefore, that a mistake has been made in limiting his salary, by Act of Parliament, to one thousand dollars per annum. This sum is totally inadequate to attract to the office any man of experience and standing in the profession. “The Secretaryship of the Board of Health” [1882] Canadian Journal of Medical Science 132 [Secretaryship].

351 Ontario, Legislative Assembly, Journals of the Legislative Assembly of the Province of Ontario, 4th Leg, 3rd Sess, vol 15 (23 February 1882) at 85 (Mr. Hardy).
352 Ontario, Legislative Assembly, Journals of the Legislative Assembly of the Province of Ontario, 4th Leg, 3rd Sess, vol 15 (7 March 1882) at 117.
Medical practitioners welcomed the passing of the Act “with a feeling of great satisfaction” and applauded “the inauguration and permanent establishment…of a satisfactory, efficient, vigorous, and comprehensive system of health-maintaining, disease-recording and preventing [g]overnment.” The editors of the Canadian Journal of Medical Science called on members of the profession to support the Board, stating:

The profession has long been agitating for the formation of a Provincial Board; this has, at length, been attained, and all that is now necessary to remove from our fair Province the stigma of being behind some of her neighbours in this path of civilization—a due attention to sanitary matters—is, that the members of the profession, one and all, should do what they can to aid the Board, both by making suggestions to it, and by helping and even anticipating its efforts in the localities where they reside and have influence.

While the doctors’ agitation for legislative reform proved successful, it did not yield the powers or level of control over public health that they sought. Municipal councils retained primary and extensive authority over public health and infectious diseases, including powers to implement various measures to prevent and manage disease outbreaks and to establish hospitals for receiving and treating infectious disease victims. Local boards of health were also empowered to implement specified measures to prevent or manage smallpox or other disease outbreaks when municipal councils neglected to do so.

355 See Secretaryship, supra note 350.
356 Supra note 354 at 128.
357 See generally An Act respecting the public health, RSO 1877 (40 & 41 Vict), c 190, ss 1-7.
358 See supra note 311, s 12.
359 See supra note 311, ss 14-18.
By contrast, the powers of Provincial Board of Health were mainly of an advisory character. The Board was not allowed any direct authority to supervise or intervene in local health affairs, or to establish or implement regulations or any concrete measures for preventing or managing infectious diseases. Rather, the Board was charged with conducting investigations into sanitary matters and the causes of disease, studying vital statistics, “drainage, water supply, disposal of excreta, heating…ventilation of…public institution[s]” and providing advisories and suggestions to provincial and local authorities regarding the prevention and introduction of diseases. The Board was also required to serve as the Central Board of Health when an emergency proclamation was in effect. Regarding vaccination matters, the Board’s authority was limited to procuring and keeping “at all times an adequate supply of vaccine matter”—actual responsibility for ordering and implementing vaccination remained with municipal councils.

Following the passage of the Act, some doctors objected to the limited scope of the Board’s authority, particularly the lack of powers to implement compulsory measures, including mandatory vaccination. Others felt the Act, though deficient in this regard, was a first step in the right direction. An editorial in the Canadian Medical Science Journal noted, for example:

360 See ibid, s 3. In 1912, the Board’s authority was expanded to include the power to carry out inspections and order structural alterations of premises in the interest of public health, and more importantly, the power to issue regulations, applicable to any part of the province, for the prevention and mitigation of disease, among other things. See An Act respecting the public health, SO 1912 (2 Geo 5), c 58, ss 6-9 [Public Health Act, 1912]. The Chief Officer of Health for Ontario (typically the Secretary of the Provincial Board of Health) was also empowered to act “[w]here a local board of health has not been established…or…has in the opinion of the Minister refused or neglected to act with sufficient promptness or efficiency in carrying out the provisions of the Act.” Public Health Act, 1912, ibid, s 34.

361 See supra note 311, s 10.

362 Ibid, s 9.

363 See supra note 243, ss 1-5.
We have heard it objected that the Act will be inoperative, inasmuch as the compulsory powers are so small, and that it should be more like the English Act; but we must remember c’est le premier pas qui coute [it is the first step that costs], and we hope that much that is desirable will follow. It is necessary to enlist the sympathies of the people individually, and, as represented by their municipal bodies, and the condition of things here and in England is very different in many respects. It will be one of the first duties of the Board and its Secretary to arouse the bodies mentioned to the consideration of the importance of preventative medicine, and to show what a profitable investment money spent in) that direction will be.\textsuperscript{364}

The Provincial Board of Health was the first and only central or provincial public health institution created in Ontario during the period covered by this study. The Board began its work in May 1882, and remained in existence, with changes in membership and structure,\textsuperscript{365} until 1924, when the provincial government centralized and transferred primary authority over public health matters to a ministerial Department of Health.\textsuperscript{366} While a detailed examination of the work and activities of the Board during this period are beyond the scope of this work, the rest of this chapter is devoted to a discussion of the Board’s influence on smallpox vaccination matters, and particularly to the role of the Board in securing more stringent vaccination policies at a time when other jurisdictions were introducing legal reforms that dampened the effect of or weakened compulsory vaccination laws. Much of the discussion that follows revolves around a legal dispute between the Provincial Board of Health and the Toronto City Council, which was included in The Globe’s list of the “leading events of 1919.”\textsuperscript{367}

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\textsuperscript{364} Supra note 354 at 128.
\textsuperscript{365} In 1919, the Board was integrated into the Department of Labour. See Heather MacDougall, “Researching Public Health Services in Ontario, 1882-1930” (1980) 10 Archivaria 157.
\textsuperscript{366} See An Act for the Establishment of the Department of Health, SO 1924, c 69.
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2.3: Advancing the People’s Welfare through Legal Action: Re Provincial Board of Health for Ontario and City of Toronto

In late fall of 1919, Ontario faced a province-wide epidemic of a mild form of smallpox.\(^{368}\) By November, there were over 1600 recorded cases in over thirty counties throughout the province.\(^{369}\) Majority of the cases occurred in Toronto, the largest city in the province, with figures placed at over 1300 victims.\(^{370}\) Over three hundred new cases were recorded in December, with Toronto again leading the numbers.\(^{371}\) By December 20, reports of virulent cases emerged, and two days later, the first death from the disease was reported.\(^{372}\) The deceased victim, Mrs. George Grobbo, “wife of a farmer living near Weston,” had not been vaccinated. Six more deaths were reported by the end of the year.\(^{374}\)

Given that the majority of smallpox cases were linked to Toronto, provincial authorities and health officials in other provinces and municipalities looked to city officials to implement measures to arrest the progress and spread of the epidemic in Toronto. By law, the authority to take direct action against smallpox or other infectious diseases resided

\(^{368}\) See Charles J Hastings, *Report Endorsing Vaccination as a Prevention Against Smallpox* (Toronto: 1919), Toronto, Archives of Ontario (RG 8-5, barcode B226467); “City has many smallpox cases”, *The Globe* (4 November 1919) 9; “More recoveries than new cases, smallpox now said to be on steady decline in City”, *The Globe* (29 November 1919) 8; Editorial, *Acton Free Press* (25 December 1919) 4; “Number of smallpox cases shows increase”, *The Globe* (3 December 1919) 8; “Smallpox cases grow in number”, *The Globe* (12 December 1919) 9.

\(^{369}\) See “City blamed for growth of epidemic: Scored by Provincial Board for non-enforcement of vaccination law”, *The Globe* (4 December 1919) 9.

\(^{370}\) See *Ibid*.

\(^{371}\) See “Smallpox cases increase in city: Provincial Board issues figures—Premier Drury is vaccinated”, *The Globe* (18 December 1919) 8.

\(^{372}\) See “Smallpox claims its first victim”, *The Globe* (23 December 1919) 7.

\(^{373}\) *Ibid*.

\(^{374}\) See *supra* note 369.
with the Toronto City Council and local Board of Health.\(^{375}\) Measures available to the city officials included removal and isolation of victims,\(^{376}\) appointment of health officials to deal with the outbreak,\(^{377}\) and ordering mandatory vaccination of unvaccinated residents.\(^{378}\) The City Council was also responsible for the costs of implementing these measures, including vaccination of poor persons.\(^{379}\) However, by the end of November, it became clear that the city officials had opted to neglect their responsibilities with regard to the smallpox epidemic.\(^{380}\)

The Provincial Board of Health initiated an investigation into the epidemic in late November,\(^{381}\) and called on all physicians in Toronto to submit reports on smallpox cases seen by them, as well as vaccinations performed.\(^{382}\) Shortly after, the Board issued a report of the findings from its investigations, which concluded that the “outbreaks in various parts of [the province]…are traceable to Toronto.”\(^{383}\) The Board also released figures showing that seventy seven percent of persons admitted to hospital for smallpox in December had never been vaccinated, and that among the vaccinated, the average time since the procedure was 29 years.\(^{384}\) The report further claimed that the “[f]ailure of the municipal authorities in Toronto to carry out the law in respect to compulsory vaccination

\(^{375}\) See generally \textit{Public Health Act}, 1912, supra note 360, ss 53-58; \textit{supra} note 244, ss 5-7 & 12.

\(^{376}\) See \textit{Public Health Act}, 1912, \textit{ibid.}

\(^{377}\) See \textit{ibid}, s 35.

\(^{378}\) See \textit{supra} note 244, s 12.

\(^{379}\) See \textit{ibid}, s 5.

\(^{380}\) See \textit{supra} note 369.

\(^{381}\) See \textit{ibid}.

\(^{382}\) See “Number of smallpox cases shows increase”, \textit{supra} note 368.

\(^{383}\) \textit{Supra} note 369.

\(^{384}\) See “Figures show vaccination is necessary: Out of 110 smallpox cases 85 were never successfully vaccinated”, \textit{The Globe} (22 December 1919) 9.
against smallpox” had caused U.S. authorities to implement quarantine and require visitors from Ontario to present proof of vaccination, and warned Toronto city officials that further neglect of their legal duties would “invite damage suits on behalf of outside points which have suffered on account of [the] neglect.”

The Provincial Board of Health also took certain steps to deal with the epidemic. In November, the Board distributed “240,000 individual doses of [the] smallpox vaccine” without charge to various municipalities in the province for vaccination of the public. On December 8, the Board, exercising its powers under the extant vaccination statute, sent a letter to Mayor Thomas “Tommy” Church of Toronto, requesting that the Toronto City Council comply with the law by issuing a proclamation “enforcing compulsory vaccination of all persons who have not been vaccinated for the past seven years.”

385 Supra note 369.
386 Ibid.
387 Ibid.
388 Ibid
389 See supra note 244, s 12. The section mandates municipal councils to order compulsory vaccination or re-vaccination of all residents whenever there was an outbreak of smallpox, or upon being notified by the Provincial or Local Board of Health that a smallpox outbreak was imminent. The section reads, in part: In every municipality where smallpox exists, or in which in the Provincial or Local Board of Health has notified the council that in its opinion there is danger of its breaking out owing to the facility of communication with the infected localities, the council of the municipality shall order the vaccination or re-vaccination of all persons resident in the municipality who have not been vaccinated within seven years, and that such vaccination or re-vaccination shall be carried out in so far as the same may be applicable in the same manner as for the vaccination of children. See also Vaccination Act, RSO 1914, c 219, s 12 [Vaccination Act 1914].
The following day, the Board’s Secretary, Dr. John W.S. McCullough, who was also the Chief Health Officer of Ontario, called upon Council in the papers to abide by the “nice, polite letter” he wrote to them, and warned that failure to comply with the law will render each councillor liable to a fine of $25 dollars and possible jail time “if they become real obstreperous.” Dr. McCullough also mentioned that the possibility that the Provincial Board could seek an order of mandamus to compel the city to act.

The City Council met that same day to discuss the letter and to deliberate on whether to implement compulsory vaccination. The question was put to a vote, and a slim majority of aldermen voted against compulsion (13 voted against, 11 for, 4 abstained, and one was absent). The aldermen who opposed the measure declared that they would rather pay a fine than pass such an order. Following the vote, Mayor Church, who voted against

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391 Dr. McCullough was also a former lecturer of public health administration and public health law at the University of Toronto. He was a dogged and ardently dutiful civil servant who devoted much of his public life to building an organized and effective public health bureaucracy for Ontario. He is widely regarded as a central figure in the history of public health in Ontario and Canada. He served as Chief Health Officer of Ontario and Secretary of the Provincial Board of Health from 1910 to 1935, during which time he initiated many notable reforms, including the reorganization of the Provincial Board of Health, establishment of public health laboratories and travelling tuberculosis clinics, and free distribution of anti-toxins and other biological products. He frequently pressed the provincial legislature for more robust public health laws, and was a firm advocate of stricter vaccination laws and centralized oversight of local boards of health. He died in 1941, aged 73, “while sitting at his typewriter, writing an article on medical health.” See “Dr. McCullough dies at desk; in 73rd year—former public health inspector for Ontario was war veteran—constant writer”, Globe and Mail (6 January 1941), 4.

392 This fine is stipulated by law. See supra note 244, s 12(3).

393 See “Must compel inoculation, City is told”, supra note 390.

394 Ibid.

395 See “Vaccination order splits City Council—Yesterday’s majority is in favour of defying provincial edict—Ready to pay fines—Meanwhile, smallpox epidemic claims more victims”, The Globe (10 December 1919) 8.

396 Ibid.

397 Ibid.
compulsion, declared he was bound by Council’s decision and refused to issue the compulsory vaccination proclamation.\textsuperscript{398}

Alderman John Cowan, representative for Kensington Market and Garment District, and the Medical Officer of Health and Chairman of the Local Board of Health for Toronto, voted in favour of compulsory vaccination.\textsuperscript{399} However, while the Local Board of Health was empowered to make provisions for vaccination if the municipal council neglected or refused to do so,\textsuperscript{400} neither the Local Board nor the Medical Officer of Health possessed the authority to order vaccination. Besides, other members of the Local Board of Health, including Mayor Church, Alderman Samuel Ryding (West Toronto Junction) and Alderman John McMulkin (Kensington Market and Garment District) either voted against compulsion or abstained from the vote.\textsuperscript{401} Alderman Ryding also procured a Council resolution to reverse an order by the Local Board of Health permitting the exclusion of unvaccinated pupils from schools in the city, much to the annoyance of Mayor Church and Alderman Cowan, who both passed the measure.\textsuperscript{402}

As December progressed, the Provincial Board of Health increased pressure on the Toronto City Council, mainly by threatening to commence legal action to compel compliance with the law.\textsuperscript{403} Other cities and organizations soon joined in demanding

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\textsuperscript{398} Ibid.
\textsuperscript{399} Ibid.
\textsuperscript{400} See supra note 244, s 6.
\textsuperscript{401} See supra note 395.
\textsuperscript{402} See “City Council reverses action of the Board of Health”, \textit{The Globe} (5 December 1919) 25.
\textsuperscript{403} See “City cannot bulldoze Ont. Health Dept.—Board holding its hand until Council meets on Monday—Law must be enforced—Province has power to place Toronto in complete quarantine”, \textit{The Globe} (12
}
action from the city. The Toronto Board of Trade, an organization representing business interests in the city, passed a resolution recommending compulsory vaccination.\(^{404}\) Health officials in Manitoba and Montreal declared quarantine against Ontario and issued orders forbidding Ontarians who could not produce certificates of successful vaccination from entering their respective regions.\(^{405}\) Montreal boasted that it has been “consistent on the smallpox issue” and that “it practiced compulsory vaccination before quarantining Ontario.”\(^{406}\) The City of St. Catherines threatened to commence legal action for compensation against Toronto if “it could be proved that the local outbreak [in St. Catherines] was directly traceable to infection in Toronto.”\(^{407}\) Still, the Toronto City Council persisted in its refusal to order or implement compulsory vaccination.

On December 16, the Provincial Board of Health followed through on its threat and instructed its lawyer, Herbert M. Mowat, K.C. — nephew to Ontario’s third and long serving premier, Sir Oliver Mowat and a Justice of the Supreme Court of Ontario from 1921 to the time of his death in 1928 — to commence legal action against the Toronto City Council.\(^{408}\) The next day, Mr. Mowat applied to the Ontario Supreme Court, High Court Division (sitting at Osgoode Hall), for an order of mandamus to compel the City

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\(^{404}\) See “Pass the buck on vaccination: Dr. McCullough and City authorities now at a deadlock”, *The Globe* (11 December 1919) 8;

\(^{405}\) See “Recommends making vaccination compulsory”, *The Globe* (26 December 1919) 3.


\(^{407}\) See “Notes and comments”, *The Globe* (19 December 1919) 6.

\(^{408}\) See “St. Catherines may have a legal claim: If the smallpox outbreak there traceable to infection in Toronto”, *The Globe* (22 December 1919) 3.

\(^{408}\) See “Health Department starts in an action against City”, *The Globe* (16 December 1919) 1. Herbert Mowat also served as a federal parliamentarian.
Council to enforce compulsory vaccination.\(^{409}\) Mayor Church was served with the notice of motion the same day, and the case was scheduled for hearing the next day before Justice Hugh Thomas Kelly.\(^{410}\) However, when hearing opened, the City’s lawyers requested an adjournment for one week to prepare for the case.\(^{411}\) The case was adjourned to December 23, and on that date, the application was heard in chambers by Justice Robert Franklin Sutherland.\(^{412}\)

At the hearing of the case, the Toronto City Council conceded the existence of smallpox within the municipality, but argued against the order sought on evidentiary and legal grounds. Regarding the evidentiary point, Council, relying on affidavit testimonies from medical professionals, sought to contradict the Health Board’s contention that vaccination was a precautionary, prophylactic measure against smallpox, arguing instead that the remedy was neither safe nor effective against the deadly disease.\(^{413}\) On the point of law, Council argued, by way of a preliminary objection, that the Provincial Board of Health was not a statutory corporation, and therefore “had no status or authority to make the motion”\(^{414}\) applied for. Responding to the legal contention, the Board relied on *Re City of Ottawa and Provincial Board of Health*\(^{415}\) to argue that it was “a body created for

\(^{409}\) See “Vaccination controversy is in courts”, *The Globe* (17 December 1919) 8.
\(^{410}\) See *ibid*.
\(^{411}\) See “City to ask one week to prepare case—The compulsory vaccination hearing opens this morning at Osgoode—Antis threaten probe—Dr. John Hall pays tribute to the value of vaccination”, *The Globe* (18 December 1919) 8.
\(^{412}\) See generally *Re Provincial Board of Health for Ontario and City of Toronto* (1920), 46 OLR 587 (Ont SC (HCD)).
\(^{413}\) See *ibid*, para 4.
\(^{415}\) (1914), 20 DLR 531, 33 OLR 1 (Ont SC).
the discharge of important administrative and quasi-judicial functions”\textsuperscript{416} and as such, it could sue and be sued.\textsuperscript{417} After hearing arguments, Justice Sutherland reserved judgment for the next day.\textsuperscript{418}

It is worth noting that at this time the Toronto City Council was not alone in resisting vaccination. Shortly after the Provincial Board of Health filed suit against the Toronto City Council, the Anti-Vaccination League of Canada—\textemdash an organization formed in Toronto in 1900 to oppose and secure the repeal of compulsory vaccination laws\textsuperscript{419}—drew up a petition and organized a “signature campaign” to oppose any attempt to implement compulsory vaccination.\textsuperscript{420} League officials also warned that if compulsory vaccination was ordered for the province, they would request that the provincial government appoint a commission to “investigate the measures…employed [by the Provincial Board of Health] to combat the present epidemic, the quality of the vaccine supplied, and alleged violations of quarantine.”\textsuperscript{421} A week later, League members secured a promise from Premier Ernest Drury to investigate the allegations against the Provincial Board of Health.\textsuperscript{422}

\textsuperscript{416} Supra note 412, para 10.
\textsuperscript{417} See “Vaccination case heard no decision”, \textit{The Globe} (24 December 1919) 9.
\textsuperscript{418} See \textit{ibid}; “The news of the day”, \textit{The Globe} (24 December 1919) 1.
\textsuperscript{419} See Katherine Arnup, “‘Victims of Vaccination?’: Opposition to Compulsory Immunization in Ontario, 1900-90” (1992) 9 Canadian Bulletin of Medical History 159; Keelan, \textit{supra} note 277.
\textsuperscript{420} See Anti-vaccination petitions”, \textit{The Globe} (23 December 1919) 6.
\textsuperscript{421} See \textit{supra} note 411.
\textsuperscript{422} See “Vaccination application is refused—Court holds Board of Health has no legal right to apply—Denied on technicality—“Antis” are promised an investigation of arguments by Drury”, \textit{The Globe} (25 December 1919) 7.
Government officials and ordinary citizens also resisted the procedure. A letter to the editor of The Globe published around the time of the dispute under discussion urged the doctors who practice vaccination and those “fighting and screaming [over] vaccination” to be the first to “line up and show their arms.”423 Around the same time, some homeopathic doctors in Toronto began to offer their patients an unspecified “internal treatment” as an “equivalent to vaccination.”424 The homeopaths also issued certificates of successful vaccination to patients who received this treatment.425 Circa 1921, Mayor Frank Plant of Ottawa announced he would rather go to jail than submit to smallpox vaccination.426 However, shortly after, in an unexplained reversal of this position, he, along with his wife and two children, got vaccinated. In 1920, fifteen hundred residents of Windsor signed a petition urging the Ontario Legislature to abolish mandatory vaccination.427 The petition also declared that “improvement of public health can be attained by sanitation, education, and improvement in living conditions, rather than by vaccination or inoculation.”428 An editorial in a 1912 issue of the Canada Law Journal titled “The Liberty of the Subject”429 declared that proposed compulsory vaccination legislation “has a very Russian aspect”430 to it, and expressed doubts that the measure can become law because it contained “some very stringent and most objectionable provisions”431 and “a large and an increasing number of the community have

425 See ibid.
428 Ibid.
430 Ibid at 182.
431 Ibid at 181.
conscientious scruples against vaccination, and...others have, to their cost and lifelong detriment, found it injurious to health.”

Furthermore, while there was significant support for vaccination among medical professionals, some physicians opposed the procedure. For example, in December 1900, twenty-one physicians, mostly based in Toronto, sent a letter to Premier James Whitney opposing compulsory vaccination, and in particular “stringent [vaccination] measures that are enforced in cases of pupils and students who wish to attend our public schools.”

The letter advanced several arguments against vaccination, including that “it has signally failed when depended upon as the chief means for stamping out or abating epidemics of smallpox,” that it is a procedure “fraught with danger...[and] of doubtful efficacy” and that “the origin of vaccine [is] unknown smallpox.” The letter also stated that smallpox had become “a rare disease in organized communities not so much because of vaccination as because of improved sanitation and the careful isolation of all persons who have been exposed to the contagion” and that “[a] very large proportion of the ratepayers of Ontario are opposed to having their children vaccinated, owing to cases of serious bodily injury, and sometimes death, that have resulted after vaccination.”

432 Ibid at 182.
434 See Circular letter from a number of doctors opposing vaccination (1 December 1900), Toronto, Archives of Ontario (Correspondence of Sir James Whitney, F 5-1, barcode B273260).
435 Ibid.
436 Ibid.
437 Ibid.
438 Ibid.
439 Ibid.
letter then concluded that that “it is reasonable and right for those who are conscientiously opposed to the practice of vaccination to ask the Legislature to relieve [them]…of all compulsion in regard to vaccination.” There is no record of a reply from Premier Whitney, but pen-marked annotations on the face of the letter bearing statements such as “quite false” and “compulsion of individuals is necessary in the interests of the general public health” suggest that the Premier (or someone with access to his correspondence) disagreed with the anti-vaccinationist physicians (see Plate B).

Also, during this period, the safety and efficacy of vaccination was a hotly debated topic, and how and why vaccination worked was not fully understood. Jennifer Keelan has argued, for example, that historical accounts of smallpox and the anti-vaccination movement in Canada fail to contextualize vaccination “in terms of the late nineteenth century debate over its efficacy” and as such, accord “a presentist priority…to those who supported compulsory smallpox vaccination.” She contends further that the question of whether vaccination was safe and efficacious was far from settled, and that “[r]ather than exemplifying a medical law, [vaccination] data could be interpreted to either support or reject smallpox vaccination,” and that “[i]n the nineteenth century, no generally accepted medical theory existed to explain how vaccination worked [and] [i]f its

440 Ibid.
441 Ibid.
442 Historical debates regarding the safety and efficacy of vaccination have been addressed in a few existing works. For the Canadian context, see e.g. Keelan, supra note 277. For the U.K., see Durbach, supra note 192. For period-specific examples of arguments regarding vaccine safety and efficacy, see generally Smallpox – Board of Control and Provincial Health Officer’s Statement (1920), Toronto, Archives of Ontario (RG 3, Series 03-04-0-201); American Medical Liberty League, “What Are You Going to Do About It?: Some Facts Regarding State Medicine”, Toronto, Archives of Ontario (Attorney General Central Registry Criminal and Civil Files, RG 4-32, barcode B248107).
443 Keelan, ibid at 17.
444 Ibid at 15.
theoretical moorings were uncertain, so too was its empirical basis.”

Nadja Durbach, writing about the U.K. context, reached a similar conclusion:

While historians have often seen anti-vaccinationism as anti-progressive, how well nineteenth century vaccination actually worked is a complicated historical question… The invasive, insanitary, and sometimes disfiguring procedure seemed to many to be potentially more harmful than beneficial… Throughout the nineteenth and early twentieth centuries, compulsory vaccination was at odds with both popular understandings of bodily economy and assumptions of the boundaries of state intervention in personal life. A history of anti-vaccinationism therefore suggests that it is the success of vaccination itself—as a medical and social practice—that requires further explanation.

A 1912 editorial published in *The Globe* confirms this uncertain and contested status of vaccination during this period. According to the editorial:

What is really known and professionally agreed upon about vaccination is that it generally entails a sore arm for a few days or weeks rarely for a year or more, and in extremely rare cases it entails permanent injury or death. As to its prevention of smallpox leading medical authorities differ widely, and as neither side has any proof except, uncertain statistics that show both ways their differences are intense, and even violent. One recognized school of medicine discards it entirely. Those who oppose vaccination deny the right of official authorities to intentionally afflict them with one disease on the uncertain hope of saving them from the uncertain danger of taking another. They say that those who seek safety have their safety. It cannot be any affair of theirs if others refuse to risk such safety. The unvaccinated are no menace to the vaccinated if the operation gives immunity. If the vaccinated reply that their immunity is uncertain the argument cuts both ways. It would be well for the law to be administered with discretion until more is known as to the danger and preventive effects of vaccination.

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446 Durbach, *supra* note 192 at 2-4.
Furthermore, the aetiology of smallpox was also the subject of much speculation and debate throughout the period of this study. An authoritative diagnostic and treatment manual for smallpox published in 1920 notes, for example:

There is hardly a disease in the whole range of medicine which cannot be successfully counterfeited by smallpox. For instance, cases diagnosed as acute mania, appendicitis, rheumatic fever, typhoid fever, lumbago, influenza,---not to mention glanders, [G]erman measles, various rare skin diseases, purport, and many more, have in the end manifested themselves as smallpox, by breeding true, and producing secondary cases. It is therefore a practice of the greatest utility to challenge mentally the diagnosis of every case, which is not absolutely clear, by the question “Can this possibly be smallpox?”… These cases will…serve to illustrate some of the difficulties we had in the way of diagnosis in the presence of an epidemic of irregular smallpox. Ordinarily the differential diagnosis of smallpox is from influenza, chicken-pox, drug rashes, and perhaps syphilis and impetigo. These were not the diseases we had to consider, but scarlet fever, measles, erysipelas, surgical conditions of the abdomen, aspirin poisoning, pelisses rheumatic and exfoliative dermatitis.448

In his ruling, Justice Sutherland accepted the City Council’s legal argument, noting that the Public Health Act,449 which provided the basis for the Provincial Board of Health’s mandate and authority, did not authorize the Board to apply for the order sought in its own name.450 The judge distinguished the case at bar from Re City of Ottawa and Provincial Board of Health,451 where it was held that a court could order a mandamus requiring the Provincial Board of Health to perform its statutory duties. According to the judge, “[i]t is one thing to say that…if [the Provincial Board of Health] fails to discharge

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449 Supra note 360. The ruling made reference to the version of the Act included in the 1914 revised statutes. See An Act respecting the Public Health, RSO 1914, c 218, ss 3-11.
450 See supra note 412, para 11.
451 Supra note 415.
or attempts to discharge in an improper way its duty, it is amenable to the jurisdiction of the Court, but quite another…to say that in its own name it has a legal right to apply to the Court for the order [of mandamus].”  Thus, the Board did not possess a legal right to a mandamus to compel a Toronto City Council to enforce the vaccination law. The judge stated further that he might have allowed the order sought if the application was brought in the name of the Crown, or by a City of Toronto ratepayer.

The judge, however, rejected the evidentiary argument, ruling that it was irrelevant in light of the Legislature’s belief that it was in the public interest to require municipal councils to order vaccination during smallpox outbreaks. Since the law, as enacted, was “binding alike upon the council, the public, and the [c]ourt,” the court needed not examine the matter, as it lacked the authority to vary the provision even if the City Council’s argument was proved. In the judge’s words:

In so far as the applicant’s material entered upon a discussion of the merits of vaccination as a precautionary and preventative measure in the interest of public health and security, and led those opposing the motion [i.e. the City Council] to file affidavits in which medical men not only questioned its utility but suggested that under some conditions it is even fraught with danger, I expressed the view on the argument that such discussion was beside the real and single question to be dealt with and determined upon the motion. The Legislature must, I think, be assumed to have come to the conclusion, before it enacted the clause in question, that where smallpox was found to exist in a municipality it was in the public interest that vaccination or re-vaccination should be ordered.

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452 Supra note 412, para 11.
453 See ibid. See also “At Osgoode Hall”, The Globe (25 December 1919) 6.
454 See ibid, para 4.
455 Ibid.
456 Ibid. A similar argument was similarly rejected in the U.S. case of Jacobson v Massachusetts, 197 US 11 (1905). See Chapter 1, Part 1.8, above, for the discussion. In Jacobson, the court ruled, on point: Looking at the propositions embodied in the defendant's rejected offers of proof it is clear that they are more formidable by their number than by their inherent value. Those offers
But that was not to be the end of the matter. Despite reports indicating that Premier Drury’s government was unwilling to pursue the matter any further or to urge the enforcement of the vaccination law “due to the general unrest existing in the country at the present time,” the Provincial Board of Health filed an appeal with the Ontario Supreme Court, Appellate Division. Arguments were heard on January 3, 1920, and three days later, the court dismissed the appeal. Riddell J, on behalf of a unanimous court, ruled that although the Board was not incorporated under the Public Health Act, it was a legal entity with rights and duties, including a right to be heard in Court. It could therefore apply to the court for remedial orders in certain circumstances. Nonetheless, the Court could not grant the mandamus order sought because the Board did not possess a clear and specific legal right under any statute or legal rule to supervise municipal councils in vaccination matters. Rather, the City Council was “a separate and distinct

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457 See supra note 422.
458 See “At Osgoode Hall”, The Globe (3 January 1920) 8.
459 See generally supra note 412, paras 13-39 (Ont SC (AD)).
460 See ibid, paras 26-27. See also “Plea of Ont. Health Board turned down”, The Globe (6 January 1920) 8; “Health Board appeal thrown out by court”, The Globe (7 January 1920) 8.
461 See supra note 412, paras 29-32 (Ont SC (AD)).
body, with its own ambit of duty prescribed by statute,"\textsuperscript{462} and as such, the Board could not interfere in the conduct of Council’s affairs, regardless of whether the City Council was in dereliction of its statutory responsibilities.

On the evidentiary issue, Riddell J agreed with the lower court decision, noting that although the law customarily allowed municipal authorities a measure of discretion with respect to dealing with matters of public health, the Vaccination Act imposed an obligation to act on municipal councils, and as such, the City Council lacked the right under the law “to bring into play [its] views on the propriety of vaccination.”\textsuperscript{463} In his opinion, to rule otherwise would amount to exercising the court’s jurisdiction in a manner “as to overlook [the] breach of a plain imperative duty imposed by Legislature.”\textsuperscript{464}

A day later, Dr. McCullough issued a statement to the press stating that “no further proceedings would be taken to enforce compulsory vaccination in Toronto.”\textsuperscript{465} However, he also offered remarks that suggested that the Provincial Board of Health was going to continue the fight in the press. According to him, “[t]he board [had] endeavored to do what it considers its duty to the public of Ontario against the neglect by the city of Toronto in carrying out the law.”\textsuperscript{466}

\textsuperscript{462} Ibid, para 32.
\textsuperscript{463} Ibid, para 21.
\textsuperscript{464} Ibid, para 22.
\textsuperscript{465} “Provincial Health Board drops vaccination action”, The Globe (8 January 1919) 8.
\textsuperscript{466} Ibid.
Before delving into the general implications of the case and decision, it is worth exploring the facts and reasons underlying the parties’ involvement in the case. For the Provincial Board of Health, three reasons are evident from the historical record.

First, since its inception, the Provincial Board of Health viewed municipal handling of public health affairs as largely weak and ineffective. The Board’s first annual report observed, for example:

There is, however, a great difficulty in getting action taken in many instances, owing to the fact of no Local Health Board having been instituted, and no Health Officer having been appointed. Cases of real nuisances existing in municipalities have come under the notice of the Secretary where, owing to members of the council not being personally interested, the difficulty of getting township councils together in the summer season, and then, even if assembled, of obtaining speedy and effective action, strongly point to the necessity of some more definite measures being taken, requiring every municipality or several adjoining municipalities, to have a Local Health Board, and a Health Officer permanently appointed, one who would possess the confidence of the community, both as to his efficiency and integrity.  

To address this problem, the Board sought to centralize and gain control over public health functions in the province or, at a minimum, to gain the authority to direct or supervise municipal handling of public health matters. The Board made the case for centralization in successive reports to the Ontario legislature. One report stated, for example:

To some it may…have appeared that the municipal machinery in existence would have obviated any great necessity for a [c]entral [a]dvisory Board…But if it be remembered for a moment what an enormous proportion of deaths…took place in Ontario in 1880, was due to preventable causes, or

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467 Supra note 253 at xxii.
what are called zymotic diseases, there can be no persons who would not grant that there is much yet to be done.\textsuperscript{468}

Another report lamented the largely advisory character of the Board’s authority, noting that “a large link is wanting between the power which advises and some power which ought to perform.”\textsuperscript{469} The report then called on the legislature to grant the Board the authority to “to see that local authorities take action where necessity for it has been amply proved.”\textsuperscript{470}

The authority to order and implement vaccination was one aspect of the municipal mandate that the Board was most interested in taking over.\textsuperscript{471} As previously noted, many physicians supported and used vaccination in their practice. Also, as the only health professionals permitted to serve as vaccinators under the law,\textsuperscript{472} physicians stood to benefit financially from widespread adoption of the procedure. The physician-dominated Board was well aware of the importance of vaccination in both respects, and they sought

\begin{footnotes}
\textsuperscript{468} \textit{Ibid} at vi.
\textsuperscript{469} See Provincial Board of Health, \textit{Second Annual Report of the Provincial Board of Health of Ontario, 1883} (Toronto: C Blackett Robinson, 1884) at xxvi. See also \textit{ibid} at xxxvii: The Board has been called upon again and again ever since its formation to step in and abate, or cause to be abated, nuisances regarding which some local authority has been wholly unconcerned or indifferent. In many cases the nuisances...have been of a most serious character. All the Provincial Board can do is either to notify the local authorities or municipal council of said complaints, inform them of their powers and call for action; or, if the Board deems it advisable, it may make an official enquiry, and advise local authorities, and still the nuisance remains unabated. A Provincial Board so constituted has no powers, either to cause the removal of the nuisance or to make the local authorities take action. Under the circumstances, there is little wonder the aggrieved parties should demand, with much reason, for what such a Board exists.
\textsuperscript{470} \textit{Ibid} at xxvi.
\textsuperscript{471} See “Vaccination: Provincial authorities interesting themselves in the carrying out of local mandate” (26 December 1920), Toronto, Archives of Ontario (Smallpox – Board of Control and Provincial Health Officer’s Statement, RG 3, Series 03-04-0-201).
\textsuperscript{472} See \textit{supra} note 244, ss 2, 5 & 12.
\end{footnotes}
to use the remedy to advance both the status of their profession and the economic well-being of their professional colleagues.

The lack of authority to order or implement vaccination did not prevent the Board from getting involved in vaccination matters. The Board pressured municipalities to implement vaccination, or to appoint local health officials exclusively from the ranks of the medical profession (presumably because they were more amenable to implementing vaccination). Shortly after the inauguration of the Board, it entered into an agreement with “National State and Local Boards of Health in the United States and in the Dominion of Canada” to implement the inspection and vaccination of immigrants. This initiative was applauded by the Ontario Medical Association, which passed a resolution approving the agreement and calling on the “individual efforts of every member” of the association to ensure its success. Lastly, the Board also lobbied for legislative reforms to strengthen and expand the coercive aspects of existing vaccination legislation, and galvanized their professional colleagues into an effective movement for control of

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473 See supra note 471 which contains a transcript of a letter from Dr. Bryce, the inaugural Secretary of the Provincial Board of Health, to W.R. Hall, Medical Health Officer of the City of Chatham, expressing the Board’s frustration with “[the] the members of [the local] Board seem to take regarding vaccination” and pointing out to the Board that “[the provincial] health officers are masters of the situation.” See also supra notes 390 and 403.

474 See “Ontario Board of Health” (1882) 14:11 Canada Lancet 333 at 334 for a resolution passed by the Provincial Board of Health to “express the opinion that the appointment of health officers by municipal councils should be confined to local medical men, who, from their professional training, are alone qualified to perform the work efficiently.”

475 See “Reports of Societies — Ontario Medical Association” (1882) 14:11 Canada Lancet 327 at 330; supra note 324 at 246.

476 Ibid.

477 See e.g. supra note 469 at v:

It is the intention of this Board to submit, at an early date, certain suggestions regarding the consolidation of the Public Health Acts already in force, and the making of certain additions thereto, in the hope that the suggestions so made may be of some service in assisting in the carrying out of [the Board’s] object[s].
vaccination affairs by encouraging ordinary practitioners to report their involvement in providing vaccination services directly to the government.\textsuperscript{478}

Second, the Board and its members believed that the protection and advancement of public health was the highest and most important concern of government, and that the state could legitimately suppress private or individual interests in order to secure and protect the welfare of the collective. To them, while state-mandated vaccination could be viewed as an intrusion on an individual’s bodily integrity and liberty, this was a negligible price to pay to protect Ontarians from the scourge of smallpox. The Board insisted that “the interests of the many, the greatest good to the greatest number, must be considered paramount, and that no individual has the right to endanger the safety, or interfere with the comfort, of others for his own pecuniary ends.”\textsuperscript{479} They urged the government of Ontario to both consider “[h]ow far the vested rights of the individual are to become secondary to the public interest in matters of health”\textsuperscript{480} and make “the preservation of the lives, health, and happiness of her people a public right and a public duty.”\textsuperscript{481} In the Board’s opinion, an interventionist approach to public health governance was both justified and necessary because “[e]ternal vigilance is the price of health as well as of liberty.”\textsuperscript{482}

\textsuperscript{478} See e.g. Number of smallpox cases shows increase, \textit{supra} note 368.
\textsuperscript{479} \textit{Supra} note 469 at xxxvii – xxxviii.
\textsuperscript{480} \textit{Supra} note 253 at 91.
\textsuperscript{481} \textit{Supra} note 469 at lx. See also \textit{ibid} at 335, which references comments from Dr. O.W. Wight, Health Officer of Detroit, in response to the claim that isolation and quarantine unduly restrict individual liberty. Dr. Wight observed: “It is not very noble to die, or even to contend for that kind of liberty. The argument denies to the public the right and sacred liberty to protect itself against contagious disease [and] combats the ancient and precious legal maxim: \textit{Salus populi est suprema lex}.”
\textsuperscript{482} \textit{Supra} note 469 at xxii.
There are numerous instances of similar appeals to *salus populi* in publications issued by the Provincial Board of Health. For example, the Board’s inaugural annual report invoked the philosophy to justify its professional status:

> In the establishment of a department, whose province and very raison d’être it is to undertake the difficult office of preventing the outbreak and spread of disease, a step has been taken, the exact bearing and significance of which are not at once, by a mere casual glance, fully comprehended. It is the recognition of the principle that the State may and ought to exercise a paternal care over the health and lives of the people, not in a fitful or accidental manner, as during epidemics of disease, but in a daily supervision of the habits and manners of living individuals and communities, in everything that tends to affect favourably or unfavourably the material well-being of the people, to speak of nothing more. Hence, it must be plain that inasmuch as the Government has delegated this power to a Board presumably, from its professional status, competent to advise in all matters pertaining to health, its responsibility is, of necessity, of the highest and most extended nature. Its relations to the people are many and ought to be intimate. As the work of the physician is largely of an individual and personal nature, so must also be that of a Board, which is engaged in a work with the intent of saving individual lives, as a unit of the body politic.⁴⁸³

Similar arguments were invoked to justify the public health reforms favoured by the Board, including compulsory vaccination and “sanitary organization” – a term that reflected the Board’s desire to populate public health bodies throughout the province with physicians. The Board argued that “[a]ny person sufficiently interested in the saving of life, health and wealth, may obtain a fair idea of what may be gained by increased attention to sanitary organization”⁴⁸⁴ and that “[p]eople will not forever listen to the erroneous nonsense about infringements of personal liberty and interference with business, whilst their children are being needlessly slaughtered by preventable disease.”⁴⁸⁵

⁴⁸³ *Supra* note 253 at xxviii.
⁴⁸⁴ *Supra* note 469 at iv.
Third, members of the Board believed that the safety and efficacy of vaccination was well established according to the standards of medical science during this period, which was based mainly on the observed effects of the procedure. Although the scientific and empirical value of vaccination was a hotly contested topic, even among medical professionals, members of the Board were unequivocal in their support for the procedure, and used it to bolster the claim that their approach to public health administration was science-based. One member of the Board proclaimed, for example, that it was “hardly necessary to argue the value of vaccination as a preventative of smallpox” and that “[a]ll the authority of scientific opinion and the experience of Ontario during the present season is so strongly favorable to this view that the noisy argument of ignorant opposition can hardly be seriously considered.”

The Board’s tactic in this regard—invoking the language of science to justify or advance a stated position or preference—was a common strategy among members of the medical profession during this period. As SED Shortt has observed, nineteenth century medical practitioners “employed the rhetoric of science in their search for professional legitimation,” and recruited “significant biological and medical innovations during the

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486 See e.g. supra note 331 at 46, where the Provincial Medical Inspector, Dr. R.W. Bell states that “personal experience of over fifteen years with the Provincial Board of Health has proven...the efficacy of vaccination.”

487 Memorandum from Dr. John W McCullough for the Attorney General (16 Feb 1920), Toronto, Archives of Ontario (“Vaccination”, RG 6-2, Correspondence of the Treasurer of Ontario, File B291083).

488 Ibid.

nineteenth century”490 and “an ahistorical definition of science”491 that ignored “the diversities which characterized medical practitioners”492 to “enhance their professional status.”493 Shortt notes further that “[p]ublic health provided a particularly appropriate field in which a medical subgroup could advance its professional status in the name of science.”494 Thus, for example, the Board relied on appeals to science to justify demands for recognition of its opinions and methods, as well as to attack its critics. In one published report, the Board described its scientific approach, involving “the investigation of…deleterious agencies…improved chemical processes and microscopic methods…[and] inductive processes of reasoning from effect to cause”495 as “hardly known—certainly not appreciated.”496 Elsewhere, the Board described its role as that of a “true apostle of [p]reventive [m]edicine”497 and proclaimed that it was working “to propagate[e] among the people…as much accurate knowledge as may be possible of the known causes which either originate or serve to propagate many diseases.”498

The Board’s motto, Ne pereat populus Scientia absente (“Let not the people perish for lack of knowledge”)499 also embodied its scientific aspirations. The Board’s inaugural annual report summed up its views on scientific pursuits:

\[\text{The foes to health are everywhere—in the daily life of the individual, in social life, in commercial and in public life. Immoral and vicious personal}\]

\[490 \text{Ibid at 52-53.}\]
\[491 \text{Ibid at 67.}\]
\[492 \text{Ibid.}\]
\[493 \text{Ibid.}\]
\[494 \text{Ibid at 65.}\]
\[495 \text{Supra note 253 at xiv.}\]
\[496 \text{Ibid.}\]
\[497 \text{Ibid at xv.}\]
\[498 \text{Ibid.}\]
\[499 \text{See supra note 20 at 22.}\]
habits everywhere abound; false social customs prevail on every hand. Commercial life, with its eager seeking after wealth, causes in too many cases, a disregard for the physical laws which regulate and promote the [well-being] of both body and mind, while public life is in too many cases so surrounded by the conventionalities and traditions which have descended from times when physical laws were very imperfectly understood, that it lays its burdens too frequently upon men who falter and finally fall under their Atlantean loads… [S]anitary science may and does very properly embrace all these questions, and finds them most properly coming under her aegis.500

Toronto City Council’s involvement in the case can also be explained in a number of ways. First, it appears majority of the aldermen, including Mayor Church, were anti-vaccinationists. At a minimum, they were not as enthusiastic as the medical elite about the value of vaccination. Although vaccination for smallpox had been available in Canada since circa 1798501 the remedy had failed to supplant other longstanding public health methods relied on by local officials for dealing with smallpox, such as sanitation, placarding of infected places, quarantine and removal / isolation of victims. These methods were routinely relied on by local authorities throughout the period of this study, and were sometimes lauded by the Provincial Board of Health.502 Competing with “time-

500 Supra note 253 at xxxii [emphasis in original]. See also ibid at xxx: As in matters bearing something of a scientific character, it has ever been necessary for the Government to teach and lead this people, so in this. Everywhere it is found that the educated and intelligent members of our communities recognize the necessity for sanitary work, and the wisdom of instituting means for carrying it out. And ibid at xiv: [W]e at once conclude that some causes have been at work tending to lessen human ills, and human mortality. These briefly stated have been the systematic and scientific methods of observing facts in relation to disease, and thence educing inferences as to causes.


502 See supra note 253 at xix-xx.
honoured” remedies, vaccination never gained widespread adoption among municipal authorities.

Local attitudes towards vaccination also appear to have been influenced by anti-vaccinationist lobby in Toronto. The main proponents of this lobby were the Anti-Vaccination League of Canada and alternative health practitioners. Both groups viewed vaccination as an attack on medical freedom and the personal right to choose among available medical options. Since by law alternative health practitioners could not serve as vaccinators, they claimed that the doctors’ main reason for supporting both vaccination and compulsion was to benefit the profession’s interests. Having deemed doctors a common enemy, both groups threw their support behind causes opposed to vaccination. The League declared vaccination to be “a system of blood-poisoning with animal diseases,” and an “unqualified abhorrence,” and referred to a recommendation by the Canadian Medical Association calling for the establishment of a national system of vaccination as a “ludicrous absurdity” and a “lavish expenditure of public money.” League officials passed a resolution to “resist all attempts at compulsory vaccination” and protested comments attributed to Dr. McCullough in the papers accusing the Toronto

503 Supra note 489 at 55.
504 See supra note 427.
505 See supra note 244, ss 2, 5 & 12.
507 Ibid.
508 Ibid.
509 Ibid.
510 “Anti-Vaccinationists elect year’s officers, also pass resolution to maintain right to medical freedom”, The Globe (25 November 1924) 13.
City Council of consciously allowing the spread of smallpox by failing to implement vaccination measures.\textsuperscript{511}

Rattled by the threat posed by vaccination and other “scientific” remedies to their folk practice and means of livelihood, alternative and eclectic health practitioners, including homeopaths, osteopaths and chiropractors, also supported the Toronto City Council’s stance against the medical establishment.\textsuperscript{512} Alternative practitioners such as the American-born, Toronto-based osteopath and self-styled “Anatomical Artist”, Frederick Payne Millard,\textsuperscript{513} led the charge against “medical tyranny and despotism” by establishing the “No Scar Club”, a society whose main object was to “take a long stride forward for the repudiation of the baneful and degrading practice of pus-punching.”\textsuperscript{514} Club members pledged never to be vaccinated “unless overpowered by physical force.”\textsuperscript{515} Millard proclaimed in the society’s correspondence that “to have a vaccination scar is a reflection on the intelligence... [and] signifies loyalty to medical superstition.”\textsuperscript{516}

Alternative practitioners also resented efforts by the medical profession to force them out of the market for health services by lobbying the provincial government to restrictively

\textsuperscript{511} See WA Littlejohn to Hon. EC Drury (6 February 1920), Toronto, Archives of Ontario (Smallpox – Board of Control and Provincial Health Officer’s Statement, RG 3, Series 03-04-0-201).
\textsuperscript{512} See Resolution of the Homeopathic Association of Toronto (12 December 1919), Toronto, Archives of Ontario (“Smallpox Epidemic”, RG 3-4, Premier E.C. Drury correspondence, file RG 3-4-0-18, MS 1657).
\textsuperscript{513} Millard was also the founder of the National League for the Prevention of Spinal Curvature and author of several books focusing on osteopathic medicine. See e.g. FP Millard, Poliomyelitis (Infant Paralysis) (Kirksville, Missouri: Journal Printing Company, 1918); FP Millard, Applied Anatomy of the Lymphatics (Kirksville, Missouri: Journal Printing Company, 1922). It appears Millard was also licensed to practice as a surgeon in the United States. See JE Hull to Attorney General (6 April 1925), Toronto, Archives of Ontario (Attorney General Central Registry Criminal and Civil Files, RG 4-32, barcode B248107).
\textsuperscript{514} FP Millard, “What You Do When You Vaccinate”, Toronto, Archives of Ontario (Attorney General Central Registry Criminal and Civil Files, RG 4-32, barcode B248107).
\textsuperscript{515} Ibid.
\textsuperscript{516} Ibid.
regulate “drugless practitioners,” a category that included “every person who practises or advertises or holds himself out in any way as practising the treatment of any ailment, disease, defect or disability of the human body by manipulation, adjustment, manual or electro-therapy or by any similar method.” In 1925, the Legislative Assembly passed the Act to provide for the Registration of Drugless Practitioners, which provided for the registration and regulation of alternative practitioners and barred them (with the exception of faith healers) from the general practice of medicine. The legislation and preceding bill received overwhelming support from medical societies and members of the medical profession. For example, J. Ferguson, Chairman of the Committee on Legislation of the Ontario Medical Association, wrote to Attorney General W.F. Nickle, in support of the legislation, stating that “[t]he entire medical profession...would welcome [it].” Medical societies and doctors throughout the Province sent telegrams to the Attorney General’s office expressing support for the bill (see examples in Plates C-G). The Porcupine District Medical Society congratulated the government for passing legislation “protecting the public from the persons to who these [b]ills refer,” and noted that the legislation would place the treatment of the sick on “a sound and [s]cientific basis.”

By contrast, alternative practitioners almost universally opposed the legislation. Gordon Waldron, lawyer for the Chiropractic Association of Ontario and Dr. Adele Peters

517 See An Act to provide for the Registration of Drugless Practitioners, SO 1925, c 49, s 2.
518 Ibid.
519 J Ferguson to Hon WF Nickle, Attorney General of Ontario (2 April 1925), Toronto, Archives of Ontario (Attorney General Central Registry Criminal and Civil Files, RG 4-32, barcode B248107).
520 See generally Attorney General Central Registry Criminal and Civil Files, Toronto, Archives of Ontario (RG 4-32, barcode B248107).
521 Porcupine District Medical Society to the Attorney General (6 April 1925), Toronto, Archives of Ontario (Attorney General Central Registry Criminal and Civil Files, RG 4-32, barcode B248107).
522 Ibid.
McLean, whose letterhead describes him as the “Pioneer Consulting Chiropractor of Canada”, wrote to the Attorney General expressing reservations towards the bill.\footnote{Gordon Waldron to Hon WF Nickle, Attorney General (6 April 1925), Toronto, Archives of Ontario (Attorney General Central Registry Criminal and Civil Files, RG 4-32, barcode B248107); Dr. Adele Peters McLean to Hon Nickle (6 April 1925), Toronto, Archives of Ontario (Attorney General Central Registry Criminal and Civil Files, RG 4-32, barcode B248107).} Mr. Waldron objected, on behalf of the chiropractors, to “one bill embracing all the arts or practices included under the term ‘drugless practitioners’”\footnote{Waldron, \textit{ibid}.} and to the disciplinary provisions in the bill, which “lend themselves to injustice against which the only protection in sight is the equity and justice of the Lieutenant-Governor-in-Council.”\footnote{Ibid.} Dr. McLean claimed that if the bill passes, “it will be internationally resented.”\footnote{McLean, supra note 523.} The Ontario Association of Osteopathy Legislation Committee also wrote to the Attorney General, noting that the Association “unanimously object[s]...[and] request[s] that the said [b]ills be withdrawn.”\footnote{Ibid.}

Brought together by common resentment of the medical establishment and of vaccination, the alternative practitioners and anti-vaccinationists formed an alliance aimed at resisting the tenets and practices of professional medicine. A memorandum prepared for the Attorney General by Allan Dymond, a law clerk to the Legislative Assembly, reveals that “most of these drugless healers [were] anti-vaccinationists and encourage disobedience to The Vaccination Act.”\footnote{Allan M Dymond, Memorandum for the Attorney General Re Medical Conference (12 March 1925), Toronto, Archives of Ontario (Attorney General Central Registry Criminal and Civil Files, RG 4-32, barcode B248107, file 659/25).} Alternative practitioners joined reputable anti-vaccination organizations such as the Anti-Vaccination League and the
American Medical Liberty League, and used anti-vaccination platforms to criticize the exclusionary antics of the medical profession. A pamphlet produced by the American Medical Liberty League and circulated in Canada through the Anti-Vaccination League, urging the abolition of state-supported medical schools, notes, for example:

The entire [medical] organization is a trust, the like of which the world has never seen. The oil trust, or the steel trust are pigmies alongside the medical trust. As the ultimate aim of the degenerated medical trust is to stamp out all other methods by which the public may maintain or recover health, so this aim and purpose is handed down to the local societies, both state and county, with instructions to get busy. And so we see the allopathic medical lobby at our state capitals year after year introducing such bills as would make a savage blush with shame. We see them oppose all legislation introduced by the drugless professions, which are introduced for the sole purpose of producing better practitioners, by keeping out the incompetents... Nothing but opposition can be expected from the entrenched medical interests. They are the inners, and all others shall be kept out.

The pamphlet further urged the reader to “show how your rights as citizens have been trampled on one by one until you are right up against the stone wall of the medical trust” by calling for legislation to “turn the medical men out of our schools” and to “do away forever with compulsory vaccination” by imposing “a heavy fine and jail sentence on any public officer who would attempt to force medication in any form on the public.”

529 See Millard, supra note 514; American Medical Liberty League, supra note 442.
530 Ibid.
531 Ibid.
532 Ibid.
533 Ibid.
534 Ibid.
In similar manner, the Homeopathic Association of Toronto opposed vaccination legislation and the Provincial Board of Health’s involvement in relation thereto. The Association passed a resolution on December 15, 1919 expressing “emphatic disapproval of any legislation enforcing vaccinations or inoculations, or interference in any way with the right of the individual to select his mode of treatment”\textsuperscript{535} and support for “all measures looking to the control of contagious diseases by means of isolation and quarantine”\textsuperscript{536} (both methods favoured by local authorities). The resolution also called for the repeal of any “law giving the Provincial Board of Health power to compel vaccination.”\textsuperscript{537}

Second, municipal funding issues may have also played a role in the City Council’s attitude to compulsory vaccination. While there is no reference to funding matters in reports of the City Council’s deliberations on the compulsory vaccination issue, there is some evidence that funding limitations were a barrier to municipal implementation of public health measures during this period. For example, in 1924, the Forest Town Council refused to implement an order issued by the Provincial Board of Health to erect a waterworks system for the town, on the ground that it would be too costly.\textsuperscript{538} When the Board threatened to fine the town $100 a day for neglecting the order, the mayor resigned in protest.\textsuperscript{539}

\textsuperscript{535} Resolution of the Homeopathic Association of Toronto (15 December 1919), Toronto, Archives of Ontario (“Smallpox Epidemic”, RG 3-4, Premier E.C. Drury correspondence, file RG 3-4-0-18, MS 1657).
\textsuperscript{536} Ibid.
\textsuperscript{537} Ibid.
\textsuperscript{538} “Defies health board”, Essex Free Press (7 March 1924) 6.
\textsuperscript{539} “Local news”, The Leamington Post (6 March 1924) 5.
Funding issues also led to legal disputes between doctors and municipalities over non-payment for vaccination and other costs of attending to smallpox patients. In Bibby v Davies,\(^\text{540}\) decided in 1902, a physician sought to hold the medical health officer and local board of health of the township of Euphrasia personally liable for unpaid costs and wages for attending to a smallpox patient as ordered by the local board. The court held that he could not recover personally from the defendants because the board “ha[d] no funds”\(^\text{541}\) and the medical health officer was not a member of the board. However, since the board “can make contracts, sue and be sued,”\(^\text{542}\) the plaintiff was entitled to recover from the township. The court ordered the township to provide money and “pay it upon the order of the board or any two members.”\(^\text{543}\) A similar decision was handed down in Bogart,\(^\text{544}\) discussed earlier, but in the latter case, the municipality attempted to get out paying for the services rendered by claiming that it had not authorized its board of health to act on the municipality’s behalf in procuring the services of the plaintiff. Lastly, in Re Derby and Local Board of Health of South Plantaganet,\(^\text{545}\) a physician successfully obtained a mandamus to compel the local board of health to sign an order authorizing the municipal treasurer to pay for services rendered during a smallpox epidemic. An earlier action brought by the physician against the municipal corporation failed for lack of a clear legal basis to make the order. The court granted the order in the second attempt under the authority of a section in the Public Health Act authorizing the treasurer to fulfill demands for payment approved by the local board of health. These cases suggest that

\(^{540}\) (1902) 1 OWR 189.  
\(^{541}\) Ibid at para 1.  
\(^{542}\) Ibid.  
\(^{543}\) Ibid.  
\(^{544}\) See supra note 123.  
\(^{545}\) [1890] 19 OR 51 (QB).
municipalities were often unwilling or unable to honour contracts for vaccination and treatment of infectious disease victims, most likely due to lack of funds for such expenses.

The legal dispute between the Provincial Board of Health and the Toronto City Council demonstrates the influence of law and the legal process in the context of historical disputes about vaccination. As previously discussed, the safety and efficacy of smallpox vaccination was a hotly disputed issue during this period, and a central point of controversy in legal disputes concerning vaccination. Although opponents of vaccination often claimed that mandatory vaccination laws interfered with their personal liberties, this view was never argued in court challenges against such laws, possibly because neither existing statutes nor the common law provided a legal basis or remedy for such a claims. Instead, challengers focused their attacks on questions surrounding the safety and efficacy of the smallpox vaccine. In rejecting the City Council’s offer to prove that the smallpox vaccine was neither safe nor effective, the court brought some finality to a highly contested social and scientific debate.

Likewise, the court’s rejection of the Provincial Board of Health’s attempt to control or oversee municipal handling of vaccination led to some changes in the direction and purpose of the Provincial Board’s involvement in public health administration. To begin with, it strengthened the resolve of the Board (and medical profession) to centralize and gain control over public health matters. Members of the Board and profession lamented a

546 See e.g. Jacobson, supra note 456. See also Clowes, supra note 260.
lack of authority to implement important public health reforms\textsuperscript{547} and organize “medical work…for social good,”\textsuperscript{548} and increased pressure on the government to enact reforms that would both “confer[…]legal authority on [the Board] to enforce its own enactments”\textsuperscript{549} and remove barriers to “greater public health work…the growth of the medical profession and the development of medical science.”\textsuperscript{550} A prominent physician in the city of Toronto called for the “socialization of medicine” and for a “[h]ealth officer of the future [that] would take an interest in nearly everything” including “[t]he height of buildings [and] the width of streets.”\textsuperscript{551}

Furthermore, shortly after the case, Dr. McCullough sent a memo to the Attorney General requesting his advice on proposed amendments to the \textit{Public Health Act}, which sought to make the Provincial Board of Health a body corporate and to authorize the Board to enforce public health and vaccination laws.\textsuperscript{552} The memo also stated that infant vaccination laws, though desirable and well tolerated by all involved, had “never been seriously enforced in Ontario,”\textsuperscript{553} and recommended requiring every school age child to produce evidence of successful vaccination prior to school admittance, as well as compulsory vaccination of all persons during an epidemic. Both measures, the memo urged, should be “be generally applicable and not subject to interference from local

\textsuperscript{547} See supra notes 469 and 487.
\textsuperscript{548} See “Emphasized need for health work: Physician speaks on ever-broadening function of M.O.H.”, \textit{The Globe} (29 March 1920) 8.
\textsuperscript{549} “Gives new power to Health Board: Hon. Walter Rollo’s bill would make it a body corporate”, \textit{The Globe} (12 May 1920) 8.
\textsuperscript{550} \textit{Supra} note 548.
\textsuperscript{551} \textit{Ibid}.
\textsuperscript{552} See \textit{supra} note 487.
\textsuperscript{553} \textit{Ibid}.
boards of health, school boards, and local council.”\textsuperscript{554} The memo further noted that the Board has encountered difficulties in enforcing the *Vaccination Act* in Toronto due to “want of power” and that the Board “cannot be reasonably successful in [protecting Ontarians against the spread of infection] or retain the respect of the public unless the law gives [it] adequate power.”\textsuperscript{555}

The Board also procured the backing of Hon. Walter Rollo, the Minister of Labour and Health on the proposed amendments, and in May 1920, Minister Rollo tabled a bill before Parliament to make the Board a body corporate,\textsuperscript{556} which passed in June 1920.\textsuperscript{557}

Conversely, but to a lesser extent, the court decision also forced the Board to seek other ways—within the scope of its legal authority—to work in concert with municipalities on implementation of public health measures. In this regard, the Board intensified its advisory and educational efforts, and provided prompt assistance to municipalities on matters ranging from appointment of local boards of health to building of sewerage systems.

It appears the court decision also had unintended negative impacts on public health and infectious disease management. For example, the decision most likely motivated instances of municipal defiance of orders issued by the Provincial Board of Health, such

\textsuperscript{554} Ibid.
\textsuperscript{555} Ibid.
\textsuperscript{556} See supra note 549.
\textsuperscript{557} See *An Act to amend the Public Health Act*, SO 1920, c 81, s 3.
as in the case of the Council of Forest Town discussed earlier.\textsuperscript{558} Furthermore, the decision indirectly contributed to an outbreak of smallpox in the City of Windsor which was blamed on three fresh cases imported from Toronto in September 1920, only a few months after Windsor recovered from a devastating outbreak.\textsuperscript{559}

The rejection of each litigant’s main argument in the case also suggests that courts of law may not have been the appropriate venue for debating or resolving health and science policy disputes, primarily because legal rules and procedures did not allow disputants much room to canvass their viewpoints and interests or permit the courts to adjudicate such interests. While the court’s handling of the evidentiary issue rightly displayed fidelity to the doctrine of legislative supremacy or sovereignty, it also allowed the factual dispute about vaccination to continue. Indeed, despite the ruling, the controversy raged on. At a meeting held on 4 February 1920, the Toronto Board of Control (the executive committee of the Toronto City Council) complained that Dr. McCullough had made disparaging and libelous comments in the newspapers stating that the City “[i]n spite of the efforts of the Provincial Board of Health…has been guilty of spreading smallpox all over the Province of Ontario, and would have spread it all over the continent had not the Americans taken steps to prevent it.”\textsuperscript{560} W.A. Littlejohn, the City Clerk, forwarded the minutes of the meeting to Premier Drury, along with a letter that called on the

\textsuperscript{558} See \textit{supra} note 538 and accompanying text.
\textsuperscript{559} See Adams CMAJ, \textit{supra} note 448; Adams AOO, \textit{supra} note 448; “Recurrence of small pox feared”, \textit{The Georgetown Herald} (1 September 1920) 1.
\textsuperscript{560} See \textit{supra} note 511; “Says that Toronto spread smallpox over Province”, \textit{The Globe} (31 January 1920) 5.
government to investigate the alleged utterances. Littlejohn’s letter was eventually transmitted to Dr. McCullough, who sent a rather terse and unapologetic response. While admitting it was possible that he did make the comments attributed to him, he declined “to be bound by what any newspaper may say” about him. He then added that if he was “inclined to discuss the matter of the City’s neglect in reference to the outbreak of smallpox, [he] could with ample justification say a good deal more than [was] attributed to him.” Also, in an annual report to the Ontario Legislature, the Provincial Board of Health wrote that the City of Toronto “was the chief and earliest centre [of the 1919 smallpox outbreak] and is largely blamed by outside municipalities for neglect to fulfil the law, thereby allowing the disease to spread.”

Lastly, the case demonstrates the degree to which local authority over public health, which had its root in pre-union local government by the Sessions courts, was maintained and protected by law. The localized origins of health governance, coupled with legislative and judicial (doctrinal) developments that allowed municipal authority to operate free from the “co-opting tendencies” of provincial authority (controlled mainly by medical professionals eager to implement a self-serving agenda), preserved variant local approaches to dealing with public health matters in different locations, with direct consequences for health care and policy outcomes.

561 See supra note 511.
562 See John W McCullough to WR Rollo (16 February 1920), Toronto, Archives of Ontario (Smallpox – Board of Control and Provincial Health Officer’s Statement, RG 3, Series 03-04-0-201, 1920).
563 Ibid.
564 Ibid.
565 Annual Report, 1919, supra note 331 at 3.
566 This phrase is borrowed from Kenneth W McKay, “Municipal Organization in Ontario” in S Morley Wickett ed, Municipal Government in Canada, vol 2 (Toronto: University of Toronto, 1907) 91 at 119.
However, the case, along with the underlying compulsory vaccination controversy, triggered a desire among provincial health officials and doctors to change the system for good, and served as a turning point in the cause for centralized management of public health affairs in Ontario. The goal was achieved merely four years after the case with the creation of Department of Health headed by a cabinet minister.\textsuperscript{567} The Provincial Board of Health ceased to exist and its powers and duties were taken over by the Department.\textsuperscript{568}

Other than the Minister of Health, the principal officers of the Department were the Chief Inspector of Health for Ontario,\textsuperscript{569} and district officers of health appointed by the Lieutenant Governor for the health districts in the province.\textsuperscript{570} By law, only legally qualified medical practitioners could be appointed to the non-cabinet positions.\textsuperscript{571} In terms of its powers and functions, the Department was charged with “the administration and enforcement of \textit{The Public Health Act} and generally all the statutes relating to the protection of the health of the people of Ontario, and of any regulations made under any such statutes.”\textsuperscript{572} The Chief Inspector of Health was also authorized to exercise any powers conferred by law on local health officials.\textsuperscript{573} Both provisions gave the Department effective control over all aspects of public health in the province, including the power to direct, supervise or override municipal actions.

\textsuperscript{567} See \textit{supra} note 366, s 2.
\textsuperscript{568} See \textit{An Act respecting the Public Health}, SO 1927, c 73, ss 4-7.
\textsuperscript{569} See \textit{ibid}, s 3; \textit{supra} note 366, s 3.
\textsuperscript{570} See \textit{supra} note 568, s 12.
\textsuperscript{571} See \textit{ibid}, ss 3, 12.
\textsuperscript{572} \textit{Supra} note 366, s 6.
\textsuperscript{573} See \textit{supra} note 568, s 3(2).
2.4 Conclusion

In Ontario, direct legal regulation of public health and the management of infectious diseases was delayed until 1833, when a province-wide cholera epidemic forced the provincial government to enact the colony’s first public health statute. However, the legislation and the existing system of public health governance handled by local magistrates were lacking in many respects, and did not provide a robust or effective framework for prevention and management of frequent and deadly infectious disease epidemics. Other social and legal factors, including lack of financial resources and lack of legal authority also impeded disease control measures and the progress of public health in general.

While developments in public health law remained slow as the nineteenth century progressed, smallpox was one area that received significant legal attention. Laws directed at measures to prevent the introduction and spread of smallpox, including compulsory vaccination, emerged in the union era, and remained in force, well into the twentieth century. However, these laws were essentially dead letters until the last quarter of the nineteenth century, when a group of elite medical doctors took up the cause for public health reform and the stringent enforcement of vaccination laws as a means to advance their professional status and interests. These doctors, operating through the Provincial Board of Health, viewed compulsory vaccination as an effective tool to gain control over public health functions and to advance their views regarding science and the role of the state in relation to public health.
The doctors’ efforts in this regard were resisted by local government officials, anti-vaccinationists and alternative health practitioners, who viewed the doctors’ action as encroaching, respectively, on their legal authority, liberties and beliefs, and livelihood. Rather than advance the interests of public health, compulsory vaccination became a pawn in legal battles for control of public health authority, professional advancement and over opposing views of scientific progress and the legitimate basis for state intervention in public health.

In concluding, the legal history of vaccination in Ontario suggests that its utility (and to some extent, success) as a tool for protecting public health did not necessarily depend on compulsory laws, but rather on the existence of robust and responsive public health laws and enforcement mechanisms that are viewed as advancing genuine public interests in health. While such a system was missing from Ontario for majority of the period covered by this study, Nova Scotia, discussed in the following chapter, offers a contrasting look that is more consistent with this conclusion.
Dear Sir,

Your careful and unbiased consideration of the question of Vaccination is hereby desired, especially in regard to the stringent measures that are enforced in cases of pupils and students who wish to attend our public schools.

A very large proportion of the ratepayers of Ontario are opposed to having their children vaccinated, owing to cases of serious bodily injury, and sometimes death, that have resulted after vaccination. (Even the most carefully prepared vaccine produces equally grave effects, though not in quite the same form.) Quite often...

The truant by-law is strictly enforced, and thus these ratepayers, parents and guardians, are driven to the alternative of becoming liable to a fine for non-attendance at school of the children or of having them submit to an operation which they conscientiously, and with good reason, believe is productive of great harm in many cases, while not proving an absolute protection against smallpox.

The injustice of such legislation will appeal to you when you study the history of vaccination, and find how it has signally failed, when depended upon as the chief means for stamping out or abating epidemics of smallpox.

Briefly the arguments against compulsory vaccination may be put as follows:

1. The source from which vaccine is derived is unknown:
   (a) It may be modified smallpox in the cow.
   (b) It may be cowpox.
   (c) It may be a product of a disease known as the “Grease,” found in horses, and transmitted accidentally from the horse to the cow by the hand of man.

   In that recognized standard of authority, “Duglison’s Medical Dictionary,” under the heading “Vaccinia,” will be found the following words: “The cowpox is a disease of the cow, arising spontaneously, or perhaps from the smallpox contagion of man, or from the matter of grease in horses conveyed by the milker, which, if transmitted to man by means of inoculation, may preserve him from smallpox contagion.” The “grease” is regarded by some authorities as being “Venereal Disease” in the horse.

2. An animal poison retains its individuality for an indefinite length of time in transmission from one individual to another. Hence whatever vaccine was in its origin it still remains the same.

3. After even recent vaccination it is common for persons exposed to smallpox to contract the disease, and for some of them to die.

4. Smallpox is now a rare disease in organized communities, because of vaccination and improved sanitation and the careful isolation of all persons who have been exposed to the contagion.

5. Evil results infrequently follow vaccination, in some cases by the vaccine being contaminated by other diseases, in other cases by arousing in an individual latent diseases which might have otherwise remained quiescent, both of which results are frequently difficult or even impossible to prove.
6. It being easily possible to completely control the spread of smallpox by means of isolation; smallpox being now a rare disease; vaccination being fraught with danger, and at the same time being of doubtful efficacy, and the origin of vaccine being unknown, it is reasonable and right for those who are conscientiously opposed to the practice of vaccination, to ask the Legislature to relieve these persons from all compulsion in regard to vaccination.

7. The recent act of the British Parliament in modifying their former stringent measures in regard to compulsory vaccination of individuals, and this only having been done after a very full enquiry by a Royal Commission, may be regarded as a worthy precedent in support of the above views. As the pleasure of the Committee of the British Medical Association on the subject is regarded as a clear and decided voice in opposition to the practice.

Trust ing that you will give your careful attention to this subject, and that the literature which will be sent to you during the winter months will have your interested examination, we remain.

Respectfully yours,

Dr. Edward Adams, M.D., Physician, 557 Yonge Street, Toronto
Dr. H. Becket, M.D., Physician, 1330 King Street West, Toronto
Dr. E. K. Richardson, M.D., Physician, 5 St Thomas Street, Toronto
Dr. D. F. Macdonald, M.D., Physician, 320 College Street, Toronto
Dr. E. A. P. Hardy, Physician, 605 Spadina Avenue, Toronto
Dr. L. H. Evans, B.A., M.D., Physician, 67 Spadina Avenue, Toronto
Dr. Thos. W. Sparrow, M.D., 118 Jamieson Avenue, Toronto
Dr. E. G. Lennox, M.D., Physician, 223 Dovercourt Road, Toronto
Dr. W. H. Howitt, M.D., Physician, 100 Carlton Street, Toronto
Dr. J. D. Tickell, M.D., Physician, 580 Sherbourne Street, Toronto
Dr. G. J. Jones, L.R.C.P., London, Physician, 126 Carlton St., Toronto
Dr. A. W. Mason, M.D., Physician, 42 Gloucester Street, Toronto
Dr. R. Percy Vivian, M.D., Physician, 633 Spadina Avenue, Toronto
Dr. R. J. Read, M.A., D.D.S., 236 Bloor Street East, Toronto
Dr. Chas. W. Lennox, Confederation Life Building, Toronto
Dr. R. Healy, M.D., C.M., Physician, 247 Dovercourt Road, Toronto
Dr. D. S. Olliffant, M.D., Physician, 74 Shuter Street, Toronto
Dr. J. Adams, Physician, 12 St Patrick Street, Toronto
Dr. W. Maclean, Berlin, Ont.
Dr. W. Lennox, Brampton, Ont.
Dr. M. Foul, Peterborough, Ont.

Officers of League:

A. K. Roy, President.
J. D. Nasmith, Vice-President.
R. S. West, Secretary-Treasurer.
3 r w 82 4 exa

Palgrave  Ont Apr 4th 1925

The Hon Attorney General
Toronto, Ont.

The Medical men of Peel County are solidly behind you in
the Medical Bills now before the House

Dr A F Remar.

Pres Peel Medical Ass'n

11.30 a.m.

USE OUR DIRECT CANADA SERVICE TO VANCOUVER, VICTORIA AND BRITISH COLUMBIA POINTS
From 165

Hon. Mr. Eickle

Toronto, Ont.

The Essex County Medical Society extend their congratulations and support in approving recent Medical Legislation.

Geo F. Lewis.

Snr'y

Windsor Ont. Apr. 4th 1925

10:38 a.m.

Use our Direct all-Canada Service to Vancouver, Victoria and British Columbia Points
B31 D

19NL 9EX

BRANTFORD ONT APRIL 5 1925

HON. W. F. NICKLE

PALLIAMENT BLDG. TORONTO ONT

AS A MEASURE FOR THE PROTECTION OF THE PUBLIC YOUR PROPOSED MEDICAL

LEGISLATION IS OF UTMOST IMPORTANCE

J. P. CALDER

M.D.

325FM

USE OUR DIRECT ALL-CANADA SERVICE TO VANCOUVER, VICTORIA AND BRITISH COLUMBIA POINTS
167

CANADIAN-NATIONAL
TELEGRAM

HEAD OFFICE, TORONTO, ONT.
W. G. BARBER, General Manager

DDO
19NL 2EX
BRANTFORD, ONT. APRIL 5 1926
HON. W. F. NICKLE
PARLIAMENT BLDGS. TORONTO, ONT.

MY CONGRATULATIONS ON THE EXCELLENT PIECE OF LEGISLATION YOU PROPOSE TO ENACT AMENDING THE ONTARIO MEDICAL ACT

W. F. NICKLE

6PM

USE OUR DIRECT ALL-CANADA SERVICE TO VANCOUVER, VICTORIA AND BRITISH COLUMBIA POINTS
Toronto, Ont.

The Norfolk County medical society heartily endorses the Proposed Medical Bill

Norfolk County Medical Society

10.65 a.

Simeon Ont Apr 4th 1923

Hon. W. F. Bickle
CHAPTER THREE – NOVA SCOTIA

“The people generally considered [vaccination] a boon conferred upon them and manifested a laudable willingness to avail themselves of the opportunity offered of having themselves and families secured from the ravages of smallpox” — Dr. Black, Vaccinator (1841).

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3.1 Introduction: A Concerted and Efficient Response to Infectious Diseases

Compared to Ontario, in Nova Scotia, the application of law to the management of smallpox and vaccination (and public health more broadly) was exemplary in many respects. The threat posed by infectious diseases to the health and economic interests of the province was recognized very early, beginning in the later half of the eighteenth century, and was met with a dynamic slate of sensible legal developments and reforms. While not without problems, legal intervention in this area was mainly characterized by proactive and practical responses to the threats posed by infectious diseases (rather than by ideology or partisan interests), reliance on a wide range of measures and approaches in protecting public health, and a responsive and effective system of enforcement and implementation based on strong local government, stringent but judicious penalties, and cooperation between local officials, medical professionals, and the provincial authorities.

By the 1830s, when Ontario was just beginning to formulate legal strategies for dealing with infectious and contagious disease outbreaks, a clear and robust public health law framework focused on managing such outbreaks was firmly in place in Nova Scotia. Backed by legislation and financial and administrative support from the provincial
government, this system was rigorously enforced by energetic local officials and medical professionals. Both groups assiduously implemented the law with the primary goal of securing and protecting the health and welfare of their respective communities.¹

¹ There are numerous examples of involvement by local officials and medical professionals in formulating and implementing public health law and policy throughout the period of this study. See e.g. Regulations passed by the Halifax Sessions in July 1800 to “preserve the [h]ealth and [c]leanliness of the [i]nhabitants of the Town of Halifax.” See Minutes of the Sessions (2 July 1800), Halifax: Archives of Nova Scotia (Halifax County Court of General Sessions of the Peace Fonds, 1770-1886, Minutes of the Sessions December 1799 – February 1801, RG 34-312 Series P, vol 2) [Halifax Regulations]. The regulations banned the slaughter of animals within the town or suburbs, except in slaughterhouses or wharves over tidal water. Inhabitants were also prohibited from leaving or dumping putrid substances, manure and rubbish on the streets and common areas. See Report from Dr. AR Melanson to the Chairman and Members of the Board of Health for the Municipality of Argyle (16 January 1919), Tusket, Argyle Township Court House & Archives (RG 3 Series M, Sub-series 2, TMS-7C-132) [Melanson]. The report states:

During the year 1918 we have had to deal with practically all contagious diseases on the list and still had to add one more. All sections of the municipality have been more or less affected… A case of small-pox contracted in Halifax might have given us a lot of trouble but we were fortunate enough to prevent the spread. It was confined to one home with another person contracting it on whom vaccine had no effect being given too late… Practically all submitted to vaccination… I have not practiced the wholesale closure of schools in this municipality because I was convinced it is not reasonable to do so… I can say that all my efforts have tended towards the protection of the community without undue inconvenience to those affected. I have had difficulties in enforcing regulations sometimes but have acted without fear or favour in the past without probably satisfying everybody but have done my best and would follow the same policy in the future if you choose to appoint me again.

The letter notes further that tuberculosis is the next threat facing the community and urges the government to formulate regulations to deal with it. See also Maurice Forbes, Sanitary Inspector of District 17, to the Board of Health for the Municipality of Argyle (5 January 1900), Tusket, Argyle Township Court House & Archives (RG 3 Series M, Sub-series 2, TMS-7C-23). The letter applauds the efforts of the local board of health in regards to various initiatives adopted for the purpose of protecting the public from the threat of infectious diseases. The letter notes: “It is believed the free distribution of the Sanitary Regulations by your Board, a few years ago, was a wise thing, and has been the means of educating the people in relation to the laws of health.” The letter also notes that schools have been supplied with “textbooks on health” and “[made] it imperative upon teachers to instruct the school children in relation to the general laws of health.” For another example, see DL Porter, Sanitary Inspector, to PS Hatfield, Clerk to the Board of Health (January 1898), Tusket, Argyle Township Court House & Archives (RG 3 Series M, Sub-series 2, TMS-7C-20). The letter reads:

Owing to the fact that many of the Wedge people contending Typhoid fever “wasn’t catching” caused much trouble in preventing the disease from spreading over the whole Wedge. It was only when a notice was posted up, in connection with the usually Placard, calling for strict attention to the Regulations adopted by the Board of Health of the Municipality that real efforts were made to stop the fever. See also Board of Health of the Municipality of Argyle Minute Book (13 February 1909), Tusket, Argyle Township and Court House Archives (RG 3 Series M, Sub-series 1) at 34, where the Board of Health recommended vaccination throughout the municipality following reports of a case of small pox in Tusket Wedge; Nova Scotia, House of Assembly, Journal and Proceedings of the House of Assembly of the Province of Nova Scotia, 1861 Sess, Appendix No 34 at 2 where Commissioner William Chearnley, Commissioner of Indian Affairs, reports:
A good population of well-trained doctors arrived in Nova Scotia between the settlement of Halifax in 1749 and mid-nineteenth century.\(^2\) The provincial government relied on these doctors to implement early public health initiatives, including vaccination programs. Unlike their counterparts in Ontario, doctors in Nova Scotia did not seek to utilize these initiatives to advance their personal or professional interests, but rather, acted out of genuine interest in securing the progress of public health in the province. They also did not seek to influence the content and direction of public policy, or to gain exclusive control over the provision of medical services, but concerned themselves mainly with performing their professional duties.\(^3\)

Inhabitants of Nova Scotia were cognizant of the constant threat of deadly infectious diseases such as smallpox, and welcomed and supported legal and other mechanisms aimed at preventing or eradicating these diseases. Instances of this positive attitude date back to 1786, when a Grand Inquest (panel of citizens) constituted to advise the

\[\text{The small pox, in a most virulent form, having broken out amongst the Indians living on the eastern shore of the county of Halifax…upon consultation with members of the Government, the Custos of the county, and a gentlemen representing the interests of the residents in that locality, I took the necessary precautionary measures to stay the progress of so fatal a disease, and also provided means to alleviate the necessities of those already attacked by it. I trust that in so doing I shall merit the approval of his Excellency. It is highly gratifying to learn that the afflicted Indians found in the professional gentlemen who attended them not only a skillful [sic] medical attendant, but a most kind and benevolent friend.}
\]

Also see Nova Scotia, House of Assembly, *Journal and Proceedings of the House of Assembly of the Province of Nova Scotia*, 1861 Sess, Appendix No 37 at 5, where DR. RS Black, Medical Superintendent of Penitentiaries, reports:

> During the months of November and December small-pox prevailed extensively in the city [of Halifax]; I therefore deemed it prudent to vaccinate such of the prisoners as were still unprotected, and to re-vaccinate the others.


\(^3\) See e.g. Melanson, *supra* note 1.
Shelburne County Court of General Sessions of the Peace regarding the implementation of existing infectious disease legislation⁴ “earnestly recommended” the rigorous implementation of the legislation, and particularly, that “no [p]ersons hav[ing] the [s]mall [p]ox be allowed to walk in the more frequented [areas] in the [t]own.”⁵ On December 27, 1800, inhabitants of The Falls, a small farming and lumbering community in Colchester County, raised objections when an affluent resident named W. Nathan Tupper welcomed a friend infected with smallpox to his home.⁶ In 1814, the inhabitants of Dartmouth, a city located on the east side of the Halifax harbour, petitioned the Lieutenant Governor to provide “necessary comforts” for persons infected by a ravaging smallpox outbreak introduced to the town by “a number of black persons…lately landed at Halifax from…Chesapeake Bay in the United States of America”, and for “vaccination to be administered to the uninfected.”⁷ Similarly, in 1865, a petition signed by inhabitants of the District of Tangier in the County of Halifax urged the Halifax Sessions and Grand Jury to “liberally reward” those who provided services to stop the further spread of smallpox in the community (consisting mainly of medical professionals), and “through whose exertions the community has been so much benefitted.”⁸

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⁴ See “The Grand Inquest of for the Town and County of Shelburne beg leave to present to the worshipful Bench of Justices for said County in Sessions assembled” (10 April 1786), Halifax, Archives of Nova Scotia (RG 34-321, Series P, vol 9, no 18).
⁵ Ibid.
⁶ See Memorial from the People at the Falls Concerning the Small Pox (27 December 1800), Halifax, Archives of Nova Scotia (MG 100, vol 190, no 15).
⁷ See Special Sessions (11 October 1814), Halifax, Archives of Nova Scotia (Halifax County Court of General Sessions of the Peace Fonds 1770-1886, RG 34-312, Series P, vol 5).
⁸ See Petition District No. 26 (Tangier) relating to smallpox remuneration for J Browner ([nd] circa January 1865), Halifax, Archives of Nova Scotia (Halifax County Public Health 1850-1869, RG 34-312, Series C, vol 2) [Tangier Petition]. See also Board of Health of the Municipality of Argyle Minute Book (25 January 1910), Tusket, Argyle Township and Court House Archives (RG 3, Series M, Sub-series 1) at 37, where a “citizen’s committee” from Tusket Wedge approached the District Board of Health to request “more efficient measures…to deal with the [smallpox] epidemic existing at present in [the] district” and that “arrangements be made at once for a temporary pest house and house of detention.” The Board acceded to
The latter petition also hints at cooperation between local officials and medical professionals in dealing with smallpox and other infectious disease outbreaks at the community level. According to the petition, sometime in January 1865, a young man from Halifax, named Vance, arrived in Tangier, a small fishing settlement on the eastern shore, to look for work, possibly at the gold mines. Gold was discovered in Tangier in 1861, and mining operations began in 1863.9 Vance brought smallpox with him. Joseph Browner, a magistrate residing in the settlement, informed the Halifax Sessions about the case. A Special Sessions was promptly convened, and two health wardens, both medical doctors, were appointed for Tangier. The petition notes that Mr. Browner, assisted by one of the wardens, Dr. Robert Jamison, “used every precaution to prevent the disease from spreading, including isolation and confinement of the inhabitants of the house where the disease was present, consisting of three families.”10 One of the inhabitants was a miner, and he was compelled to stay away from work. The isolated families were supported and provided for by one Mr. James Leary, under instructions from the Clerk of the Peace. Mr. Browner also enforced the isolation order by keeping watch over the house “to prevent the inmates from spreading the contagion, and supplied them with everything that was necessary.”11 In another case recounted in the petition, Mr. Browner


10 See Tangier Petition, supra note 8.

11 Ibid.
and Mrs. Jennings, a nurse, worked for two months to stay and destroy the smallpox contagion by implementing isolation.\textsuperscript{12}

The social response to vaccination was equally remarkable. Although the procedure was not required by law in Nova Scotia until 1851, it was in widespread use decades before, and was considered by medical doctors and provincial and local authorities to be a primary tool in the fight against smallpox.\textsuperscript{13} In 1815, for example, the Nova Scotia House of Assembly placed the sum of £500 at the Lieutenant Governor’s disposal for any purpose deemed “most effectual to prevent the spreading of the [s]mall-[p]ox, by promoting [v]accination throughout the [p]rovince.”\textsuperscript{14} In 1833, Assembly approved an allocation of £50 to the Halifax Dispensary for the purpose of procuring and keeping a sufficient supply of vaccine lymph for distribution to medical doctors.\textsuperscript{15} The following year, Assembly granted a petition praying for financial support brought by two Halifax doctors for purposes of “[keeping] ready a quantity of virus or ‘matter fit for

\textsuperscript{12} \textit{Ibid.}


In 1841, justices of the peace of the County of Guysborough sent a petition to the House of Assembly, through the Lieutenant Governor, urging the “necessity of a sum of money being granted and applied in the vaccination of the children of poor persons.”

The petition was referred to a committee of the House. The committee’s report, reproduced below, highlights the importance of the procedure within the context of the management of infectious diseases during this period:

[We] are of [the] opinion that the most prompt measures should be adopted by the [i]nhabitants of [the] County [of Guysborough], as well for their safety as that of the [p]rovince generally, to arrest the progress of the disease by an immediate vaccination of all [c]lasses who have not hitherto undergone the operation, and that the necessity of this step should be strongly urged upon the people by the [m]agistrates… With a view also to prevent the spread of [s]mall [p]ox in other parts of the [p]rovince, [we] submit whether it would not be advisable that the attention of the [m]agistrates in other [c]ounties should be directed to this subject, and to authorise the vaccination of the poor classes generally, including the Indians, to whom particular attention ought to be paid.

Vaccination rates rose dramatically whenever there was a smallpox outbreak or epidemic; in one epidemic year, over 6000 persons submitted themselves to the vaccine. In 1827, one thousand two hundred and fifty six persons were “vaccinated for the cow pox” in the north suburbs of Halifax. In 1841, 635 persons were vaccinated “on the side of the County of Halifax eastward of Halifax” by order of the Lieutenant Governor. That same year, “68 Indians and 8 children” in Antigonish County, who were “utterly unable to bear...
the charges themselves”, received the vaccine to save them from the ravages of smallpox then raging in nearby Guysborough.22 In Dartmouth, Preston and Chezzetcook, three communities in Halifax County “where vaccination had been almost wholly neglected,” 654 persons were vaccinated in 1842, the “majority of whom [were] colored and French people.”23 Four hundred and ten poor persons received the smallpox vaccine in the County of Pictou that same year,24 and in the Township of Argyle, 344 persons were vaccinated by Dr. Thomas Geddes “at the request of the magistrates” during the prevalence of the smallpox in the District of Argyle in the months of July and August 1841 “in accordance [with a] circular from the…Secretary of the Province.”25

The procedure was also available in remote sparsely-populated communities, mainly fishing settlements where there were no local boards of health. For example, sometime in 1841, a medical doctor named Black received instructions from the Central Board of Health to carry out a general vaccination of persons residing in several remote fishing settlements, including North West Arm, Purcell’s Cove, Ferguson’s Cove, Herring Cove, Sambro, Kitch Harbour, Hallibut Bay, Bear Cove, Upper and Lower Prospect, and

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22 See Antigonish Co. Vaccinations. Poor Persons by Dr. Creed. Done at the time small pox was raging at Guysboro (1841), Halifax: Archives of Nova Scotia (RG 25 Series C, vol 1, Papers re vaccinations).
24 See Charles Martin, Health Officer Pictou to Rupert D George, Provincial Secretary, with account for vaccinating poor persons in County of Pictou, Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Papers re vaccinations); List of poor persons in the County of Pictou vaccinated by me in pursuance of the instructions issued by command of his Excellency, by Charles Martin, Health Officer, Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Papers re vaccinations).
25 See List of persons vaccinated gratuitously in the Township of Argyle, during the prevalence of the small pox in that District in the months of July and August 1841 in accordance to the circular from the…Secretary of the Province (30 March 1842), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Papers re vaccinations).
Portuguese Cove. 36 383 persons were vaccinated under this commission, including “every person…who had not either suffered from small-pox, or been vaccinated at some previous period.” 27 Dr. Black’s report on the vaccinations provides some insight on the popular response to the procedure at the time. According to the report:

Some few, indeed, of those who had been previously vaccinated, but who expressed a desire to have the operation again performed, from a doubt as to the success of the previous operation, were vaccinated. The people generally considered it a boon conferred upon them and manifested a laudable willingness to avail themselves of the opportunity offered of having themselves and families secured from the ravages of smallpox. 28

The successful implementation of vaccination programs during this early period was made possible through cooperation between provincial and local authorities. Whenever there was a smallpox outbreak or threat of such outbreak in the province, the Lieutenant Governor would issue instructions to the magistrates in Sessions in the affected counties, requiring or recommending vaccination of county inhabitants. The Sessions courts, acting as a full court or through a Special Sessions of two or more magistrates constituted as a board of health, would then appoint a vaccinator, typically a medical professional, to carry out the procedure.

The provincial government provided financial support for these early vaccination initiatives, mainly by providing funds to local boards of health to cover vaccination expenses, or by issuing direct monetary payments and reimbursements to medical professionals for services provided and costs incurred in vaccinating the population. A

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26 See List of persons vaccinated in accordance with the recommendation of the Board of Health, Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Papers re vaccinations).
27 Ibid.
28 Ibid [emphasis added].
government circular sent by Provincial Secretary Rupert D. George to the Colchester Board of Health in 1841 notes, for example:

The Small Pox having made its appearance in two or three parts of this Province, it has become of the utmost importance that every precaution be taken to prevent the spread of that disease. His Excellency has therefore commanded me to request that you will use your best endeavours to induce to be vaccinated all persons within the County of Colchester who are not already protected from the infection. As some of the inhabitants of that County besides the Indians, whom his Excellency regards as having peculiarly strong claims upon our attention on the present occasion, may not have the means to pay for the professional services they require in this respect, I am [directed] to add that the gentleman employed by your direction to vaccinate such persons will receive a reasonable remuneration from the Government on your transmitting a list of the Poor persons so vaccinated with a certificate that they are utterly unable to bear the charges themselves.29

However, provincial financial support was limited to relief of the poor; the government was willing to pay for expenses incurred in vaccinating poor persons, but not for vaccination of the general population.30 To be considered eligible for payment, doctors who provided vaccination services were required to prepare a list or return of poor persons vaccinated and an invoice for services provided, and to have both documents certified by Sessions, Special Sessions, or a local magistrate.31 The certification served as confirmation that the list consisted only of persons whose names appear in the poor roll,

29 See Circular from Rupert D George to the Colchester Board of Health (30 March 1841), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Papers re vaccinations).
30 See supra note 18: Your committee would advise as the preferable course, that a strict account should be kept and rendered to His Excellency the Lieutenant Governor, of every individual vaccinated, who, in the opinion of the [j]ustices…in General, or Special Sessions, are unable to pay the charge; and that His Excellency should be authorized to pay the amount thereof…whenever it is made satisfactorily to appear to His Excellency, either by the [c]ertificate of said [j]ustices or otherwise, that the charges are fair and reasonable.
31 See ibid.
and who were deemed unable to pay for the medical services provided. The vaccination returns and invoices were then sent to the Lieutenant Governor’s office for processing, verification and payment. To prevent the use of provincial funds for “vaccinating those who have the means of bearing the expense themselves,” medical doctors were discouraged from seeking payment directly from the provincial government.

Municipalities did not rely exclusively on vaccination in dealing with smallpox and other infectious disease threats and outbreaks. Rather, vaccination was one of several measures used by health officials, along with mandatory reporting of infectious disease cases, quarantine, isolation of affected persons, employing “watchmen” to prevent persons “coming from localities where smallpox exists” from visiting, sanitation, disinfection of contaminated items and closure of public places such as schools and public squares. No particular measure was emphasized or prioritized over others; rather, each was presented

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32 See *ibid*.
33 *Ibid* at 149.
34 See e.g. Copy of resolutions passed by the Board of Health Port Hawkesbury (18 November 1885), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Smallpox Epidemic).
35 See generally Sanatory Orders, Municipality of Yarmouth, Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Smallpox Epidemic) [Yarmouth Orders]; Municipality of Yarmouth, Additional Sanatory Orders Passed by the Board of Health (12 December 1885), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Smallpox Epidemic) [Yarmouth Additional Orders]; Board of Health for the County of Victoria, Sanitary Orders (6 November 1885), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Smallpox Epidemic); By[]-Laws and Sanitary Orders of the Board of Health of the Ports of Bridgewater & LaHave in the County of Lunenburg, in relation to Small-Pox (1885), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Smallpox Epidemic); By[]-Laws and Sanitary Orders of the Board of Health of No. One Polling District of the County of Lunenburg, in relation to Small-Pox (18 November 1885), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Smallpox Epidemic); By[]-Laws and Sanitary Orders made by the Board of Health for Polling Sections Numbers One, Two and Seven, in the County of Pictou, the Seventeenth day of November, 1885, and to be in force from that date, Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Smallpox Epidemic); By-Laws and Sanitary Orders of the Board of Health of the City of Halifax in relation to Small-Pox (14 November 1885), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Smallpox Epidemic); Government Notice — Smallpox Regulations, Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Smallpox Epidemic); Sanatory Orders made by the Board of Health for ‘The Town of [unclear]’ in the County of Colchester (21 November 1885), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Smallpox Epidemic).
as part of general efforts to prevent the introduction and spread of diseases. For example, sanitary regulations passed by the Municipality of Yarmouth in 1885, when smallpox was prevalent in Ontario, Quebec, Prince Edward Island and Cape Breton, required all persons arriving in the municipality from those locations and “all other ports infected with [s]mall [p]ox or other infectious or contagious diseases” to be vaccinated or show proof of vaccination before being allowed entry into the municipality. The regulations also established mandatory reporting, quarantine, isolation and disinfection measures, and required the closure of schools and places of “general or public gathering.” Lastly, health officials also placed a lot of emphasis on educating the public regarding health regulations.

3.2 Preliminary Observations and Chapter Structure

This early, across-the-board responsiveness and attention to infectious diseases was mainly a response to the constant threat of disease outbreaks. From around 1749, when the British established a permanent settlement in Halifax, to the mid-nineteenth century, there was a steady influx of disease-bearing immigrants into the province. The Port of Halifax, which was ice-free and open all-year round, served as a popular and major port of entry into the New World for trading and military vessels and the diseases they brought with them. As Allan Marble has observed, between the founding of Halifax and the end of the 18th century, large numbers of military and naval personnel and their

36 Yarmouth Orders, ibid.
37 Yarmouth Additional Orders, supra note 35.
38 See supra note 2 at 13-14.
families arrived in Halifax and the surrounding areas, bringing with them disease epidemics, mainly of smallpox.40 These epidemics posed a direct threat to British colonial interests, including immigration, settlement of the province, trade, and conquest in the war against French troops. Colonial authorities had little choice but to respond or risk jeopardizing the development of the fledgling province. Immigrant diseases remained a threat and a primary focus of public health law and policy well into the twentieth century. This point is neatly summarized in a memorandum issued in 1905 by Dr. A.P. Reid, the Provincial Health Officer and Secretary of the Provincial Board of Health, to wardens and councillors of the Municipality of Argyle, urging the implementation of the Public Health Act:

We must not ignore the fact that our shores, as well as inland communities, are being continually visited by people from all surrounding as well as distant countries, owing to the facilities for travel, and hence we are liable to have any type of disease conveyed to us, and also that by no practicable means can we prevent its importation… Preventible disease causes 75 per cent of the sickness, fatalities, worry and expense imposed on our people, and their presence to any extent argues either ignorance, carelessness, or both.41

Another general observation regarding the management of infectious diseases and public health governance in Nova Scotia is the absence of the social tensions, missed opportunities and controversies that characterized corresponding developments in Ontario. The social controversies provoked by vaccination in many other jurisdictions

40 See supra note 2 at 27, 35, 37, 54-61; See generally Minutes of the Sessions, 1810-1814, Halifax, Archives of Nova Scotia (Halifax County Court of General Sessions of the Peace Fonds, 1770-1886, RG 34-312 Series P, vol 5); “Orders to Prevent Capt. Alden’s Crew Coming Ashore for Fear of the Smallpox 26 September 1731” in Archibald M Macmechan, ed, Original Minutes of His Majesty’s Council at Annapolis Royal, 1720-1739 (Halifax: Archives of Nova Scotia III: 1908) 31-33 [Macmechan].
41 Circular from Dr. AP Reid, Provincial Health Officer, to Wardens and Councillors of the Municipality of Argyle (26 December 1905), Tusket, Argyle Township and Court House Archives (RG 3 Series M, Sub-series 4).
were largely absent in Nova Scotia, as the people of the province submitted themselves to procedure without questioning its (scientific) merits, benefits, or impact on their personal liberties. Unlike in Ontario and England, organized anti-vaccination movements never gained a foothold within the province. This remained the case through introduction of compulsory vaccination legislation, which transpired years earlier than when similar measures were enacted into law in Ontario and England.

As we shall see, much of the credit for the province’s success with creating sustained, effective and well-received infectious diseases / public health management programs is owed to two factors. The first factor relates to the legal response to infectious diseases and public health in general. As stated earlier, the colonial / provincial authorities responded promptly to the threat of infectious diseases by creating legislation to govern management strategies and establish governance systems. These strategies and systems were revised and fine-tuned over time to anticipate, accommodate and address practical concerns and emerging trends in both management methods and infectious disease policy. The use of legislation in this manner imparted a strong sense of legality to, and facilitated general interest in infectious disease and public health programs.

The second factor relates to implementation of the law, which, for most of the nineteenth century, was entrusted to local officials, and later, to both central and local administrators. Those charged with implementing the law cooperated with one another and with energetic medical professionals to tackle, prevent and eradicate infectious disease threats and outbreaks. Also, for the most part, these persons carried out their
responsibilities with the primary (and sole) aim of protecting and preserving public health, and did not utilize their legal authority to seek or achieve personal or professional interests.

The foregoing suggests that the legal history of smallpox and vaccination in Nova Scotia (and of infectious diseases and public health more broadly) does not, at least from the perspective of the limited comparative analysis contemplated in this work, offer the level of intrigue or controversy that characterized the Ontario history. This is true to some extent; the inaction, dysfunction, ideological debates, and social tensions that produced controversy and legal challenges in Ontario are largely missing from the Nova Scotia history. However, what the latter lacks in intrigue it makes up for by providing a solid historical account of how better public health governance outcomes can be achieved through a responsive legal and administrative system that is focused more on practical solutions rather than ideological appeal or promotion of progressive but partisan interests.

More importantly, the Nova Scotia history, viewed in general terms, is a straightforward account of the presence of the *salus populi* and localized law concepts within the Canadian context. Specifically, colonial and provincial governments in early Nova Scotia relied *aggressively* on legislation, and a localized system of governance and administration of justice, to govern public health and the management of infectious diseases, in line with the dominant trends in nineteenth century North American legal history described in the introductory chapter. Unlike in Ontario, where these trends were largely absent (especially in the first half of the nineteenth century), Nova Scotians responded promptly (starting from the eighteenth century) to the threat posed by
infectious diseases mainly by adopting legislation primarily intended to secure the welfare of their people and province. The province also avoided the controversies associated with the legal history of infectious diseases in Ontario, mainly because implementation of the law was focused on the singular “public interest” goal of preventing and eradicating disease, rather than being intermingled with the personal and professional interests of those charged with implementing the law, as was the case in Ontario. Also, in Nova Scotia, implementation was achieved through cooperation and collaboration among different stakeholders, including local officials, doctors and the provincial government, rather than through divisive legal and philosophical contests for status and authority.

The rest of this chapter provides support for the points raised in this introduction, mainly through a detailed and chronological overview of legal developments relating to public health, infectious diseases, and in particular smallpox and vaccination. This discussion will raise and address distinctive features of the legal framework, social and political considerations that necessitated legal intervention, the role of local government, and cooperation between medical professionals and local and provincial authorities. For brevity sake, and to avoid repetition, I will support the narrative with the best examples from my archival research. The discussion will also highlight throughout, and in line with the chronological narrative, the sole administrative issue encountered in the implementation of the legal regime, namely disputes over responsibility for settlement of vaccination expenses. The latter issue was the major source of tension and contention between local and provincial authorities, and although the issue was not as divisive as the anti-vaccination disputes in the Ontario context, it serves to highlight how infectious
disease matters (and smallpox and vaccination specifically) affected and shaped the relationship between both levels of government in the nineteenth century. In concluding the chapter, I will argue that the contrasting histories of smallpox, vaccination and infectious diseases in Nova Scotia and Ontario suggests that legal mechanisms (or public health laws) and the manner in which they are implemented directly and strongly influenced public health outcomes. Both histories also indicate that the ideological merits of any system of public health laws may be less important to its success than a focus on practical solutions, such as reliance on a variety of management strategies, and establishing implementation systems and goals that avoid needless social controversy.

3.3 Smallpox, Vaccination, Infectious Diseases, and Public Health: Overview of the Legal Framework

3.3.1 Pre-1800

Nova Scotia legislation dealing with infectious diseases (and the first public health legislation in the province) dates back to 1761, when the General Assembly passed a statute titled *An Act to prevent the spreading of contagious distempers*[^42] (“*Infectious Diseases Act of 1761*”). While this was the first legislation to deal with the threat posed to the province by infectious and contagious diseases, the topic received some official attention earlier by way of quarantine orders issued by Council.[^43] On 26 September 1731, for example, Council issued two resolutions preventing the vessel Two Brothers, arriving

[^42]: SNS 1761 (1 Geo 3), c 6.
[^43]: See *supra* note 2 at 41.
at the British military garrison at Annapolis Royal port from Boston, from anchoring, due
to the presence of smallpox on board the vessel. The resolutions read:

[R]esolved and [a]greed that a message from his Honour be sent on board
[said] [v]essel…to examin[e] the Master [relating] to [said] distemper
and [o]rders him to anchor under the fort [sic] and let none of his crew
come on shore till further [o]rders from his Honour.

Advised and Agreed. That it is for the safety of this place and Province
[t]hat an [o]rder be sent from the Hon. Live. Governor to [said] Alden
[captain and master of the Two Brothers] [t]hat no woollen goods; [c]otton
wool &c (that may hold said infection) be landed here at this place, until
such time as they are first aired, at some distant place from this Garrison
as his Honour shall think proper.

The Infectious Diseases Act of 1761 was primarily aimed at preventing the introduction
of contagious and infectious diseases into the province. The Act required the quarantine
of vessels arriving at provincial ports if carrying passengers infected with smallpox, the
plague, malignant fever or other contagious diseases. While the Act applied throughout
the province, the quarantine provisions were mainly directed at the Port of Halifax, the
busiest. Vessels arriving at the Port of Halifax were required to anchor two miles at sea
from the town of Halifax, and to hoist a sign “with the union downwards” on its
masthead indicating the presence of disease. The master of the vessel was required to
notify the provincial authorities of the conditions on board the vessel within twenty four
hours of arrival, and to carry out any orders issued by the authorities, including
quarantine, airing and cleansing of passengers, vessel and contents, and removal of

\[44\text{ Macmechan, supra note 40.}\]
\[45\text{ Ibid.}\]
\[46\text{ See supra note 42, s 1.}\]
\[47\text{ See ibid.}\]
\[48\text{ See ibid.}\]
infected persons from the vessel.\textsuperscript{49} The master was responsible for the costs of caring for sick persons removed from the vessel, and was required to provide security for the settlement of accounts incurred by the authorities in caring for the sick and infected.\textsuperscript{50} Contravention of the Act attracted a fine of one hundred pounds recoverable by “bill, plaint, or information, in any of his Majesty's courts of record.”\textsuperscript{51} By contrast, in early Ontario legislation, similar offences against the public health were laid before justices of the peace.

In places other than Halifax, the Act placed the responsibility for enforcing vessel quarantine on local justices of the peace “residing within or nearest to such town…where any vessel infected with smallpox or infectious distemper, shall arrive.”\textsuperscript{52} However, the justices’ authority over quarantine was limited to the following specific matters: preventing or restraining persons on board infected vessels from leaving or coming onshore, ordering passengers who had come onshore from infected vessels to return on board, and preventing residents from going on board infected vessels.\textsuperscript{53} Besides quarantine, the justices were also empowered to establish and implement general measures for preventing the introduction and spread of infectious diseases in their respective localities.\textsuperscript{54} Justices, alone or in Sessions, could issue warrants directing town

\textsuperscript{49} See ibid.
\textsuperscript{50} See ibid, s 2.
\textsuperscript{51} See ibid, s 3.
\textsuperscript{52} See ibid, s 4.
\textsuperscript{53} See ibid.
\textsuperscript{54} See ibid.
constables to execute or carry out their orders, and were required to immediately notify the Lieutenant Governor of actions taken in this regard.\textsuperscript{55}

It is not surprising that local justices were entrusted with the responsibility of implementing this maiden public health statute in counties other than Halifax. Similar to Ontario, justices of the peace already exercised this role as part of their responsibility for local government. For example, in 1775, magistrates in the town of Liverpool and one of the overseers of the poor met “at Mrs. Doggett’s”\textsuperscript{56} house to discuss proper measures to prevent the spread of smallpox introduced into the town by the warship Senegal arriving from Halifax, which, along with its passengers “except ye mate, and a negro”\textsuperscript{57} had been taken into custody “on suspicion that contraband goods [were] on board.”\textsuperscript{58} The magistrates recommended that one of the smallpox victims, Jonathan Cromwell, who contracted the disease from the doctor of the Senegal, be kept at a place at “a sufficient distance from the highway, and that a flag must hang out.”\textsuperscript{59} They also wrote to the captain of the vessel to demand that “no infected person may come among the inhabitants.”\textsuperscript{60} Subsequently, the magistrates ordered the inoculation of passengers on schooners entering into the town harbour.\textsuperscript{61} Several residents of the town were also inoculated under the orders of the Liverpool Sessions.\textsuperscript{62}

\textsuperscript{55} See \textit{ibid}.
\textsuperscript{56} Simeon Perkins, \textit{The Diary of Simeon Perkins, 1766-1780} (Toronto: Champlain Society, 1948) 111.
\textsuperscript{57} \textit{Ibid} at 110.
\textsuperscript{58} \textit{Ibid}.
\textsuperscript{59} \textit{Ibid} at 111.
\textsuperscript{60} \textit{Ibid}.
\textsuperscript{61} \textit{Ibid} at 111-112.
\textsuperscript{62} See generally \textit{ibid} at 112-119. Note however that there was some resistance to inoculation during this period out of concern that the procedure will further the spread of smallpox. See \textit{ibid} at 116, 278-79. During a smallpox outbreak in January 1801, the Liverpool Sessions met at the court house to discuss the
It appears therefore that the *Infectious Diseases Act* of 1761 merely formalized roles and responsibilities performed by local magistrates as part of local government. However, the limitations placed on the justices’ quarantine powers appears to be a contraction of their local government authority. These limitations, and the notification provisions in the Act, were likely intended to limit, prevent or monitor interference with free passage of naval ships, which were vital to Britain’s war efforts against the French and Revolutionary forces. Nonetheless, this early legislation recognized a role for local officials in the administration and enforcement of public health laws and measures.

The dominant focus on vessel quarantine is also not surprising when one considers that the obvious motivation for the Act was to deal with the threat of immigrant diseases. While the Act did not specify other methods and strategies for dealing with infectious diseases, it did allow justices of the peace broad discretion and exclusive jurisdiction to establish and implement measures for preventing the introduction and spread of such diseases. In doing so, the Act prompted and enabled flexibility and innovation in the implementation of public health measures. Specifically, it allowed local officials to fashion approaches to managing infectious diseases that were specific to the needs of their respective communities. Local officials relied on this discretionary power to introduce and utilize innovative measures, such as smallpox inoculation.\(^63\) Also, as we shall soon see, subsequent legislation adopted a variety of new and established strategies

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\(^{63}\) See *e.g.* *supra* notes 56-62 and accompanying text.
for dealing with infection diseases, including vaccination, vessel quarantine, removal and isolation of infected persons, inoculation, sanitation and disinfection, and placarding of infected locations.

A curious provision in the Act is the distinction between Halifax and other counties in terms of the application of the statute. In Halifax, the responsibility for implementing and enforcing the provisions of the Act was placed on the colonial government (i.e. the Lieutenant Governor), rather than justices of the peace. This distinction emphasized the nascent status and strategic importance of Halifax to the province. Following the founding of Halifax in 1749, the steady arrivals of British troops and their families transformed the town from a mere seaport to a major military and naval base.64 Prior to 1761, it was home to nearly all British settlers in Nova Scotia, and the welfare of the town and its settlers was of special interest and importance to an imperial government that was eager to encourage immigration to the region.

Furthermore, direct motivation for the distinctive focus on Halifax may have come from two major smallpox epidemics that occurred there in 1755 and 1757. The first epidemic was most likely introduced to the town by a fleet of royal navy ships that arrived in Halifax in the summer of 1755. On board the ships were French sailors afflicted with the disease who had been captured and taken prisoner at Louisbourg.65 Allan Marble has speculated that the second epidemic was a deliberate act of war by the French, who in August 1757, shipped captured British prisoners afflicted with smallpox back to

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64 See supra note 2 at 37-38.
65 See ibid at 48.
Halifax. According to Marble, the second epidemic had a “significant effect” on the decision of the British colonial authorities stationed in Halifax to cancel the invasion of the French settlement of Louisbourg in August 1757. Accounts of both epidemics also suggest that Halifax was particularly vulnerable to disease threats, whether from immigrants, war and trading vessels, or as a target of acts of war. Over 2600 Haligonians fell victim to the disease, and a fifth of that number died from it.

The second epidemic prompted the Executive Council to consider more formal measures for preventing the spread of smallpox. However, the introduction of a bill was delayed by the war with the French, particularly the siege and capture of Louisbourg and Quebec in June 1758 and September 1759 respectively. In December 1759, a bill to establish measures for preventing the introduction and spread of diseases was sent by the Executive Council to the House of Assembly. The bill was rejected by the House, possibly because Council did not seek input from the Board of Trade and Plantations, which was a committee of the Privy Council charged with control of colonial matters and “advis[ing] the Crown on matters relating to economic activity in the United Kingdom and Commonwealth.” The rejection prompted Council to issue an order that all vessels

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66 See ibid at 57.
67 See ibid at 55.
68 See generally John Joseph Heagerty, *Four Centuries of Medical History in Canada, and a Sketch of the Medical History of Newfoundland*, vol 1 (Toronto: MacMillan, 1928) 74-5.
69 Ibid at 75.
70 See supra note 2 at 55.
71 See ibid at 64-5.
72 See ibid at 67.
73 Ibid. The reasons for the rejection are not stated in ibid.
arriving at the Halifax harbour dock for inspection at St. George’s Island.  

In December 1760, Lieutenant Governor Belcher sent a “copy of a bill to prevent the spreading contagious distempers” to the Board of Trade and Plantations in London, England. The bill was enclosed in a letter asking for “directions as to the powers of government for preventing contagious distempers.” Three months later, the Board responded by sending Lord Belcher copies of infectious disease statutes “passed and approved of in the Colonies of Georgia, South Carolina, and Bermuda,” accompanied by a letter directing him “to judge what regulations may be proper to be made in the like case in the Province of Nova Scotia.” Shortly after, Council submitted a revised bill to the House of Assembly, which became the Infectious Diseases Act of 1761.

This distinction between Halifax and other towns and counties was maintained in a supplementary Act enacted in 1775 (“Infectious Diseases Act of 1775”), which specifically stated that its provisions would not apply to Halifax. Both initial statutes therefore established two distinct public health governance regimes: one for Halifax, under the administrative authority of the Lieutenant Governor, and the other for the rest of the province, managed or administered by local officials. As explained above, this


75 See supra note 2 at 67.


77 Ibid.

78 Ibid at para 191.

79 Ibid.

80 See An Act in addition to an Act, made in the first year of his present Majesty’s reign, entitled, An Act to prevent the spreading of contagious distempers, SNS 1775 (16 Geo 3), c 11, s 3. The section reads: “[N]othing in this Act contained, shall be construed to extend to the town of Halifax.”
administrative structure highlights the strategic importance of Halifax to the colonial government. However, following the capture of Louisbourg and end of the Seven Years’ War, the British population in Halifax dispersed to other parts of the province. An amendment to the *Infectious Diseases Act* of 1775, passed in 1799, eliminated the distinction, and empowered Council to issue province-wide quarantine orders.81

The *Infectious Diseases Act* of 1775 was a legislative response to a protracted continent-wide smallpox epidemic that ravished American and British forces during the Revolutionary War.82 The epidemic began in 1775 and persisted until 1782. Historians have compared the impact of the epidemic on the North American continent to the war itself, especially in terms of the attention it drew from the colonial and revolutionary authorities. Elizabeth Fenn has observed, for example, that “the smallpox scourge of 1775-82...took many more...lives than the war”83 and that “while colonial independence reshaped global politics forever, the contagion was the defining and determining event of the era for many residents of North America [and]...the greatest upheaval to afflict the continent in [those] years.”84

The 1775 Act significantly expanded the roles and powers of justices of the peace in relation to the prevention and management of infectious diseases, and created new

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81 See *An Act in amendment of an Act, passed in the first year of his present Majesty’s reign, entitled, an Act to prevent the spreading of contagious distempers, and also in amendment of an Act, passed in the sixteenth year of the said reign, entitled, an Act in addition to the before recited Act, SNS 1799 (39 Geo 3), c 3.*
83 Ibid at 9.
84 Ibid.
responsibilities for the overseers of the poor. Specifically, the Act empowered panels constituted by two or more justices and the overseers of the poor for each town to investigate disease epidemics and to take such steps as they deem necessary for the prevention and management of infectious disease epidemics.\textsuperscript{85} The panels were authorized to order the removal of infected persons to a designated place where they would be cared for at their own expense if able to pay, and if otherwise unable to pay, at the expense of the town where such persons reside.\textsuperscript{86} Accounts for treating or caring for indigent non-residents who contracted smallpox or other infectious diseases while visiting a town were to be laid before the Court of General or Special Sessions of the Peace of the county or district, and upon approval, was to be paid by the overseers of the poor.\textsuperscript{87} The overseers could apply by warrant to the Lieutenant Governor to have such charges reimbursed from the public treasury.\textsuperscript{88}

The principal reason for bringing the poor relief system within the public health governance framework relates to the rise in the number of poor and indigent persons in the province in the period following the British capture of Louisbourg in 1758 and the signing of the Treaty of Paris in February 1763. The treaty brought the Seven Years’ War between Britain and France to an end.\textsuperscript{89} An in-depth account of this outward expansion of poor relief is well covered in Allan Marble’s book on smallpox and poor relief in

\textsuperscript{85} See \textit{supra} note 80, s 1.
\textsuperscript{86} See \textit{ibid}.
\textsuperscript{87} See \textit{ibid}.
\textsuperscript{88} See \textit{ibid}.
\textsuperscript{89} See \textit{supra} note 2 at 73-6.
eighteenth century Nova Scotia,\textsuperscript{90} and need not be repeated here. As Marble points out, both events - the capture of Louisbourg and the end of the war - led to the departure of military and naval personnel from Halifax, which then resulted in “a dramatic lessening in the demand for goods and services in Halifax…the emergence of unemployment”\textsuperscript{91}, and a steep increase in the number of destitute and helpless persons, mainly women abandoned by the departing regiments. The outward movement of these destitute persons from Halifax to other places in the colony most likely triggered a need to extend existing infectious disease legislation to areas not previously covered or accounted for.

The \textit{Infectious Diseases Act} of 1775 was innovative in another respect. The Act formally recognized inoculation as a means of preventing smallpox, a step which suggests that lawmakers were aware of trends in the management of the disease at the time, and were willing to employ every available method at their disposal in the fight against smallpox. However, recognizing that inoculation with smallpox could lead to further propagation of the disease, the Act stipulated that the procedure was to be performed only in a house “one hundred and fifty rods” from other dwellings, and that the person performing the procedure should notify the public of the presence of infection by hanging a flag on the house.\textsuperscript{92} This proviso was mostly likely added to address the concerns of several surgeons in Halifax who recommended against the procedure for fear that it would contribute to the spread of smallpox.\textsuperscript{93}

\textsuperscript{90} See generally, \textit{ibid}.
\textsuperscript{91} \textit{Ibid} at 73.
\textsuperscript{92} See \textit{supra} note 80, s 2.
\textsuperscript{93} See \textit{supra} note 2 at 70-71.
In 1799, a rampaging and highly destructive yellow fever epidemic raging in the United States provoked an amendment to the Infectious Diseases Acts. The amendment made more extensive provisions for quarantine of vessels and persons and for “punishing offenders in a more expeditious manner, than can be done by an ordinary court of Law.”

The Act authorized the Lieutenant Governor in Council to issue orders requiring the quarantine of vessels, persons and cargo arriving at any port or place in the province from the United States or the West Indian Islands, upon suspicion of the presence of or if judged probable of introducing infectious diseases into the province. In order to limit interference with and prevent the detention of vessels and cargo based on mere suspicion, the Lieutenant Governor was empowered to appoint one or more paid health officers to carry out and enforce quarantine orders, including obtaining information from the masters of arriving vessels regarding specified matters relating to the condition of the vessel and its passengers/merchandise, the presence of infectious diseases on the vessel, and details regarding events that occurred during its voyage. This attempt to prevent interference with free movement of vessels, persons and cargo in and out of the province suggests that the provincial legislature was concerned about the impact that vessel quarantine might have on immigration and trade. Health officers were further empowered to compel the removal of persons and merchandise to designated isolation centres, and perform storing, opening and airing of merchandise. Health officers who were guilty of wilful breach of

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94 See supra note 81.
95 Ibid, Preamble.
96 See ibid, s 1.
97 See ibid, s 2.
98 See ibid, s 5.
neglect of their statutory duties were liable to forfeit their office and to a fine of fifty pounds recoverable in any Court of Record.99

Penalties for contravention of quarantine orders were harsh,100 reflecting the heightened sense of apprehension surrounding the introduction of infectious diseases into the province. Masters of arriving vessels who concealed or failed to notify the authorities of infectious disease cases were subject to twelve months imprisonment,101 and persons refusing to perform quarantine, or who unlawfully enter or leave a quarantined vessels were liable upon conviction to six months imprisonment and a fine of fifty pounds.102 The Act further authorized the use of necessary force to implement quarantine, including “firing of guns upon [the offending] ship or vessel.”103 Penalties under the Act were enforceable or recoverable in any of the courts of record in the province, by action for debt, bill, plaint or information.104 The Act also created a number of felony offences (“without benefit of clergy”105), including falsely certifying that a vessel under quarantine

99 See ibid, s 9.
100 See ibid, ss 2-9, 12, 14.
101 See ibid, s 2.
102 See ibid, s 3.
103 See ibid, s 2.
104 See ibid, s 3.
105 Ibid, ss 11 & 12. This term “benefit of clergy” refers to a plea traditionally used to avoid the death penalty in English criminal law. The plea conferred “clerical immunity” on clergymen accused of crimes punishable by death. Under the terms of the plea, which was negotiated by the Church of England and granted by Henry II in the late 12th century, an accused clergyman who produced letters of ordination would be tried in an ecclesiastical court, which never imposed the death penalty. The plea would later become available to laymen, and was applied by the courts as a discretionary device to mitigate harsh criminal law penalties. For more on the plea, see Encyclopaedia Britannica, online ed, sub verbo “benefit of clergy”, online: Encyclopaedia Britannica <http://www.britannica.com/EBchecked/topic/121291/benefit-of-clergy>; John Briggs, Christopher Harrison, Angus McInnes & David Vincent, Crime and Punishment in England: An Introductory History (New York: Routledge, 2005) 74-6, 81-2, 85.
is free of infection,\textsuperscript{106} and concealment of goods or merchandise exposed to infection on board a vessel.\textsuperscript{107}

Although the Act significantly expanded the jurisdiction of the Lieutenant Governor, this expansion was mainly limited to quarantine matters. Authority for implementing other measures for the prevention and management of infectious diseases remained with the justices of the peace and overseers of the poor.\textsuperscript{108} The justices were specifically empowered by the Act to perform quarantine of vessels arriving at ports in their respective municipalities on which infection was present, to remove and isolate persons on board such vessels who were infected with disease, and to store, open and air contaminated or exposed goods and merchandise.\textsuperscript{109} The Act also authorized two justices, upon notice and due proof supplied on oath by “one or more credible witnesses”, to order the burning or purification of contaminated beds, beddings, household goods and apparel.\textsuperscript{110} Enforcement expenses were to be paid by owners of affected goods or cargo or by infected persons, unless indigent, in which case such expenses were to be paid or reimbursed from the provincial treasury upon approval of the account by the Court of General or Quarter Sessions of the Peace.\textsuperscript{111}

The foregoing review indicates that infectious diseases, especially smallpox and yellow fever triggered the enactment of public health laws in the early period of Nova Scotia’s

\textsuperscript{106} See supra note 82, s 11.
\textsuperscript{107} See ibid, s 12.
\textsuperscript{108} See ibid, s 4.
\textsuperscript{109} See ibid.
\textsuperscript{110} See ibid, s 10.
\textsuperscript{111} See ibid, s 4.
history. While it is clear that the primary focus of the statutes was to address the introduction of diseases into the province, the statutes also targeted measures for addressing the spread and management of infectious diseases within the province. The responsibility for implementing these early statutes was placed on local officials, including magistrates and overseers of the poor, except in Halifax, where the Acts were mainly administered by the colonial/provincial government. Local officials were allowed wide discretion under the Acts to devise and implement measures to prevent the introduction and spread of infectious diseases. Legislation in this period introduced a number of innovative approaches to dealing with the threat of infectious diseases, such as smallpox inoculation and reliance on the poor relief system as a form of medical welfare for the indigent.

The use of legislation to manage infectious diseases in this early period was very successful. The province was free from major epidemics in the final fifteen years of the eighteenth century. However, there were “numerous instances” of various fevers, smallpox and black scurvy. Minor epidemics of smallpox occurred in the last decade in various towns, including Guysborough, Lunenburg, Shelburne, Port Medway and Liverpool, and the disease was a constant threat at the turn of the century and beyond. Inoculation was blamed for these minor epidemics, and towards the end of the century, doctors, magistrates and overseers of the poor began to recommend against or

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112 See supra note 2 at 156.
113 Ibid.
114 See ibid at 157
115 See ibid at 158-9.
take actions to stop the practice. Council was also hesitant to recommend the practice; an application submitted by physicians and inhabitants of Halifax for leave to perform inoculations during a smallpox scare in May 1799 was rejected by Council, which recommended instead that persons desirous of performing the procedure do so outside Halifax. A month later, on 9 July, the House of Assembly passed *An Act for regulating the practice of inoculating for the small pox*. The Act allowed the practice of inoculation to continue, but limited the dates that it could be performed to between October 1 and April 30.

3.3.2 Post-1800: Quarantine and infectious diseases become distinct subjects of legislation

The three public health statutes discussed above remained in force until 1832, when the House of Assembly passed two statutes to regulate, respectively, quarantine of incoming vessels, and the management of infectious disease outbreaks. Both enactments marked the formal separation of quarantine and infectious diseases as subjects of legislation, and both subjects subsequently developed along separate legislative trajectories. Both statutes were also a response to the transcontinental cholera epidemic

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116 See *ibid* at 157-8. See also Circular letter to surgeons regarding stopping the process of inoculation signed by Dr. William Burns, Dr. John Perry, and Dr. John House (1 April 1791), Halifax, Archives of Nova Scotia (Shelburne County General Sessions of the Peace Fonds, RG 34-321, Series C, vol 321).
117 See *ibid* at 158.
118 SNS 1799 (39 Geo 3), c 7.
119 *An Act to prevent the spreading of contagious diseases, and for the performance of quarantine*, SNS 1832 (2 Will 4), c 13.
120 *An Act more effectually to provide against the introduction of infectious or contagious diseases, and the spreading thereof in this province*, SNS 1832 (2 Will 4), c 14.
that provoked similar legislation in Ontario and elsewhere. This rationale is explicitly stated in the preamble to the statute dealing with infectious disease outbreaks, as follows:

WHEREAS, a malignant and highly dangerous disease, called the Cholera, or Spasmodic or Indian Cholera, has for some time past prevailed on the Continent of Europe, and in Great Britain, and apprehensions are entertained that the same may be introduced into this Province: And whereas, in the event of the introduction of the said disease, or any other infectious plague, disease or distemper, into this Province, it may be impossible, by the authority of the General Assembly, to establish, with sufficient promptitude to meet the exigencies of any such cases as may occur, such regulations as may be necessary in the several ports and places of this Province, for averting, diminishing or preventing, as far as may be possible, the spreading of any such infectious disease therein. And whereas also, it may become necessary to adopt more effectual measures than are now in use, for preventing the introduction of…Cholera, or other infectious or contagious distempers, into this Province.

The quarantine statute repealed all existing statutes relating to the performance of quarantine, and established more extensive provisions for the performance of quarantine on vessels, “including His Majesty’s Ships of War, coming from, or having touched, at any place” declared by Council to be infected with “Plague, Small Pox, Yellow-Fever, Typhus Fever, Cholera Morbus, or any other infections disease, or contagious distemper.” While the Act maintained the provisions in the earlier statutes, it made further provisions regarding the performance of quarantine, including extensive provisions relating to the duties, responsibilities and liabilities of officials appointed to implement and enforce the Act. The Act also included a provision requiring infected

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121 See Part 2.1 of Chapter 2, above, for more on this topic.
122 Supra note 120, Preamble.
123 See supra note 119, Preamble.
124 Ibid, s 3.
125 Ibid.
126 See generally ibid, ss 1-33.
incoming vessels to hoist signals to alert the authorities of the need for quarantine.\textsuperscript{127} The Lieutenant Governor was empowered to declare and deal with emergencies, including the power “to cut off all communication between any persons infected with…disease or distemper…and the rest of His Majesty’s subjects.”\textsuperscript{128} Implementation of the Act was to be carried out by health officials and the newly created office of Superintendent of Quarantine,\textsuperscript{129} and prosecutions for violation of the Act were to be laid only in the name of the Attorney or Solicitor General before any of His Majesty’s courts of record.\textsuperscript{130} Unlike the previous statutes, the role of local justices of the peace in relation to quarantine was very limited, and relegated to trying offences for which the Act did not specify any penalty.\textsuperscript{131}

The second statute dealt directly with the management of infectious or contagious disease outbreaks. The primary intent of this statute was to establish proactive and “more effectual measures than [were then] in use” for “averting, diminishing or preventing” the further spread of infectious disease outbreaks.\textsuperscript{132} Principally, the Act authorized Council to establish, by regulation, such orders as were “necessary or expedient” to prevent the spread of infectious diseases, for the relief of infected persons, or for the “safe and speedy interment” of persons who died from infection.\textsuperscript{133} Orders were to be certified by the Provincial Secretary and published in the Royal Gazette, and were admissible as

\textsuperscript{127} See \textit{ibid}, s 8.
\textsuperscript{128} \textit{Ibid}, s 6.
\textsuperscript{129} See \textit{ibid}, s 12.
\textsuperscript{130} See \textit{ibid}, s 29.
\textsuperscript{131} \textit{Ibid}, s 31.
\textsuperscript{132} See \textit{supra} note 120, Preamble.
\textsuperscript{133} See \textit{ibid}, s 1.
proof of its contents in court.\textsuperscript{134} The Lieutenant Governor in Council was further empowered to appoint boards of health and health officers to implement the Act and subsequent orders and regulations throughout the province, and to authorize them to make rules and regulations considered necessary for the preservation of public health.\textsuperscript{135} A Central Board of Health, based in Halifax, was established pursuant to this provision shortly after the Act was passed. Local boards of health, constituted mainly by medical doctors and magistrates, were also established for most communities in the province. In places without a board of health, a Special Sessions made up of two or more magistrates served as the board of health. Boards of health constituted mainly by doctors and magistrates were also established for most communities in the province, and in places without a board of health, a Special Sessions served as the board of health.\textsuperscript{136}

Although not specifically stated in the Act, it is clear that the foregoing provisions were intended to provide the provincial authorities with ultimate oversight of matters relating to public health throughout the province. However, the Act also recognized that the provincial government, even with the assistance of health officers, mostly based in

\textsuperscript{134} See \textit{ibid}, s 2.
\textsuperscript{135} See \textit{ibid}, s 4.
\textsuperscript{136} See e.g. various orders issued between 1840 and 1841 by a Special Sessions acting as a Board of Health for the County of Digby, and orders issued by the Digby County General Sessions of the Peace certifying payments to Dr. William L Bent and others for “medical services under the direction of the Board attending small-pox patients” (including vaccination), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Papers re vaccinations). See also Order of the Special Sessions to James Rogers, Esq, Clerk of the Peace (23 September 1834), Halifax, Archives of Nova Scotia (RG 34-319, Series C vol 3, Queen’s County Papers) summoning him to record the proceedings of the court’s special sessions which will be discussing “what is necessary and expedient to be done in order to put into force the several Acts of this Province” in particular to protect against the introduction of infectious or contagious Diseases, and the spreading thereof in this Province; Minutes of the Special Sessions, Maitland, written by JJ O’Brien and Charles Putnam, Secretary (29 April 1873), Halifax, Archives of Nova Scotia (RG 34-313, Series C vol 6, Hants County Board of Health & General Papers) containing a record of the resolutions of the Special Sessions held on 29 April 1873 calling for general vaccination of the residents of Maitland prompted by a smallpox outbreak in the United States.
Halifax, could neither realistically nor expeditiously oversee the day-to-day management of infectious disease outbreaks in communities throughout the province. To address the latter issue, the Act authorized local justices of the peace (in places other than Halifax\textsuperscript{137}) to appoint unpaid health wardens\textsuperscript{138} to enforce and execute the Act and regulations, including responsibility for health inspections and investigations and the removal, cleansing and destruction of nuisances and public health threats.\textsuperscript{139}

Both statutes expired at the end of the legislative session. However, as was customary at the time, the statutes were continued until 1851, when both were revised and included in a consolidation of the provincial statutes.\textsuperscript{140} A new provision was introduced in the infectious disease statute in 1833 to empower health wardens to institute summary prosecutions against offenders before two or more justices of the peace.\textsuperscript{141}

3.3.3 The role played by local officials in implementing the infectious disease statutes

Local officials and institutions were actively engaged in the implementation of these early statutes. Throughout the province, sessions courts, grand juries and local boards of health exercised their respective powers under the public health statutes to deal with nuisances, infectious disease outbreaks, and local quarantine. For example, in 1800, the Halifax Sessions passed extensive regulations to “preserve the [h]ealth and [c]leanliness

\begin{itemize}
  \item \textsuperscript{137} See \textit{supra} note 120, s 9.
  \item \textsuperscript{138} See \textit{ibid}.
  \item \textsuperscript{139} See \textit{ibid}.
  \item \textsuperscript{140} See \textit{Of the Public Health}, RSNS 1851, c 53; \textit{Of Boards of Health and Infectious Disease}, RSNS 1851, c 54.
  \item \textsuperscript{141} See \textit{An Act to alter and continue the Act more effectually to provide against the introduction of infectious or contagious diseases, and the spreading thereof in this province}, SNS 1833 (3 Will 4), c 36, s 2.
\end{itemize}
of the [inhabitants of the Town of Halifax."

The regulations prohibited the dumping of putrid matter on the streets and the slaughter of animals in places other than slaughter houses or wharves located over tidal water. Further regulations in 1802 stipulated that meat not fit for food must be burnt or otherwise destroyed. Vaccination was ordered by a Special Sessions following two smallpox outbreaks in 1806 and 1814. Earlier, between 1794 and 1799, the Halifax Grand Jury and Special Sessions issued several orders requiring the removal of nuisances from city streets and the destruction of foods that were unfit for consumption.

These implementation actions were not limited to Halifax. Local officials in Shelburne, Digby, Hants and Queen’s implemented a range of measures aimed at preventing the introduction or spread of infectious and contagious diseases, such as removal and destruction of nuisances, local and vessel quarantine, placarding of infected houses and vessels, isolation of infected persons, and vaccination. Sessions courts in these places

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142 Halifax Regulations, supra note 1.
143 See ibid.
146 See supra note 7.
147 See e.g. Minutes of the Sessions (17 September 1798), Halifax, Archives of Nova Scotia (Halifax County Court of General Sessions of the Peace Fonds, 1770-1886, Minutes of the Quarter Sessions for Halifax County June 1791-November 1799, RG 34-312 Series P, vol 1).
148 See generally supra notes 34 & 35. See also Minutes of the Digby County Court of General Sessions of the Peace (9 June 1846), Halifax: Archives of Nova Scotia (RG 34-310 Series P, vol 3, 1838-1847); Special Sessions of the Peace held at the House of Gideon White (4 July 1832), Halifax, Archives of Nova Scotia (Shelburne County General Sessions of the Peace Fonds, RG 34-321 Series C, vol 316) [Shelburne Special Sessions Regulations]; Hants County, Board of Health & General Papers (1867-73), Halifax, Archives of Nova Scotia (RG 34-313 Series C, vol 6); Summons issued by the Special Session of the Peace held at the Court House 23 September 1834, Queen’s County, Halifax, Archives of Nova Scotia (RG 34-319 Series C, vol 3) [Queen’s Summons].
also passed public health regulations and prosecuted offences and violations of the statutes and regulations. For example, in August 1834, the Queen’s County Special Sessions for Prevention of the Cholera ordered the clerk of the peace to summon all magistrates in the county to consider and discuss “necessary measures to carry into effect the [l]aws of the [p]rovince, for preventing the spread of contagious diseases.”

On September 19, 1834, a charge (information) was laid before a Special Sessions of the Queen’s County General Sessions of the Peace by the county board of health against four passengers on board the Schooner Dolphin arriving from Halifax who broke quarantine in violation of a regulation recently passed by the board. The said regulation, which was aimed at preventing “the introduction and spreading of the malignant [d]isorder called the Cholera, no[w] raging at Halifax, the capital of this Province”, required all vessels coming from Halifax to perform quarantine and that “no [p]erson whatever be allowed to land from such vessels…until examined and permitted by [a] [h]ealth [o]fficer[.]” The Special Sessions ordered the four offenders, Samuel Barry, James Knaut, William Collins and Francis Collins, to each pay a fine of five pounds to the sheriff of the Town “as the law directs.”

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149 Order or Warrant from Joshua Newton Esq, Custos Rotulorum for Special Sessions for Prevention of the Cholera (29 August 1834), Halifax, Archives of Nova Scotia (RG 34-319 Series C, vol 3).
150 See Minutes from the Local Board of Health (19 September 1834), Halifax, Archives of Nova Scotia (RG 34-319 Series C, vol 3). See also Summons Issued by the Sessions to Samuel Barry, James Knaut, William Collins & Francis Collins (23 September 1834), Halifax, Archives of Nova Scotia (RG 34-319 Series C, vol 3) [Four Offenders]; Summons issued by the Special Session of the Peace held at the Court House (23 September 1834), Halifax, Archives of Nova Scotia (RG 34-319 Series C, vol 3) [Summons]; Special Meeting of the Board of Health (18-19 September 1834), Halifax, Archives of Nova Scotia (RG 34-319 Series C, vol 3); Copy of Minutes from the Local Board of Health 1 September 1834, read at the Special Sessions 23 Sept 1834, Halifax, Archives of Nova Scotia (RG 34-319 Series C, vol 3).
151 Summons, ibid.
152 See Four Offenders, supra note 152.
Similar regulations and actions were passed or taken by local officials in Digby and Shelburne against vessels arriving from places where infectious diseases existed. The Digby Sessions was especially active in regards to public health, and produced a host of health regulations, necessitating the establishment in the late 1860s of a committee to revise said regulations.\footnote{Report of Committee appointed to revise the different Regulations of the Sessions OR Regulations made in November Term (1869), Halifax, Archives of Nova Scotia (RG 34-310 Series P, 1864-75).} One regulation stipulated that vessels arriving from the United States were prohibited from approaching the Harbour of Digby “nearer than half a mile”, unless permitted to do so by the county health officer.\footnote{Digby Court of the General Sessions of the Peace (9 June 1846), Halifax, Archives of Nova Scotia (RG 34-310 Series P, vol 3).} Such vessels were also required to show a signal or flag in the main rigging as an invitation to the health officer to board the ship.\footnote{Ibid.} As discussed earlier, in 1786, a Grand Inquest constituted for the town and county of Shelburne urged Sessions to pass regulations to implement the “Act relating to infectious and epidemical Disorders” by preventing persons infected with smallpox from walking in the “more frequented [places] in the [t]own.”\footnote{See supra note 4.} In 1803, the Shelburne Sessions passed regulations empowering the health officer to board every vessel arriving from a place where infectious diseases were present for the purpose of directing such vessels to a quarantine station.\footnote{See “To the Worshipful Magistrates in Session Assembled from the Grand Jury” (6 December 1803), Halifax, Archives of Nova Scotia (RG 34-321 Series P, vol 95). See also G White JP and JN Buskirk JP to Dr. Joseph Prescott (9 September 1803), Halifax, Archives of Nova Scotia (Shelburne County General Sessions of the Peace Fonds, RG 34-321 Series C, vol 313) about the vessel Neptune which just arrived at the Port of Halifax with yellow or typhoid fever or some other infectious disease on board. Dr. Prescott is ordered to go on board and take action to prevent disease from coming to town; Dr. Joseph Prescott to White and Buskirk (9 September 1803), Halifax, Archives of Nova Scotia (Shelburne County General Sessions of the Peace Fonds, RG 34-321 Series C, vol 314) where Dr. Prescott reports that he boarded the Neptune “just arrived from New York and everyone appears to be in perfect health and to have had no intercourse with the diseases in that City.”} Lastly, during the cholera epidemic in the early 1830s, the magistrates of the Shelburne Sessions passed successive quarantine regulations for
the purposes of “carrying into force and effect the Proclamation of His Excellency the Lieutenant Governor to Provide against the introduction and spreading of Infectious diseases”\(^{158}\) and for “carrying into force the Act of the Province to prevent the spreading of infectious diseases.”\(^{159}\) The court also ordered the Clerk of the Peace to post three copies of the first set of regulations “in the most public places” in the town of Shelburne, and to send one copy each to the satellite settlements of Sandy Point and Gunning Cove.\(^{160}\) On 22 June, 1837, the health officer for the Port of Shelburne boarded the Brig Hannah from Plymouth, Massachusetts to investigate what caused the death of a crew member at sea. Upon discovering seven cases of smallpox among the crew, the health officer recommended that the statutes concerning quarantine and infectious diseases be put in force, and ordered that “all persons dying on board the Hannah or other Infected Vessels be buried on Harts Point below what is called the fish...point.”\(^{161}\) These orders were also made public by posting them at the Court House “and other places in the Town of Shelburne.”\(^{162}\)

3.3.4 The Province adopts vaccination legislation

In the year 1850, the Nova Scotia Legislature enacted a statute titled *An Act to provide for expenses of boards of health and of vaccination* (1850 Vaccination Act).\(^{163}\) The Act

\(^{158}\) Shelburne Special Sessions Regulations, *supra* note 148.
\(^{159}\) See Rough Minutes of a Special Session of the Peace, (30 August 1834), Halifax, Archives of Nova Scotia (Shelburne County General Sessions of the Peace Fonds, RG 34-321 Series C, vol 317).
\(^{160}\) See *supra* note 148.
\(^{161}\) Special Sessions of the Peace regarding quarantine and infectious diseases (28 June 1837), Halifax, Archives of Nova Scotia (Shelburne County General Sessions of the Peace Fonds RG 34-321 Series C, vol 318).
\(^{162}\) *Ibid.*
\(^{163}\) SNS 1850 (13 Vict), c 15.
passed on March 28, and it preceded the Act which introduced compulsory vaccination in England. The Act authorized the General Sessions of the Peace, or any Special Sessions, consisting of no less than seven magistrates, to order and make provisions for the general vaccination of their county or district residents, whenever the magistrates felt such order was necessary to prevent the spread of smallpox, or if the order was requisitioned by the local board of health. The Act further stipulated that expenses for vaccinating persons who were indigent or unable to pay were to be settled out of county or district funds. This meant that vaccination expenses were to be paid out of funds designated for county or district administration purposes, and not from funds held or administered by the overseers of the poor. Persons seeking payment for vaccination expenses were required to submit statements of account and lists of the names of indigent persons vaccinated to the Grand Jury and Sessions for consideration, confirmation and approval. Following approval, the accounts would then be paid in the same manner as other sums for county purposes.” The overseers of the poor were therefore sidelined or excluded from the administrative processes established by the 1850 Act.


165 See supra note 163, s 1.

166 See ibid.

167 See ibid, s 2-3.

168 Ibid, s 3.
The 1850 Vaccination Act is noteworthy in two important respects. Firstly, the Act neither imposed vaccination of the general population, nor did it, as was the case in England three years later, require mandatory vaccination of infants. Rather, it authorized municipal authorities to order vaccination of county or district inhabitants only when circumstances demanded. This approach suggests that the Legislature’s intention was to define (or clarify) the administrative framework for implementing vaccination, and not to impose measures that may have been viewed as intruding on individual freedoms.

Another feature of the Act that lends support to the latter point is that it did not specify any penalties for non-compliance. While a person who failed to comply with a vaccination order issued by the magistrates could still be tried and convicted for disobedience of a judicial order, the absence of any specific or direct penalties in the Act further suggests that the Legislature did not contemplate or anticipate opposition to a procedure that was commonly practiced and well established in the province during this period. As previously noted, Nova Scotia doctors began to administer vaccination soon after it was discovered by Jenner, often with the support of local officials and the provincial government. Indeed, unlike subsequent compulsory vaccination laws in England and the Province of Canada, which both faced strong opposition from anti-vaccinationists for imposing vaccination on infants and the general population, the Nova Scotia law did not generate much controversy, if at all.

169 See supra note 163, s 1.
170 See e.g. Melanson, supra note 1; supra note 13, 28 and accompanying text.
The provision in the Act that authorized local authorities to order general vaccination did, however, attract some opposition during the legislative debates on the preceding bill.\textsuperscript{171} A majority of the Legislative Council voted to re-commit the bill to a Committee of the Whole House to consider whether the operation of the bill should be confined to reimbursement of vaccination expenses.\textsuperscript{172} However, the provision was retained after consideration in committee. Council also introduced an amendment requiring that no less than seven magistrates approve the vaccination order.\textsuperscript{173} The amendment suggests that members of Council viewed the power to order vaccinations as a powerful or serious mandate, and wanted to ensure that such orders were issued by a representative body. The quorum requirement further suggests that the legislators wanted to ensure that proposals seeking to impose vaccination on the people were subjected to a deliberative process, and that the resulting orders were not made for arbitrary or capricious reasons.\textsuperscript{174}

Secondly, the Act eliminated the existing practice whereby expenses incurred at the municipal level for vaccination of poor persons were paid or reimbursed by the provincial treasury, and placed the responsibility for finding the means to pay for such expenses squarely on the shoulders of local authorities.\textsuperscript{175} As previously noted, in the period

\textsuperscript{172} \textit{Ibid}.
\textsuperscript{174} Council members were also likely aware of the controversies surrounding the introduction of compulsory vaccination in England and elsewhere.
preceding the passing of the Act, the Legislature authorized appropriations to provide for vaccination expenses incurred at both the provincial and local levels.\textsuperscript{176} Initial appropriations were primarily for the purpose of procuring vaccine matter for use by or distribution to medical practitioners.\textsuperscript{177} Appropriations to support pauper vaccination began in 1841, and became a routine yearly expense as the decade progressed.\textsuperscript{178} The impetus for the latter appropriations appears to have come from two sources; a report by a committee of the House of Assembly in response to a petition from the Guysborough Sessions praying for funds to support vaccination of poor persons, discussed earlier,\textsuperscript{179} and the Central Board of Health. On February 22, 1841, the Central Board of Health sent a letter to the Lieutenant Governor, which he forwarded to the Legislature for consideration.\textsuperscript{180} The letter reads, in part:

The Health Wardens for the Town of Halifax have visited their several [wards during the last week, in order to ascertain the number of persons who have either not been vaccinated or had the Small Pox; have reported that there are in their respective [wards, upwards of eleven hundred

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\textsuperscript{176} See \textit{ibid}; \textit{supra} note 29 and accompanying text.
\textsuperscript{177} See \textit{supra} notes 14-16.
\textsuperscript{178} See \textit{supra} note 175.
\textsuperscript{179} See \textit{supra} notes 17 \& 18 and accompanying notes.
persons unprotected from the contagion of Small Pox, and that during the last two days, one death and four fresh cases of Small Pox have been reported; and in neighbourhoods where a number of poor children reside, that have not been vaccinated, and as a general vaccination of the [p]oor is the only means likely to prevent that loathsome disease becoming general in the [t]own and throughout the Province; and as this Board has considered that the [m]edical gentlemen of the [t]own give gratuitously to the [p]oor, a large portion of their time and medicine; therefore *resolved* that it be recommended to His Excellency the Lieutenant Governor, that the Medical Health Wardens of their respective [w]ards be requested to vaccinate all the [p]oor within such [w]ards, for which this Board conceives they should be paid such sums as they may be deemed properly by your Excellency for each poor person vaccinated, the [a]ccounts to be verified by [c]ertificates of the other Health Wardens of each [w]ard.\textsuperscript{181}

The letter was referred to the Committee of Supply, and following their consideration and approval, the Legislature authorized the Lieutenant Governor to provide an amount not exceeding two hundred pounds “for the immediate vaccination of the [p]oor of the Town of Halifax, to prevent the spread of the Small Pox.”\textsuperscript{182}

Other appropriations followed, mostly intended to pay for or reimburse expenses incurred in implementing vaccination orders issued by the Lieutenant Governor. For example, a letter written by one Dr. Sturges of Annapolis County, dated February 16, 1842, and attached to vaccination returns (i.e. a list of poor persons vaccinated), notes that the vaccinations were ordered by the Lieutenant Governor, and that the purpose of the returns was to provide proof that would allow the doctors who provided the vaccination services

\textsuperscript{181} *Ibid.* The Board also recommended that Assembly enact a statute to render vaccination compulsory by “rendering it obligatory upon each head or master of a family, to cause all members of his family to be vaccinated.” This recommendation did not receive consideration or further mention in the legislative records, which suggests that it was either ignored or judged not be necessary for the purposes of implementing vaccination. It is also likely that the legislators were aware of and wanted to avoid developments in the UK, where Parliament had rejected similar agitation for compulsion in favour of a system of state-supported free optional vaccination for those who could not afford to pay for the remedy. \textsuperscript{182} *Supra* note 180 at 62.
to “participate in the remuneration given by the Legislature in such cases.”

Similarly, in March 1841, in response to a smallpox outbreak in the County of Colchester, the Lieutenant Governor sent a letter, through Provincial Secretary Rupert D. George, to the Colchester Board of Health, requesting that the Board “use…[its] best endeavours” to vaccinate all persons resident in the county “who are not already protected from the infection.” The letter made reference to vaccination of paupers, noting:

As some of the inhabitants of that County besides the Indians, whom his Excellency regards as having peculiarly strong claims upon our attention on the present occasion, may not have the means to pay for the professional services they require in this respect, I am [directed] to add that the Gentleman employed by your direction to vaccinate such persons will receive a reasonable remuneration from the Government on your transmitting a list of the Poor persons so vaccinated with a certificate that they are utterly unable to bear the charges themselves.

Claims for reimbursement of expenses for general vaccination, or accounts not submitted in the proper form (accompanied with a certified list of poor persons), were generally denied or rejected by the provincial authorities. A report issued in 1842 by a committee of the House of Assembly charged with dealing with several applications for the compensation of vaccination expenses, states, on point:

[This] Committee [has] had great difficulty in coming to any conclusion with respect to the numerous claims for [v]accination throughout the [p]rovince, as with very few exceptions, the applicants have neglected to furnish the [c]ertificate…required [attesting that persons listed in the certificate are unable to pay for the procedure]… [I]n the opinion of the Committee, the House did not contemplate incurring the [e]xpenses of a general [v]accination,

184 See supra note 29.
185 Ibid.
186 Ibid. The Board of Health appointed a vaccinator shortly after. See Response from Board of Health (General Sessions of the Peace) (7 April 1841), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Papers re vaccinations). See also Hon. Anderson, Secretary, Pictou Board of Health to RD George, Provincial Secretary (31 August 1847), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 2, Pictou County)
but merely of those persons who were wholly unable to bear the cost themselves, and [this] Committee would therefore have felt themselves justified in rejecting the whole of said claims, except those certified as required, but considering the great public advantage which has resulted from the performance of this service by the [m]edical [g]entlemen engaged in it, and that many of the persons [v]accinated were wholly unable to pay...[the] Committee...recommend[s]...the payment for two thirds of the persons whose names are returned.187

This policy of underwriting only expenses for vaccination of poor persons sometimes frustrated local vaccination efforts, and rendered it especially difficult for local officials to comply with directives from the Central Board of Health recommending general vaccination.188 An exchange that occurred in 1849 between the provincial government and the Board of Health of the County of Pictou illustrates this point.189 In or around April 1849, the Board of Health of the County of Pictou received a commission from the Central Board of Health in Halifax recommending general vaccination of county inhabitants.190 The local board of health unanimously approved the commission, but wrote back to the Central Board requesting information on “how they are to be provided with the funds necessary for carrying out the various objects contemplated.”191 The Central Board never responded. The local board subsequently wrote to the Lieutenant Governor to request guidance on the matter. The letter noted that “before the board can consent to act [on the commission], they require distinct answers to the...question...respecting

188 It is not clear why the Central Board of Health issued such directives, which were at odds with the provincial government’s policy on payment for vaccination expenses.
189 Pictou County Board of Health Minutes (1849-1853), Halifax, Archives of Nova Scotia (RG 34-318, Series C vol 1).
190 See ibid at 6-8.
191 Ibid at 6.
providing of funds,”192 and that if the board were to implement the commission, each board member would be personally liable for 40 percent of the vaccination expenditures, “which is a responsibility they cannot assume.”193

Responding on the Lieutenant Governor’s behalf, Provincial Secretary Joseph Howe informed the local board that the Legislature had made no provisions for funds to support vaccination of the general population.194 Dismayed by the government’s position, several Board members declined to carry out the commission “in consequence of the difficulties likely to arise from”195 doing so.

A month later, the Halifax Board of Health received a similar response to a request for funds to cover vaccination expenses.196 In a letter to the Board dated 14 May 1849, the provincial government acknowledged the existence of a smallpox outbreak in Halifax, but declined to pay for general vaccination of the population because this expense “was not contemplated or provided for by…legislation” and any expenditures incurred in regards to general vaccination “might not be approved by those without whose sanction…money for such purposes cannot be paid.”197 The letter further stated that “[s]hould the Board of Health attempt and accomplish a general vaccination of the

192 Ibid at 8.
193 Ibid. Even if local officials were able to collect payments for the actual vaccination procedure prospectively from non-indigent persons, they still ran the risk of being held personally responsible for the cost of procuring enough quantities of vaccine lymph for vaccination of the whole population.
194 See ibid at 10.
195 Ibid.
196 Central Board of Health to the Local Board of Health (1 June 1849), Halifax, Halifax Regional Municipality Archives (City Health Board Minute Book March 18, 1848 – June 13, 1870, RG 35-102, Series 28 A.1).
197 Ibid.
citizens of Halifax, upon their own responsibility, His Excellency [the Lieutenant Governor] will not be indisposed to submit the accounts for such service to the Assembly.”\textsuperscript{198} However, the provincial government did provide public funds to the Halifax Dispensary to cover expenses for vaccinating the poor. Interestingly, the dispensary continued to charge five shillings for each person vaccinated, which led the Board to pass a resolution declaring “that ‘no charge should be made for vaccination at a public establishment, supported by public money, such as the Halifax Dispensary is supposed to be.”\textsuperscript{199}

The provision in the 1850 Vaccination Act requiring payment of vaccination expenses out of county funds generated some debate during consideration of the preceding bill.\textsuperscript{200} The provision was added to the bill in the House of Assembly, and appears to have been based on an earlier resolution of that house requiring that “all [a]counts for [v]accination of indigent persons in the year 1849, or any previous year, should be made a charge on the several [c]ounties or [d]istricts of the [p]rovince.”\textsuperscript{201} The provision, along with the entire bill, passed in the House of Assembly without debate or fuss, but ran into opposition in the Legislative Council. A select committee of the Legislative Council proposed a couple of amendments to the provision aimed at imposing the responsibility

\begin{flushright}
\textsuperscript{198} \textit{Ibid.}
\textsuperscript{199} \textit{Ibid.}
\textsuperscript{201} Nova Scotia, House of Assembly, \textit{Journal and Proceedings of the House of Assembly for the Province of Nova Scotia}, 1850 Sess, (16 February 1850) at 491. See also \textit{ibid}, Appendix No 53 at 189, where the Committee appointed to consider the accounts submitted by the county boards of health for cases of smallpox rejected an account submitted by the County of Wilmot because the accounts “[do] not…constitute any charge upon the Treasury [and]…must be provided for out of the funds of the County.”
\end{flushright}
for general vaccination expenses on the provincial government.\textsuperscript{202} The first amendment required the payment of such expenses out of the provincial treasury.\textsuperscript{203} The second amendment sought to place responsibility for decisions relating to such payments on the Financial Secretary of the Province.\textsuperscript{204} Upon return to the House of Assembly, the amendments to the bill were rejected. Council did not press the matter further, and the bill passed with the original provision.

While the reasons for the rejection are not stated in legislative journals, a report issued by the Sick Immigrant Committee of the House of Assembly shortly before the Act passed suggests that the measures were rejected because the provincial authorities had no means of verifying expense claims for or preventing extravagant spending on general vaccination of the population carried out at the local level. According to the report:

[The Committee] are unanimously of [the] opinion that all expenses incurred by the Boards hereafter, for cases of actual [s]mall [p]ox—unless a strong and peculiar case upon the bounty of the Legislature occur, from a body of [e]migrants afflicted with some infectious disease being unexpectedly thrown into one of our [s]eaports—be paid out of the [c]ounty funds, \textit{it being in [our] opinion practically impossible to prevent otherwise extravagant expenditure}.\textsuperscript{205}

\textsuperscript{202} See supra note 200.

\textsuperscript{203} See \textit{ibid} at 57.

\textsuperscript{204} \textit{Ibid}.

\textsuperscript{205} Nova Scotia, House of Assembly, \textit{Journal and Proceedings of the House of Assembly for the Province of Nova Scotia}, 1850 Sess, Appendix No 67 at 206 [Sick Immigrant Committee]. See generally \textit{ibid} at 205-6; \textit{ibid}, (6 February 1850) at 460-61. See also Extract of report of the Sick Immigrant Committee (of the Provincial Legislature) sent to local boards of health and advertised in the newspapers (11 March 1850), Halifax, Archives of Nova Scotia (Halifax County Public Health 1850-1869, RG 34-312, Series C, vol 2). The policy change may also have been intended to serve as a restraint on unnecessary or arbitrary application of the law. Without the assurance of legislative appropriations to cover vaccination expenses, local officials were less likely to spend limited municipal funds on frivolous vaccination campaigns.
The Legislature made no further appropriations for vaccination purposes after the 1850 Vaccination Act passed. Starved of provincial funds, local authorities became reluctant to approve vaccination accounts submitted to them by medical doctors. In one 1865 case, a medical doctor named Robert Jamison submitted an account to the Halifax Sessions for vaccination services rendered during a smallpox epidemic in Tangier, a mining settlement in Halifax County. The account was certified by Mr. Joseph Browner, the local justice of the peace, prior to submission. Mr. Browner also submitted an account to cover his personal expenses for attending to persons infected by smallpox. Shortly after, Dr. Jamison received a letter from the Halifax Sessions demanding “information [on] why [he sent in] this account against the County, and by what authority [he did] so.” The letter further noted that the vaccination returns accompanying the expense claim “contains the names of those who are not poor and indigent contemplated by the Act” and “names of a number of females…many of whom have parents or relatives able to pay.” In his response to the letter, Dr. Jamison noted that he was authorized by Mr. Browner to vaccinate all inhabitants of the County as the Health Warden appointed by Sessions was “away surveying” at the time of the smallpox outbreak and there was no other health warden near enough to be of any service. Regarding the inclusion of non-paupers in the vaccination returns, he explained:

I cannot amend it satisfactorily for all those whose names are on the list either plead poverty and many were vaccinated against their wishes, many of these ignorant people dreading vaccination almost as much as the

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206 Statement of Account for vaccination expenses incurred during the Tangier smallpox epidemic of Dr. Robert Jamison certified by Joseph Browner JP (1 September 1865), Halifax, Archives of Nova Scotia (Halifax County Public Health 1850-1869, RG 34-312, Series C vol 2).
207 Napean Clarke to Dr. Robert Jamieson (11 November 1865), Halifax, Archives of Nova Scotia (Halifax County Public Health 1850-1869, RG 34-312, Series C vol 2).
208 R Jamison MD to Napean Clarke (20 November 1865), Halifax, Archives of Nova Scotia (Halifax County Public Health 1850-1869, RG 34-312, Series C vol 2).
smallpox itself, and when I consulted Mr Browner as to what cause to pursue in such cases, he answered to put their names on the list also.\footnote{Ibid.}

The doctor’s response generated a debate in Sessions. A committee of justices appointed to deal with the matter recommended that the county settle the vaccination expenses, but not the amounts spent towards caring for the infected. A member of the committee strenuously objected to this recommendation, and urged Sessions to reimburse or pay all reasonable expenses incurred in dealing with the smallpox epidemic.\footnote{Minority Report (8 December 1865), Halifax, Archives of Nova Scotia (Halifax County Public Health 1850-1869, RG 34-312, Series C vol 2).} His reasons, reproduced below, pointed to a concern that the ability of local officials to deal with disease threats and outbreaks would be severely curtailed if Sessions declined to pay all reasonable expenses or if such officials had to wait for express directives from Sessions before acting:

I dissent from the opinion of the Committee appointed on smallpox affairs—because, although the statements of Dr. Jamison and Mr Browner as submitted to us—contain some discrepancies—yet it may firmly be presumed that through their united efforts the disease was confined to four families. It is very true, that no directives were sent to these gentlemen to take action in the matter, but owing to the absence of Health Wardens appointed by the Sessions, it was quite necessary that the resident justice should use his utmost endeavours to stay the ravages of the disease. I do not think that Dr. Jamison has any right to receive the whole amount of his claim for attendance, but a reasonable sum ought to be paid to him for his services. Mr Browner is also entitled to a fair equivalent for the assistance ordered by him. What that ought to be, is a question to be decided when full particulars are obtained. If the nurse attended other than her own family, she ought also to receive some remuneration. I agree with the majority in their recommendation of payment, both to Dr. Pryer and Dr. Jamison, for their successful cases of vaccination.\footnote{Ibid.}
Disagreements over responsibility for vaccination expenses also produced legal challenges. In the *Municipality of the County of Cape Breton v McKay*, decided in 1891, the plaintiff/respondent medical doctor, Dr. Thomas McKay, sued the County of Cape Breton for breach of contract and unpaid bills amounting to $350 for attending to smallpox patients in North Sydney, an important seaport community within the county situated north of the Sydney Harbour. The plaintiff claimed he was retained by the North Sydney Board of Health to provide vaccination and other services to the smallpox patients, and that the defendant/appellant, through the local board of health, had agreed to pay for his services at a rate of $6.50 per day. Based on this agreement, he gave up his practice and devoted himself entirely to the commission. Subsequently, and for reasons unknown, the defendant discharged him of his duties and employed other medical practitioners to deal with the smallpox outbreak. Dr. McKay also asked the court to grant him special damages amounting to $550 for the wrongful dismissal.

In its defence, the county denied having employed or entered into any agreement with the plaintiff. They also denied having discharged the plaintiff or that the county employed other medical practitioners to deal with the smallpox outbreak. They further argued that the local board of health that purportedly employed the plaintiff doctor was not legally constituted, and that the board had justifiably discharged the plaintiff because he

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212 [1891] 18 SCR 639.
214 *Ibid* at 641.
215 *Ibid*. This claim was based on a legal technicality. The board of health was appointed by the Lieutenant Governor on the recommendation of the residents of North Sydney pursuant to *Of Board of Health and Infectious Diseases*, RSNS 1873, c 29, s 2. The defendant county claimed that the section and mode of appointment had been repealed in effect by the *County Incorporation Act*, SNS 1879, c 1, s 67, which authorized newly-created municipal corporations to constitute and appoint members of local boards of
refused to “act or consult with [another] physician” appointed by the Board to supervise him.217

The following facts were established at trial.218 In February 1880, a smallpox outbreak occurred in North Sydney. Residents met to “consider the best means to be used to prevent the spread of the disease,” and a board of health was constituted. The board was subsequently formally appointed by the Lieutenant Governor. At its first meeting, held on 17 February, the board passed a resolution appointing Dr. McKay to attend to persons affected by smallpox, and specifying a per diem of $6.50 for his services. The plaintiff commenced work immediately. On March 5, he received a letter from the secretary of the board informing him of a board resolution appointing another physician, Dr. McPherson, to serve as consulting physician and “to report his opinions of the treatment and condition of the patients therein to the board daily.” The plaintiff was also instructed in the letter to consult with Dr. McPherson and to note his consent to do so by replying to the letter by 10.30am the next day.221 The plaintiff sent a reply on March 8, in which he informed the board that he “will not act in pursuance with [their] resolution” and that he would only consult with Dr. McPherson in “serious cases only.”222

health, appoint health officers, health wardens and health inspectors, and generally to exercise the authority and powers formally held by the Sessions courts.

216 Supra note 212 at 641.
217 Ibid.
218 See generally ibid at 641-44.
219 Ibid.
220 Ibid at 643.
221 See ibid.
222 Ibid.
On March 12, the plaintiff was informed by letter that a resolution had been passed by board relieving him of his duties and appointing Dr. McPherson in his place. He was paid for his services from February 18 to March 12 at the agreed rate. The plaintiff commenced a lawsuit against the individual members of the board, claiming payment for unpaid services, including the cost of “medicines and other necessary things” supplied by him and unpaid bills for the period of time that the defendants employed other physicians to attend to the smallpox patients. He also claimed special damages on the basis that “his patients and others requiring his services would not, for a long period of time, employ him from dread of infection and contagion from said disease through him.” The lawsuit against the board members was unsuccessful, and in 1886, the plaintiff commenced the lawsuit that is the present focus of this discussion, against the County of Cape Breton.

In the case against the county, the trial judge ruled that there was no justifiable basis for dismissing the plaintiff, and awarded the plaintiff damages of $300. The trial decision was affirmed on appeal to the Supreme Court of Nova Scotia. Specifically, the appeal court ruled that the municipality was liable to the plaintiff on the basis of the contract

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223 McKay v Moore (1883), 16 NSR 326, 4 Russ & Geld 326 (NS CA) [cited to Russ & Geld].
224 Ibid at 326-7.
225 Ibid at 327.
226 Ibid.
227 See supra note 212 at 641, 644.
228 Cape Breton (Municipality) v. McKay (1889), 21 NSR 492 (NS SC) [Townsend J].
entered into by the board of health, and that the “attempt to terminate [the contract] on March 12th was nugatory.”

On further appeal to the Supreme Court of Canada, the county restated the argument that the local board of health was not legally constituted, and as such, could not bind the municipality in contract with the respondent. The county further argued that if the court were to find otherwise, or that the contract between the board and respondent was legally binding on it, then it should only be held liable for services actually performed by Dr. McKay, for which he has been paid. Finally, the appellant also argued that the evidence showed justification for the dismissal of the respondent by the local board.

A majority of four justices in the six-panel Supreme Court of Canada dismissed the appeal, and affirmed the decisions of the lower courts. The majority held that there was no basis in law to find the board of health was not duly constituted or appointed. They also characterized the case as purely a matter of breach of contract, and ruled that the local board had breached its contract with the respondent by dismissing him and

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229 Ibid at para 1. One of the appellate judges ruled, obiter, that the proper remedy to enforce the municipality’s obligation to pay for goods supplied at the request of the board of health would be by writ of mandamus rather than an action for breach of contract. Ibid at para 5 [Ritchie J, McDonald CJ concurring].

230 See supra note 212 at 645.

231 Gwynne, Fournier, Taschereau, and Patterson JJ. Gwynne and Patterson JJ wrote opinions, the other two judges concurred with Gwynne J. Patterson J ruled, obiter, and in response to an issue raised in the Supreme Court of Nova Scotia decision, that the proper remedy was by action for breach of contract and not by writ of mandamus. See generally ibid at 653-666.

232 In their opinion, section 67 of the County Incorporation Act did not expressly or impliedly repeal section 2 of the Board of Health and Infectious Diseases Act. According to the court:

It is obvious that the powers thus conferred upon county municipal corporations did not repeal the powers given to the Lieutenant Governor to constitute boards of health… It may be that the legislature thought it prudent thus to provide against the injurious consequences which might result in the case of neglect or delay upon the part of the municipal authorities.” Ibid at 654.
procuring the services of another medical doctor. The justices reasoned further damages resulting from the board’s breach were “a charge and liability upon the county corporation for which they are bound to pay.”

While the provincial government’s approach to vaccination expenses may have been motivated by legitimate financial and administrative concerns, it failed to anticipate or address possible barriers to local implementation of vaccination programs. Two such barriers are evident from the foregoing discussion, particularly as relates to the “poor persons only” policy that preceded the 1850 Vaccination Act. Firstly, the policy relied on the cooperation of the non-indigent, who were expected to cover their own vaccination expenses. Without these willing well off persons, local vaccination efforts were less likely to yield success, as smallpox did not discriminate between rich or poor, and vaccination of only a segment of the population was unlikely to be effective in preventing further spread of the disease. While I could not determine the extent to which the non-indigent complied with this policy from available archival information (consisting mainly of lists of poor persons vaccinated), there is some evidence that persons who were not eligible for poverty relief did “plead poverty” in order to obtain vaccination services. Furthermore, medical doctors who served as vaccinators sometimes submitted accounts for vaccination services provided to non-indigent persons, which suggests that these

233 Supra note 212 at 661. The dissenting justices, Ritchie CJ and Strong J, disagreed on all the elements of the majority opinion. See generally ibid at 645-53.
234 See supra note 209 and accompanying text.
235 See e.g. Nova Scotia, House of Assembly, Journals and Proceedings of the House of Assembly of the Province of Nova Scotia, 1849 Sess, Appendix No 87 at 497-8 for a statement from the Argyle Township Board of Health showing accounts submitted by Drs. Thomas Geddes and Thomas Kirby, for vaccination services provided to 133 and 252 persons respectively. The accounts were carefully vetted by the Board, and revised to exclude charges “incurred by those able to pay for themselves.” Ibid at 498.
persons did not disclose their financial status prior to the procedure, or perhaps that the 
doctors viewed turning away patients, rich or not, as a breach of their professional ethics.

Secondly, the policy did not allow local officials the freedom or flexibility to take certain 
prospective steps, such as procuring vaccine lymph in enough quantities for vaccination 
of the whole population, or securing an appropriate venue for the procedure. To 
accomplish such steps, individual magistrates would have had to bear the costs 
personally, without any hope of being recompensed by the provincial government. As the 
Pictou and Halifax cases discussed above illustrate, local officials were not willing to 
take that risk. The risk would remain even if local officials set up a system to collect 
payment from the non-indigent for vaccination services, as is doubtful that they would 
have been able to obtain global compliance with the law given the lack of penalties in the 
Act.

Besides vaccination expenses, the provincial government continued to provide financial 
support for other methods of dealing with smallpox. However, provincial support was 
subject to certain strict limitations outlined in a series of resolutions passed by the House 
of Assembly in 1849. The resolutions, discussed in more detail in the next section, were

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236 See e.g. An Act for applying certain monies therein mentioned for the service of the year one thousand eight hundred and fifty-three, and other purposes, SNS 1853 (17 Vict), c 33, s 1 (approving a reimbursement of £13.10 to the Pictou Board of Health “to replace clothes of small pox patients, destroyed before liberation”); An Act for applying certain monies therein mentioned for the service of the year one thousand eight hundred and fifty-three, and other purposes, SNS 1853 (18 Vict), c 41, s 1 (reimbursement of £66.17 to Pictou Board of Health for smallpox expenses).

237 See Nova Scotia, House of Assembly, Journal and Proceedings of the House of Assembly for the Province of Nova Scotia, 1849 Sess, (24 March 1849) at 372 [Assembly 24 March]. See also Sick Immigrant Committee, supra note 205, where the Sick Immigrant Committee states that claims for
primarily aimed at establishing procedures for accessing provincial funds for purposes of dealing with smallpox and the care of sick immigrants. However, in practice, they placed further strain on local smallpox management efforts, and sometimes led to disputes between local and provincial authorities, and between municipalities, regarding responsibility for settling expenses incurred in dealing with smallpox. These disputes are also discussed in the next section.

3.3.5 Payment Disputes

In the nineteenth century, fighting infectious diseases was costly business. At a time when an amount over a hundred pounds or dollars was considered “enough to knock the wind out of most any person,” the annual provincial expense of dealing with infectious diseases amounted to thousands. By way of example, in 1847 and 1848, the province spent up to £2400 and £1500, respectively, for expenses in connection with cases of smallpox, sick immigrants and shipwrecked sailors. Municipalities could not afford to pay such expenses out of local rates, and relied on the provincial government to underwrite the costs of implementing public health/infectious disease programs and laws. However, these expenses were also considered “a serious burden upon the [provincial]

smallpox expenses will not be entertained by the House of Assembly “unless the [r]esolutions passed last session be strictly complied with.”

238 Corning & Chipman to Charles K Hurlbert, Esq, Clerk of the Municipality of Argyle (3 December 1901), Tusket, Argyle Township and Court House Archives (RG 3 Series M, Sub-series 4, TMS-7D-1901-14). The reference is to a doctor’s bill in the amount of $104 for medical care provided to two boys infected with smallpox.


240 See ibid, Appendix No 87 at 493, 495-6. Majority of the expenses were incurred in dealing with smallpox and sick emigrants.
[t]reasury”241, and by mid-century, Assembly took steps to arrest or tame expenditures by enacting resolutions to establish payment procedures.

The aforementioned resolutions were proposed by a committee appointed by Assembly to examine claims for reimbursement of advances made in connection with cases of smallpox, sick immigrants and shipwrecked sailors in different counties throughout the province. The committee’s recommendations was presented to the full House on 24 March, 1849 by its Chairman, George Renny Young, representative for Pictou County (also a lawyer, prolific author, and the founding editor of the *Novascotian*, a weekly newspaper),242 who also championed the 1850 Vaccination Act in the House of Assembly. The recommendations were unanimously carried, resulting in a series of resolutions, reproduced, in part, below:

> **Whereas**, the demand upon the Treasury on account of sick [e]migrants, cases of [s]mall [p]ox and [s]hipwrecked [s]ailors, have lately increased to such an extent as to become a serious burden upon the Treasury, and it is necessary to introduce additional and more stringent guards upon such expenditures, in order to prevent inaccuracy and to promote economy:  
> **Resolved**, [t]hat before any advances are made from the Treasury for and on account of any expenditures made by the local Board of Health, whether for sick [e]migrants or cases of [s]mall [p]ox, the vouchers setting out the items and details, and [a]ccounts therefor, shall have been previously submitted to the General or Special Sessions of the Peace in the [c]ounty where such expenditures have been made, in order that the same may be examined and reported upon—such [r]eport to be forwarded to the Provincial Secretary, and to be deposited in the office of the Treasurer, together with the vouchers, before the [w]arrant is drawn or paid…  
> **Resolved**, [t]hat in no case shall the advances be made from the Treasury for and on account of such expenditures exceed the proportion of 60 per

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241 Ibid, Appendix No 87 at 493.  

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cent, on the whole, until such expenditures have been so examined and reported upon by a Committee of this House.243

Although not stated in the resolutions, there was also an expectation that the owners or masters of vessels facing quarantine at any ports in the province would be directly responsible for any expenses incurred in dealing with any diseases on board and for caring for infected passengers.244 Local officials were encouraged to seek a surety or bond against such expenses from masters or owners, and to consider passengers removed onshore for medical care as “on board for all legal purposes”.245 The provincial authorities blamed the imperial authorities for sanctioning a system that allowed “landed proprietors…to inundate [the province] with the paupers from their estates”246, and made it clear that amounts expended in dealing with destitute and sick immigrants must either be borne by these proprietors or “be refunded to the [provincial] [t]reasury from [i]mperial funds.”247

In practice, however, it was not always clear when local officials should collect such sureties. In one interesting case that arose in June 1849, the provincial authorities squabbled with local health officers in the County of Pictou over charges imposed on the master of a Quebec trading vessel, for the care of a seaman who was suffering from “premonitory symptoms” of smallpox and an advanced case of syphilis.248 The vessel, Stella Maria, arrived at the Port of Pictou from Halifax sometime around June 11th 1849,
carrying the sick seaman, named Alexander Stewart. In his sea chest were letters from his father, Donald Stewart of Louisburg Road, Cape Breton, which indicated that Alexander was “short of money and had been otherwise unfortunate”\textsuperscript{249}, and his clothes were “of the most wretched and filthy description.”\textsuperscript{250}

Upon arrival in Pictou, Mr. Stewart went onshore and consulted with Drs. Johnston and Anderson, the county health officers, regarding his condition. The health officers in turn notified the Board of Health, whose members convened forthwith and passed resolutions authorizing the health officers to “take steps immediately to get the sick seaman put on board his vessel…institute a strict investigation into the state of the ship and subject her if necessary to such restrictions as the law directs.”\textsuperscript{251} The Board also ordered that “all vessels arriving from Halifax should be subject to detention for examination so long as the Board should have reason to believe that there exists danger of the introduction of small pox from that Port” and that “the Provincial Secretary be notified of the passing of this order.”\textsuperscript{252}

A few days later, the Provincial Secretary, Joseph Howe, wrote to the Board to inform them that the Lieutenant Governor had declined to approve the quarantine order as this would “extend the cumbersome operation of quarantine regulations to vessels arriving from one [to] any other Port of this Province.”\textsuperscript{253} A second letter to the Board clarified

\begin{footnotes}
\item[249] Ibid at 19.
\item[250] Ibid.
\item[251] Ibid at 14.
\item[252] Ibid
\item[253] Ibid at 16.
\end{footnotes}
that the “[q]uarantine regulations…were never intended to apply to vessels passing from one port of Nova Scotia to another.”\textsuperscript{254} Since the Stella Maria had arrived in Pictou from Halifax, it was therefore exempt from the regulations. Dissatisfied with this response, the Board passed another resolution instructing Dr. Johnston to inform the master of the ship, Captain Louis Bernier, of the option to either proceed to quarantine or to provide a deposit of £25 to meet expenses likely to be incurred in removing Mr. Stewart to the quarantine hospital. Captain Bernier “voluntarily chose the latter alternative.”\textsuperscript{255} The Board ordered the removal of the sick seaman, who subsequently died in the quarantine hospital, and allowed the vessel to proceed to sea without docking at Pictou. The amount deposited by Captain Bernier was applied in part payment of expenses in the amount of £29 incurred by the health officers and others in attending to the sick seaman.\textsuperscript{256}

Captain Bernier subsequently lodged a complaint with the Lieutenant Governor seeking to recover the £25 deposit paid to the Board of Health. He claimed that the deceased seaman had been “labouring under syphillis and nothing else,”\textsuperscript{257} and as such, hospitalization or quarantine was unnecessary in the circumstances. Upon receipt of the complaint, the Lieutenant Governor demanded an explanation from the health officers, who sent a detailed report, and in which they noted specifically that Captain Bernier

\textsuperscript{254} This interpretation was not directly referenced or reflected in the legislation or legislative history as recorded in the Assembly journals. It is therefore most likely an anecdotal reference or mere opinion. A statement in the Provincial Secretary’s letter to the Board also suggests that the interpretation may have been based on “the “experience of other countries”, which “warrant the conclusion that such regulations usually or invariably fail in the attainment of their object” if directed at intra-regional vessels. \textit{Ibid.}

\textsuperscript{255} \textit{Ibid} at 30.

\textsuperscript{256} \textit{Ibid} at 20.

\textsuperscript{257} \textit{Ibid} at 23.
chose to pay the deposit and that the Stella Maria “was not sent to quarantine.” 258 The health officers also forwarded letters sent to them by Captain Bernier asking for their help in attending to the sick seaman and citing apprehension among crew members that “they may catch the disorder.”259

Despite what seemed to be a persuasive explanation, the Lieutenant Governor ordered the health officers to “repay to Captain Bernier the amount charged to him.”260 The Lieutenant Governor gave two reasons for this order. First, that the operation of the quarantine regulations was not meant to apply to intra-provincial vessels, and the health officers and the Board of Health therefore lacked the authority or a basis to take any actions against the Stella Maria. Second, he ruled that the deceased seaman ought to have been considered a “transient pauper”261 and “reimbursement of expenses incurred for his relief must be sought in the mode prescribed by the Legislature”262 (through the overseers of the poor).

The health officers refused to comply with the order to repay. In a letter to the Lieutenant Governor, they argued they were protected by doctrine of privity of contract, as they were neither in a contractual relationship with nor did they receive payment for their services from Captain Bernier.263 They further argued that since their services were procured by the Board and charged to and paid by the Board, the amount in question was duly earned

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258 Ibid.
259 Ibid.
260 Ibid.
261 Ibid at 24.
262 Ibid.
263 See ibid at 22-25.
and should not be refunded. The health officers also wrote to Captain Bernier, asking that he seek repayment directly from the Board of Health.\textsuperscript{264} The captain wrote twice to the Secretary of the Board seeking to convene a meeting of the Board to discuss the matter. Meetings were called both times, but no one showed up.\textsuperscript{265} Following a third attempt prompted by the Lieutenant Governor and the health officers,\textsuperscript{266} the Board finally met on September 1, 1849.

Following their deliberations, the Board sent a tersely worded letter to the Lieutenant Governor which recounted a version of what transpired that corresponded to the health officers’ account. The letter contended that Captain Bernier’s claims amounted to “gross falsehoods and misrepresentations,”\textsuperscript{267} and that the Board’s actions were a proper “exercise of the authority which…they possess under [the law].”\textsuperscript{268} The letter also challenged the Lieutenant Governor’s characterization of the deceased seaman’s care as a matter that fell within the purview of the poor relief system. In the Board’s opinion, “they were unaware of any law by which the overseers of [the] poor could be called upon to provide for sick persons so situated as they would for transient paupers particularly in such a case as the present that of an articled seaman and one attached to a vessel belonging to another Province.”\textsuperscript{269} The letter concluded with the following strong stance:

\textsuperscript{264} Perhaps not to be seen as influencing the Board’s decision on the matter, the health officers, who were then members of the Board, immediately resigned, citing “circumstances [which] have arisen to convince [them] that [they] can discharge [their] duties as health officers more efficiently or perhaps more satisfactorily to the public…by ceasing to be members of the Board of Health” \textit{Ibid} at 15.

\textsuperscript{265} \textit{Ibid} at 27.

\textsuperscript{266} \textit{Ibid} at 28-29.

\textsuperscript{267} \textit{Ibid} at 30.

\textsuperscript{268} \textit{Ibid}.

\textsuperscript{269} \textit{Ibid} at 31.
The Board would wish it distinctly understood that they never would have consented to accept office nor can they agree to continue to hold it if it is expected that they in addition to the gratuitous discharge of very troublesome and often vexatious duties they are to advance or become responsible for out of their own pockets the expenses which must be incurred in the general discharge of their duties.\(^{270}\)

It is not clear how the matter was eventually resolved as there is no record of a response to this letter from the Lieutenant Governor in the archival records. However, subsequent events indicate that the Board continued to favour their interpretation of the governing statute regarding quarantine of intra-provincial vessels. For example, the Board met on 26\(^{th}\) Sept 1850 to discuss the matter of “two cases of sickness on board [a] ship…just arrived from [Black Georges] Savannah”,\(^{271}\) a rural community in Yarmouth County. The Board ordered that the sick men, who were labouring from smallpox, be removed to the lazaretto, and that the owners of the ship provide a surety to cover expenses for caring for the sick men. They also ordered quarantine and fumigation of the ship.\(^{272}\)

In another case that arose in 1903, Dr. Reid, the secretary of the Provincial Board of Health, while on a work tour of the province, discovered that a number of seamen were labouring under smallpox in a railway car stationed in Middleton, a town in Annapolis County, in the Municipality of Argyle. He ordered the railway company to immediately “shunt the car and return the men to Halifax”\(^{273}\) to be placed in quarantine or cared for in

\(^{270}\) Ibid.
\(^{271}\) Ibid at 32-33.
\(^{272}\) Ibid.
\(^{273}\) Corning & Chapman to AM Comeau, Municipal Clerk, Clare (Feb 1903) and to Charles K Hurlbert, Municipal Clerk, Argyle (10 February 1903), Tusket, Argyle Township and Court House Archives (RG 3 Series M, Sub-series 4, TMS-7D-1901-14).
the infection wards of the provincial hospital. For reasons not apparent from the archival
records, the car was subsequently allowed to proceed to the railway station in Meteghan,
a small, coastal, unincorporated fishing community in Digby County in the Municipality
of Clare populated mainly by Acadians. Three days after the sick seamen arrived in
Meteghan, Dr. Reid paid them a visit for the purpose of making “such arrangements as
would conduce to their wellbeing and the safety of the community.”274 He commissioned
a local team, led by William Thibodeau, a nurse, to care for the seamen. After nursing the
seamen back to health, Mr. Thibodeau sent an invoice for his services, amounting to
$135, to the provincial government. The account was duly settled.275

Two other persons who assisted Mr. Thibodeau in caring for the sick seamen, a nurse
named Maggie Comeau, and Joseph Jeddry, who supplied food, also requested payment
for their services, but from the Municipality of Clare. The municipality refused to pay,
and referred them instead to the Municipality of Argyle, on the grounds that the seamen
contracted the smallpox in Middleton, which is located in the municipality of Argyle. The
claimants, Ms. Comeau and Mr. Jeddry, contacted Corning & Chipman, a Yarmouth-
based law firm, to help them obtain payment from the Municipality of Argyle, but the
firm declined the brief as they were lawyers for the municipality. However, they advised
the claimants to seek payment directly from the provincial government.

The Municipality of Clare also wrote to the Municipality of Argyle requesting that they
settle the unpaid accounts or agree to reimburse the amounts if paid by Clare. Responding

274 Ibid.
275 Ibid.
to this request through its lawyers, Corning & Chipman, the Municipality of Argyle argued that neither they nor Clare was responsible for settling the unpaid accounts. Rather, the responsibility fell first to the patients, if they are able to pay, in accordance with the governing statute.\textsuperscript{276} In this case, the men, who were “young…good fishermen, unmarried” should be able to pay.\textsuperscript{277} However, if they were unable to pay, the Municipality of Argyle was not liable at all, as a strict interpretation of the law held that charges for care of paupers be paid by the municipality “in which such person is”\textsuperscript{278}, which in this case, the lawyers argued, was Meteghan, where the patients received treatment. Alternatively, the lawyers argued, the accounts should be paid by the provincial government or Provincial Board of Health since the care of the sick seamen was carried out under its commission and directions. The lawyers concluded that the Municipality of Clare was not “morally or legally liable, as the quarantining of the men at Meteghan Station was entirely due to the remissness of Dr. Reid in his official duty.”\textsuperscript{279}

It is important to note, however, that these financial disagreements did not affect cooperation among and between the local and provincial governments with respect to dealing with infectious diseases. Local government officials maintained a good working relationship with the provincial authorities, and often sought advice from them regarding interpretation and implementation of public health laws.\textsuperscript{280} At the same time, local

\textsuperscript{276} Ibid.
\textsuperscript{277} Ibid.
\textsuperscript{278} Ibid.
\textsuperscript{279} Ibid. There are no further communications on this matter in the archival records. It is therefore not clear who eventually settled the bills.
\textsuperscript{280} See e.g. supra note 189 at 35-36, where the Board sought the advice and approval of the Government on actions taken with respect to dealing with a smallpox outbreak, including vaccination, on a ship just arrived at the Pictou Port. The letter states that the Board, “not being aware of any quarantine regulations having
officials engaged in a relationship with the provincial government on their own terms, and sought to exercise their statutory authority without undue interference from the central authorities.

To avoid such interference, local officials limited their consultations with the provincial authorities to two main purposes. Firstly, they sought advice on whether regulations have been or will be enacted to clarify or provide details on matters covered in the existing public health statutes, especially matters relating to implementation and enforcement strategies. In 1852, for example, the Pictou Board of Health sought advice from Provincial Secretary Joseph Howe regarding whether any quarantine regulations have been passed pursuant to the extant quarantine statute, noting that such regulations would assist the Board in dealing with difficulties that had arisen with respect to the Scottish vessel Tongataboo, arrived at the Port of Pictou from the Glasgow, Scotland, carrying passengers taken ill with the smallpox. The Board also sought clarification from the provincial government regarding the scope and duration of its authority in relation to

been passed by the Government since the passing of the revised statutes have thought it proper to submit their acts in this matter to his Honor the administrator of the Government for his approval.” Board communicated frequently with the Lieutenant Governor’s office, including seeking advice with respect to management of smallpox outbreaks and quarantine. See also Pictou Board of Health to Provincial Secretary (30 October 1847), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 2, Pictou County); Letter dated 23 November 1847, Halifax, Archives of Nova Scotia (RG 25 Series C, vol 2, Pictou County). These communications continued throughout the century, ranging from matters concerning appointment of Board members and requests for funds to support public health causes. See e.g. Telegram from Dr. M Johnston to Provincial Secretary (29 April 1864), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Public Health General 1864-1900) (“smallpox lazaretto “in ruins and no funds to repair it - no board of health here - can government place any funds at disposal of authorities here to meet exigency?”); Telegram from Board to Provincial Secretary (11 May 1864), Halifax, Archives of Nova Scotia (RG 25 Series C, vol 1, Public Health General 1864-1900), requesting funds to offer 100 dollar reward for information regarding culprit who burned down hospital.

281 See supra note 189 at 44.
management of infectious diseases, and as to “whether they ha[d] the power to make an order detaining by force any person entering the [local smallpox] Lazaretto contrary to orders.”

The latter request for advice was motivated by the detention of a religious minister, Rev. Mr. O’Reilly, who had entered the Lazaretto to minister to the sick in violation of a widely-advertised resolution issued by the Board which warned that persons who entered the Lazaretto without permission from the Board be subject to detention and payment of a £100 penalty. In a letter responding to the Board’s request for advice, Provincial Secretary Howe stated that the Lieutenant Governor was of the opinion that the authority to pass such resolution lay with the Governor in Council, and not the Board. The letter also advised that “any order for detaining by force any visitant of a Lazaretto is not legal and that any order restraining a clergyman for visiting a dying inmate when required is unprecedented” as “[r]everend [g]entlemen hav[e] without exception been allowed access wherever medical men exercise the right of visiting.”

Secondly, local officials sought advice from the provincial government as a means of protecting or indemnifying themselves from legal and financial liability for actions undertaken in implementing public health statutes. In the Tongataboo case, the Pictou Board of Health ordered the vessel to proceed to quarantine, and instructed the county

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282 Ibid at 45.
283 Ibid at 61-62.
284 See ibid.
285 Ibid at 75.
286 Ibid.
287 See ibid at 36-52.
health officers to board the ship, inspect the state of its crew and contents, and remove all
those infected to the lazaretto. To allow for cleaning and fumigation of the vessel, the
health officers were instructed to secure a comfortable place to accommodate non-
infected passengers or those who had already gained immunity from previous encounters
with the disease.\(^{288}\) The health officers promptly carried out these instructions, but were
unable to obtain accommodation for non-infected crew members and passengers, causing
them to remain on the vessel.\(^{289}\) The master of the ship, Captain McKenzie, fearing that
the ship would be detained in quarantine longer than necessary and that persons
remaining on board might become infected from contaminated cargo if they remained on
board, procured a house belonging to a deceased Pictou resident for the accommodation
of crew and passengers and “undertook to render it habitable and comfortable.”\(^{290}\) The
Board of Health passed a resolution approving this undertaking on 14 May 1852.

Three days later, one Mr. John Forbes, who claimed he was in possession of the house
that Captain McKenzie had procured for accommodation of the crew and passengers, sent
a letter through his lawyer to the Board threatening legal action for trespass and
“violation of his rights” of possession if the crew and passengers took up residence in the
house.\(^{291}\) In a second letter to be Board, Mr. Forbes and a “committee of neighbours”
complained that the Board’s resolution unfairly sought to expose them to the danger of
infection “because we are not so wealthy as you”, and vowed to prevent the passengers

\(^{288}\) See ibid at 36-37.
\(^{289}\) See ibid at 38.
\(^{290}\) Ibid at 41.
\(^{291}\) Ibid at 42.
from leaving the ship and coming onshore.\textsuperscript{292} When the Board received the letters, they passed the following resolution to withdraw support for the accommodation plan:

\begin{quote}
Resolved that the Secretary inform Capt. McKenzie that doubts have been raised as to the ownership of the House selected by him for the accommodation of the passengers on board the Tongataboo. That the Board have been threatened with prosecution if they permit it to be occupied by said passengers, and that unless the Board be indemnified by him from all consequences they cannot give any authority for the landing of said passengers there and that they hereby revoke and withdraw the order made relative thereto.\textsuperscript{293}
\end{quote}

The Board also instructed its Secretary to send a telegraph to the Provincial Secretary asking whether the government “approve[d] of what the Board has done”\textsuperscript{294} in relation to the Tongataboo incident, and whether the Board’s existing commission was still in force. Responding on behalf of the provincial government, Secretary Howe wrote that the government “will approve of any act of the Board which the law sanctions” but that the Board “must take the responsibility of deviation.”\textsuperscript{295} He also assured the Board that if they encountered “technical difficulties”\textsuperscript{296} in carrying out its commission, the government “will indemnify.”\textsuperscript{297}

3.3 Central Administration, and the Emergence of a Formal Public Health Bureau

The foregoing discussion demonstrates that by mid-nineteenth century, Nova Scotia had established a robust, efficient and effective legal system for the management of infectious

\begin{footnotesize}
\textsuperscript{292} See \textit{ibid} at 43.
\textsuperscript{293} \textit{Ibid} at 44.
\textsuperscript{294} \textit{Ibid}.
\textsuperscript{295} \textit{Ibid} at 45.
\textsuperscript{296} \textit{Ibid}.
\textsuperscript{297} \textit{Ibid}. There are no further records relating to the case.
\end{footnotesize}
diseases and public health in general. Under this system, the responsibility for managing and protecting public health was shared by the provincial and local governments; the provincial government was primarily responsible for quarantine and public health emergencies, while the management of infectious disease outbreaks and implementation of preventive measures such as vaccination were handled primarily by the local authorities. A variety of officials and institutions, including legislators, the provincial executive, local magistrates and Sessions courts, health officers, boards of health, overseers of the poor and the Grand Jury, worked within both levels of government to implement public health functions, coordinate implementation efforts, and exchange information about public health threats and ways of dealing with them. The system also allowed for a variety of approaches to dealing with infectious diseases and other public health threats, including quarantine, isolation, placarding, notifications, sanitation, decontamination, and vaccination.

The 1850 Vaccination Act was the last major piece of legislation enacted to govern the management of infectious diseases prior to confederation. The Act, along with the quarantine and infectious disease statutes, provided the structure for further legal developments and public health governance throughout the nineteenth century. Both
Two noteworthy legislative developments occurred post-confederation. The first took place in 1879, when the legislature passed the *County Incorporation Act*. The Act provided for the incorporation of counties within the province, and for the establishment of elected municipal councils to govern them. Significantly, the seat of municipal power and administration was relocated from the Sessions courts to the elected councils. Public health powers and responsibilities formerly exercised by Sessions were also transferred to municipal councils, including the power to appoint health officers,

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298 For example, two new provisions were introduced in the consolidation included in the 1886 Revised Statutes. See *Of Boards of Health and Infectious Diseases*, RSNS 1884, c 26. The first required the flagging of houses, vessels or places in which a smallpox or cholera infection exists or infected person resides. See *ibid*, s 11. The second increased the penalty for the offence of bringing an infected person into the province to a minimum of $100 and a maximum of $400. See *ibid*, s 10.

299 See *Of Quarantine*, RSNS 1859, c 53, *Of Boards of Health and Infectious Diseases*, RSNS 1859, c 54; *Of Quarantine*, RSNS 1864, c 52, *Of Boards of Health and Infectious Diseases*, RSNS 1864, c 53; *Of Boards of Health and Infectious Diseases*, RSNS 1873, c 29; *Of Boards of Health and Infectious Diseases*, RSNS 1884, c 26.

300 See *An Act entitled “The County Incorporation Act”*, SNS 1879 (42 Vict), c 1. Prior to the passing of the Act, Halifax was the only incorporated county. The Act recognized 20 new counties.

301 See *ibid*, s 1.

302 See generally *ibid*, ss 3-26.

303 See *ibid*, s 73. The section reads, in part:

> All power and authorities now vested by law in the grand jury and Sessions, in Special Sessions, or in justices of the peace, to make bye-laws, impose rates or assessments, appoint township or county officers, or make regulations for any county purpose whatever, after the incorporation of any municipality shall be transferred to, vested in, and be exercised by the municipality council only.

See also *ibid*, s 78 (“[t]he jurisdiction of the General Sessions of the Peace and of the grand jury, in all matters over which, by this act, jurisdiction is given to the municipal council, is taken away”).

304 See *ibid*, s 67. The scope of this authority did not extend to general oversight of public health, but was limited to abating and removal of nuisances and powers specifically assigned to municipal councils under the public health statutes. See *ibid*, s 84.
wardens, inspectors and boards of health,305 and all powers and functions relating to infectious diseases.306

The County Incorporation Act also marked the formal separation of judicial and administrative functions at the local government level. Power over the administration of justice and jurisdiction over criminal matters remained with the justices of the peace,307 and councillors were exempted from serving on grand or petit juries.308

The second development was the enactment, in 1890, of the Public Health Act.309 The Act consolidated, revised, and modernized the existing statutes relating to public health, and updated municipal government responsibilities within the context of the Act to reflect the transfer of public health powers from Sessions to municipal councils. By way of example, municipal councils were authorized to order general vaccination, and to receive, approve and settle vaccination accounts.310 As discussed earlier, this responsibility was formerly within the purview of Sessions and the Grand Jury. An amendment to the Act, passed in 1893,311 established a Provincial Board of Health for the province.312

The creation of the Provincial Board marked the beginning of the centralization and bureaucratization of public health governance in Nova Scotia. This process was similar,
in many respects, to the Ontario experience, which also began with the creation of a provincial board of health. Similar to Ontario, municipal powers and authority over infectious diseases and public health were not altered by the creation of the Provincial Board of Health. Instead, the Board was charged mainly with “mak[ing] suggestions as to the prevention and introduction of contagious and infectious diseases”\textsuperscript{313}, and with providing advice to the provincial government and local boards of health on public health matters,\textsuperscript{314} conducting investigations and inquiries about sanitary matters, causes of disease, epidemics and mortality,\textsuperscript{315} and disseminating public health literature.\textsuperscript{316}

However, unlike its Ontario counterpart, the Nova Scotia Board enjoyed extensive powers of supervision over local boards of health, including the power to demand a report on measures instituted by the local boards “for the limitation of any existing dangerous contagious or infectious disease”\textsuperscript{317}, and to require non-performing boards “to exercise and enforce any…powers which, in the opinion of the Provincial Board, the urgency of the case demands.”\textsuperscript{318} The Board was also empowered to exercise and enforce any powers or measures neglected by non-compliant local boards, “at the expense of the municipality or district”,\textsuperscript{319} and to make bylaws to aid or accomplish its business.\textsuperscript{320} Given that the Nova Scotia Board was established a little over a decade after the creation of its Ontario counterpart, the latter provisions may have been intended to address the

\textsuperscript{313} Ibid, s 9.
\textsuperscript{314} See Ibid.
\textsuperscript{315} See Ibid.
\textsuperscript{316} See Ibid, s 10.
\textsuperscript{317} Ibid, s 9.
\textsuperscript{318} Ibid.
\textsuperscript{319} Ibid.
\textsuperscript{320} See Ibid, s 8.
difficulties encountered by the Ontario Board with respect to municipal apathy towards implementation of public health laws.

The membership of the Nova Scotia Board also differed significantly from that of the Ontario Board, which was dominated by medical doctors. The Nova Scotia Board was composed of the Provincial Secretary (who also served as chairman of the board), the Attorney General, the Commissioner of Public Works and Mines, the Medical Superintendents of the Victoria General Hospital and the Nova Scotia Hospital for the Insane, and four medical practitioners appointed by Council. The diverse composition of the Board helped ensure that the Board’s agenda was not determined or driven by the interests of the medical profession, as was the case with the Ontario Board. In 1904, the Provincial Board of Health was replaced by the Department of Public Health, led by the Provincial Secretary. In 1930, it became a ministerial department.

### 3.4 Conclusion

Unlike Ontario, the legal response to infectious diseases in Nova Scotia was timely and efficient. Early public health laws in the colony, including vaccination laws, were drawn and implemented with the singular goal of preventing and managing diseases such as smallpox and yellow fever. Implementation efforts were very collaborative, and largely devoid of the apathy, delays, turf wars and self-interested agendas that characterized similar efforts in Ontario. Vaccination was welcomed by Nova Scotians, mainly because

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321 See ibid, s 1.
of the constant visitations of deadly smallpox epidemics, but also because the procedure was promoted as one of many measures directed at preventing and controlling the spread of the disease. It also helped that vaccination laws in the province were significantly less intrusive on personal liberties compared to other jurisdictions, as they were designed to provide municipalities with the authority to invoke the measure only when circumstances demanded.

Nineteenth century legal culture in Nova Scotia also serves to explain the difference from Ontario both in terms of the management of infectious diseases and attitudes towards government intervention in public health matters. The main elements of this legal culture were high law (including health statutes and common law) and localized public health systems operated mainly by committed magistrates, local boards of health and medical professionals. Although the same is true (to some extent) about nineteenth century legal culture in Ontario, it was more evident in practice in Nova Scotia. Put differently, the development and progress of public health in Nova Scotia was shaped and characterized by law, local institutions, public spirit and an “alliance of health and polity”\(^\text{322}\) manifested in a widespread appreciation of the importance of public health to societal welfare and progress. Public health, to paraphrase Novak, provided “a raison d’être for [both] political organization”\(^\text{323}\) and development of legal frameworks, particularly at the local level, where it was a principal concern and function of local government. While the initial response to infectious diseases may have been triggered largely by the colony’s coastal


\(^{323}\) *Ibid* at 193.
geography and frequent disease threats, subsequent outcomes, refinements and successes are owed to the presence of a responsive, efficient and civic-minded legal culture.

Lastly, the legal history of vaccination in Nova Scotia history clearly shows that debates and controversies surrounding mandatory policies were less about the legitimacy or acceptability of the intervention, but instead, focused more on practical matters affecting implementation, such as payment of vaccination expenses and lack of clarity regarding legal rules and authority. Also, the success of mandatory policies in Nova Scotia was driven not just by legal initiatives, but by a social and political context that provided a keen awareness of and pressing need to respond to infectious diseases in a timely and efficient manner, including high influx of immigrants, constant disease threats due to geography, and a population that was more accepting and supportive of public health interventions.
Plate H: Document showing number of persons that received the smallpox vaccine in Halifax (circa 1841) (2 pages)
Plate I: Board of Health Regulations for the Ports of Bridgewater & LaHave in the County of Lunenburg, in relation to Small-Pox (1885)

BYE-LAWS AND SANITARY ORDERS OF THE BOARD OF HEALTH OF THE Ports of BRIDGEMEER & LAHAVE in the County of Lunenburg, in relation to SMALL-POX.

WHEREAS, the infectious disease of smallpox is prevolently in the District of Bridgewater, LaHave, and in Cape Breton and other parts of the Province of New Brunswick, and there is imminent danger of the introduction into the Port of LaHave and Bridgewater and

WHEREAS, that such disease may not be introduced and spread in the and Port of LaHave and Bridgewater, and

and that the health and safety of their inhabitants be not endangered, it is desirable to make Bye-Laws and Sanitary Orders to prevent the introduction and spread of the said disease, to the authority of Chap. 32 of the Revised Statutes, "Of Boards of Health and Infected Disease," and

All persons intending to land in said Ports of LaHave and Bridgewater shall answer to the Board of Health for said Ports of LaHave and Bridgewater.

1. To and after the 25th day of November, A.D. 1884, no person domiciled or resident without the County of Lunenburg shall come into the Ports of LaHave and Bridgewater, unless the same shall have, within seven days previous, been examined and found to be free from all contagious or infectious disease, and in such possession, ready to be produced upon request being made by any officer of the Board of Health for the said Ports of LaHave and Bridgewater, in carrying out the purposes of this law, and a board of health may then be established, the said health may be then proceeded against, and no person or persons shall be admitted to the possession of the said Port of LaHave and Bridgewater, except such as shall have been examined and found to be free from all contagious or infectious disease, and in such possession ready to be produced upon request being made by any officer of the Board of Health for the said Ports of LaHave and Bridgewater.

5. Any persons violating any of the provisions of this byelaw or who may travel within said District of LaHave and Bridgewater shall each have power and authority to detain and take possession of all persons or vessels brought by vessel or otherwise from the ports of LaHave or Bridgewater, and before the same are delivered up to the authorities thereof may cause the same to be searched and to be thoroughly examined, registered and accounted, and if they be found infected with the said disease, the health may be then proceeded against, and no person or persons shall be admitted to the possession of the said Port of LaHave and Bridgewater, except such as shall have been examined and found to be free from all contagious or infectious disease and in such possession ready to be produced upon request being made by any officer of the Board of Health for the said Ports of LaHave and Bridgewater.

10. After the expiration of the time of quarantine, no person or persons shall be admitted to the said Ports of LaHave and Bridgewater, except such as shall have been examined and found to be free from all contagious or infectious disease, and in such possession ready to be produced upon request being made by any officer of the Board of Health for the said Ports of LaHave and Bridgewater, and shall have obtained their requisite papers.

Any person or persons violating any of the said Bye-Laws or Sanitary Orders shall on conviction be fined a sum not exceeding $250.

This Act to take effect and be in force from and after the 20th day of November, A.D. 1884.
CONCLUDING THOUGHTS

This dissertation set out to explore the legal history of vaccination in nineteenth to early twentieth century Ontario and Nova Scotia. The principal aims were to provide an original account of vaccination law and policy during this period that encompasses the diverse contexts, factors, ideas and controversies that shaped and influenced legal developments, examine the role of legal rules and institutions in the design, implementation and outcomes of smallpox vaccination policies, and establish where vaccination laws fit within the broader history of public health in Canada.

Through the course of two main chapters, the study demonstrated that the legal regulation of vaccination and the broader legal response to infectious diseases and public health in Ontario was slow and largely ineffective for most of the period under study. This was mainly due to late establishment and organization of public health laws and associated governance frameworks, coupled with lack of public and political interest in advancing or supporting public health causes. As the nineteenth century progressed, reform-minded medical practitioners sought to reverse this trend, but for diverse reasons, including advancing the status and parochial interests of their profession. They found vaccination to be an attractive tool for this purpose, mainly due to the innovativeness of the remedy and government willingness to use legal means to enforce it. Motivated by the appeal of legal authority and societal recognition as champions of salus populi, these practitioners sought to centralize and gain legal authority over the implementation of vaccination laws. Their efforts in this regard were resisted by local officials, antivaccinationists and alternative
practitioners, who variously viewed the doctors’ motives and actions as a threat to their legal authority over public health matters, personal liberties, or professional interests. Tensions over the implementation and enforcement of vaccination laws led to legal disputes, which, in turn, produced foundational precedents on questions of scientific uncertainty, philosophical justifications for public health, and the locus of legal authority to implement and enforce public health laws.

Nova Scotia offered a contrasting picture in almost every respect. Faced with constant threats of infectious disease outbreaks due to its littoral geography, the colony’s response was characterized by early establishment of legal and governance systems and collaborative and progressive implementation and implementation of public health laws. Government officials at the local and provincial levels worked with a highly trained group of doctors to implement vaccination and other infectious disease management strategies, in some cases long before the enactment of legal rules to govern such matters. The people of Nova Scotia were also welcoming of public health measures, and there was little or no resistance to vaccination in the colony or province. Most significantly, the idea of salus populi, though not explicitly argued as was the case in Ontario, was reflected in the attitudes and efforts to protect the province and its citizens from smallpox and other infectious diseases. While implementation was not without problems, they were practical in nature, involving issues of resource constraints and responsibility for enforcement expenses.
A few concluding thoughts arise from the study. Firstly, the law played an important and wide-ranging role both as a tool for enforcing vaccination and by providing rules, institutions and mechanisms for settling disputes arising from implementation of vaccination programs. The history of vaccination discussed in this work implicated a wide variety of legal rules, processes and institutions, including localized legal systems that emphasized and symbolized the symbiotic relationship between law and local traditions, and forms of high law that offered technical rulings based on statutes and long-established common law principles.

Secondly, and more importantly, the design of legal measures mattered. This is clearly demonstrated by social responses to the two main approaches to mandatory vaccination during the period of the study. The first required routine vaccination of every infant either at birth or prior to school admission. While this approach was designed with the sensible aim of achieving “herd immunity”, it provoked much resistance from parents and organized anti-vaccination groups, who viewed it as highly intrusive on personal liberties. The second approach handed power to local officials to impose vaccination on the population only when circumstances demand, such as when the community faced the threat of a smallpox outbreak. As we have seen, this approach was highly effective and less socially controversial, especially in Nova Scotia, where those charged with implementing it exercised reasonable discretion in invoking and applying the measure. This was not the case in Ontario, but mainly because of the enforcement antics of the physician-dominated Provincial Board of Health. The latter approach is also more consistent with modern approaches to public health enforcement, which generally
provide public health officials with the discretion to invoke any measure, including vaccination, during a public health emergency. Although proof of vaccination before school entry is still required in Ontario, parents are allowed to seek an exemption on medical, religious or conscientious grounds.

In general, the study suggests that implementation and enforcement efforts benefitted from legal governance frameworks designed to protect public health in the least interventionist or intrusive manner possible, and which emphasize the practical necessity of preventing the introduction and spread of diseases rather than lofty philosophical justifications that provoke debate and conflict. It also mattered that implementation efforts did not focus exclusively on vaccination, which, though innovative, was unfamiliar to many. Over reliance on vaccination also provoked concerns about the medicalization of public health at a time when the causes of disease were a matter of profound scientific uncertainty.

Thirdly, the social context in which public health measures were applied also emerged as an important consideration. Factors that proved influential in this regard include the geography of both provinces, the presence and frequency of infectious disease threats, and general social attitudes to and support for public health causes.

Lastly, the dissertation provided some insights on the origins of public health in Canada, and in particular the philosophical and practical questions and issues that informed and
influenced the establishment of public health systems in two founding Canadian provinces. The dissertation offered two contrasting accounts of these early beginnings; a chaotic, acrimonious, reformistic and ideology-heavy start for Ontario, and a responsive, fluid, cooperative and practical approach in Nova Scotia. Smallpox, vaccination and infectious disease matters played a role in relation thereto, and serve to demonstrate that although the journey ended at similar destinations, the roads that led both provinces there were very distinct.
LEGISLATION


An Act for applying certain monies therein mentioned for the service of the year one thousand eight hundred and fifty-three, and other purposes, SNS 1853 (17 Vict), c 33.

An Act for applying certain monies therein mentioned for the service of the year one thousand eight hundred and fifty-three, and other purposes, SNS 1853 (18 Vict), c 41.

An Act for applying certain monies therein mentioned for the service of the year of our lord one thousand eight hundred and forty, and for other purposes therein specified, SNS 1840 (3 Vict) c 1.

An Act for applying certain monies therein mentioned for the service of the year of our lord one thousand eight hundred and forty-one, and for other purposes, SNS 1841 (4 Vict) c 1.

An Act for applying certain monies therein mentioned for the service of the year of our lord one thousand eight hundred and forty-two, and for other purposes, SNS 1842 (5 Vict) c 1.

An Act for applying certain monies therein mentioned for the service of the year of our lord one thousand eight hundred and forty-three, and for other purposes, SNS 1843 (6 Vict) c 1.

An Act for applying certain monies therein mentioned for the service of the year of our lord one thousand eight hundred and forty-four, and for other purposes, SNS 1844 (7 Vict) c 1.

An Act for applying certain monies therein mentioned for the service of the year of our lord one thousand eight hundred and forty-six, and for other purposes, SNS 1846 (9 Vict) c 1.

An Act for applying certain monies therein mentioned for the service of the year of our lord one thousand eight hundred and forty-seven, and for other purposes, SNS 1849 (12 Vict) c 1.

An Act for erecting a lazaret on Chetney Hill, in the County of Kent; and for reducing into one Act the laws relating to quarantine; and for making further provision therein, 1800 (UK), 39 & 40 Geo III, c 80.

An Act for regulating the practice of inoculating for the small pox, SNS 1799 (39 Geo 3), c 7.

An Act for the better preventing [of] the spreading of the infection of the small pox in Charlestown, 1738 Stat SC Acts 513-515.

An Act for the establishment of a temporary fever hospital for the reception of persons infected with contagious diseases, SLC 1830 (10 &11 Geo 4), c 18.

An Act for the Establishment of the Department of Health, SO 1924, c 69.
An Act for, providing hospitals for inoculation, and preventing infection from the smallpox, and for repealing several acts heretofore made for that purpose, c 58, 1792 Mass Acts 85.

An Act further to extend and make compulsory the Practice of Vaccination, 1853 (UK) 16 & 17 Vict, c 100.

An Act granting a sum of money for the relief of sick and destitute emigrants at Prescott, SUC 1833 (3 Will 4), c 52.

An Act granting one hundred pounds in aid of the funds of the Female Benevolent Society of Kingston, SUC 1830 (11 Geo 4), c 32.

An Act granting to his Majesty a certain sum of money to enable His Majesty to defray certain charges incurred during the prevalence of the cholera during the last summer, SUC 1833 (3 Will 4), c 57.


An Act in addition to an Act, made in the first year of his present Majesty’s reign, entitled, An Act to prevent the spreading of contagious distempers, SNS 1775 (16 Geo 3), c 11.

An Act in addition to an Act, made in the first year of his present Majesty’s reign, entitled, an Act to prevent the spreading of contagious distempers, SNS 1775 (15 & 16 Geo 3), c 2.

An Act in amendment of an Act, passed in the first year of his present Majesty’s reign, entitled, an Act to prevent the spreading of contagious distempers, and also in amendment of an Act, passed in the sixteenth year of the said reign, entitled, an Act in addition to the before recited Act, SNS 1799 (39 Geo 3), c 3.

An Act more effectually to provide against the introduction of infectious or contagious diseases, and the spreading thereof in this province, SNS 1832 (2 Will 4), c 14.


An Act relating to quarantine and public health, SC 1868 (32 Vict), c 63.

An Act Respecting Inoculation and Vaccination, SC 1859 (22 Vict), c 39.

An Act Respecting Inoculation and Vaccination, SM 1877 (40 Vict) c 24.


An Act Respecting Public Health, SA 1907, c 12.

An Act Respecting the Preservation of the Public Health, SM 1877 (40 Vict), c 1.

An Act respecting the public health, RSO 1877 (40 & 41 Vict), c 190.

An Act respecting the Public Health, RSO 1914, c 218.

An Act Respecting the Public Health, SNS 1890 (54 Vict), c 21.

An Act respecting the Public Health, SO 1873 (36 Vict), c 43.

An Act respecting the public health, SO 1873 (36 Vict), c 63.

An Act respecting the public health, SO 1912 (2 Geo 5), c 58.

An Act respecting the Public Health, SO 1927, c 73.

An Act respecting vaccination and inoculation, RSO 1877 (40 Vict), c 191.

An Act respecting vaccination and inoculation, SO 1912 (2 Geo 5), c 59.

An Act to alter and continue the Act more effectually to provide against the introduction of infectious or contagious diseases, and the spreading thereof in this province, SNS 1833 (3 Will 4), c 36.
Amend and consolidate the Acts relating to the profession of medicine and surgery, SO 1869 (32 Vict), c 45.

Amend and consolidate the laws relative to emigrants and quarantine, S Prov C 1853 (16 Vict), c 85.

Amend the Act respecting vaccination and inoculation, SO 1886 (49 Vict), c 43.

Amend the law with respect to vaccination, 1898 (UK), 61 & 62 Vict, c 49, s 3.

Amend the Laws relating to Public Health, SNS 1893 (56 Vict), c 12.

Amend the Public Health Act, SO 1920, c 81, s 3.

Amend the Quarantine Act, S Prov C 1849 (12 Vict), c 7.

Amend the Vaccination Act, 1871 (UK), 34 & 35 Vict, c 98.

Appropriate a certain sum of money there-in mentioned, towards the support of the emigrant hospital established in Quebec, SLC 1829 (9 Geo 4), c 2.

Appropriate a certain sum of money therein mentioned, for the promotion of vaccine inoculation, SLC 1817 (57 Geo 3), c 15.

Appropriate a certain sum of money therein mentioned, towards the support of the Emigrant Hospital, established in Quebec, SLC 1824 (4 Geo 4), c 32.

Appropriate a sum of money to facilitate the execution of an Act therein mentioned, commonly called the Quarantine Act, and for other purposes, SLC 1823 (3 Geo 4), c 20.

Appropriate certain sums of money for the support of the Emigrant Hospital at Quebec and of the Fever Hospital at Point Levi, and for other purposes therein mentioned, SLC 1832 (2 Will 4), c 15.

Authorize the Quarter Sessions of the Home district to provide for the relief of insane destitute persons in that district, SUC 1830 (11 Geo 4), c 20.

Consolidate and amend the laws relating to vaccination, 1867 (UK), 30 & 31 Vict, c 84.

Continue and make perpetual an Act passed in the fifth year of the reign of King William the Fourth, entitled "An Act to promote the public health, and to guard against infectious diseases in this Province", SUC 1839 (2 Vict), c 21.

Continue for a limited time an act entitled, "An Act to promote the public health, and to guard against infectious disease in this Province, SUC 1837 (7 Will 4), c 26.

Diffuse the benefits of inoculation for the cow pox, c 117, 1809 Mass Acts 204.

Encourage and diffuse the practice of vaccine inoculation, SLC 1815 (55 Geo 3), c 6.

Encourage the practice of vaccine inoculation and to appropriate a certain sum of money for that purpose, SLC 1821 (1 Geo 4), c 7.

Encourage, and to provide for the extension of the practice of Vaccination, S Prov C 1858 (22 Vict), c 89.

Establish a Provincial Board of Health, and to give increased powers to Local Boards of Health, SO 1882 (45 Vict), c 29.

Establish boards of health within this Province, and to enforce an effectual system of quarantine, SLC 1832 (2 Will 4), c 16.

Establish boards of health, and to guard against the introduction of malignant, contagious and infectious diseases, in this Province, SUC 1833 (4 Will), c 48.

Establish regulations for preventing contagious diseases in Ireland, 1819 (UK), 59 Geo III, c 41.
An Act to explain the Vaccination Act, 1871, 1874 (UK), 37 & 38 Vict, c 75.
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An Act to give further powers to the Executive Government to prevent the introduction or spreading of infectious or contagious diseases in this Province, SLC 1800 (40 Geo 3), c 5.
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An Act to make provision for the preservation of the public health in certain emergencies, S Prov C 1849 (12 Vict), c 8.
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An Act to provide for the better internal Government of that part of this Province which formerly constituted the Province of Upper Canada, by the establishment of Local or Municipal authorities therein, S Prov C 1841 (4 & 5 Vict), c 10.
An Act to provide for the more general adoption of the practice of vaccination, S Prov C 1861 (24 Vict), c 24.
An Act to provide for the Registration of Drugless Practitioners, SO 1925, c 49.
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An Act to reduce into one, the several Acts for regulating the inoculation of the small-pox within this Commonwealth, Statutes of Virginia, 1792 Va. Acts 209-211.
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An Act to repeal certain Acts therein mentioned, and to make further provision respecting emigrants, S Prov C 1849 (12 Vict), c 6.
An Act to repeal the Vaccination Act, SO 1964, c 122.
An Act to restrain the injurious practice of inoculating with the Small Pox, S Prov C 1853 (16 Vict), c 170.
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