

From the Grey Nuns to the Streets: A Critical History of Outreach Nursing in Canada

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ABSTRACT This article traces the historic antecedents of outreach nursing in Canada, going as far back as the Grey Nuns in what is now Quebec. It attempts to place modern-day street nursing in a historical context, which includes Nightingale, Wald, the early Victorian Order of Nurses, and the social reform movements of the early 20th century. The article critiques the involvement of nursing in less than virtuous aspects of social control with respect to impoverished and otherwise marginalized groups. The article goes on to trace the origins of modern Canadian street nursing in three cities: Vancouver, Toronto, and Montreal. It uses both a search of the nursing literature and, because much of this history is undocumented, oral history and anecdotal information as well. It critiques nursing's traditional avoidance of political action and calls upon modern-day nurses to support and educate one another to engage in this work.

Key words: homelessness, outreach nursing, political action, poverty, street nursing.

“Street nursing,” or nursing outreach to homeless people, has become an established nursing specialty not only across Canada but in America, Great Britain, Europe, and Australia. It takes its place in nursing history amidst a legacy of “nursing the poor” almost from the earliest days of organized nursing. While often considered a noble pursuit, careful analysis of our history also reveals less virtuous aspects. Under scrutiny, one finds that the provision of nursing services to impoverished, vulnerable people has often been characterized by racial and class biases, social control agendas, superficial approaches to structural problems, naïve and ineffectual activism, and an inflated sense of the importance of nurses that distracts attention from profound systemic problems.

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Historical Antecedents of Outreach Nursing

The Grey Nuns

One could consider the practical origins of modern Canadian outreach nursing to be found in the early 1700s, when the Grey Nuns began public health visits to the sick poor in what is now Quebec. Also known as The Sisters of Charity, the Grey Nuns were founded by Marguerite d'Youville. Married to a bootlegger who left her a widow at the age of 28, d'Youville began taking impoverished people into her home in 1737. Three other women were inspired to join her, and by the end of that year had consecrated themselves to service in the care of the poor. Her reputation marred by her deceased husband's traffic in liquor, d'Youville and her colleagues were ridiculed by people who shouted at them a French word meaning “intoxicated,” which also means “grey” (Sisters of Charity of Montreal, 2003). Later, d'Youville took this name to remind her order of its humble beginnings.

The order grew, and by 1750, d'Youville and her colleagues had renovated the ruined General Hospital of Montreal and opened it has a “home” to all. Word among the destitute was “go to the Grey Nuns, they never refuse,” (Sisters of Charity of Montreal, 2003).

In the first half of the 19th century, the Grey Nuns spread to Canada's west and north, founding most of the first hospitals and schools in Manitoba, Saskatchewan, and Alberta (Gonzalez, 1999). Today, the Grey Nuns continue to provide care, including nursing care, to the poor across Canada and in the United States. They work with people affected by poverty, abuse, and incarceration. They have supported debt relief for developing nations and have opposed nuclear arms and capital punishment (*Grey Nuns of the Sacred Heart*, 2002).

Nightingale, Wald, and the Victorian Order of Nurses (VON)

It was not until the mid 19th century in Britain that Florence Nightingale first articulated the interactions between social conditions and illness. Although Nightingale's legacy of "disciplined middle class gentility" has come under rightful scrutiny "by a generation of scholars . . ." (Strong-Boag, 1991, p. 237) through the lenses of gender, class, and race, there is no doubt that she saw the need to influence policy to improve the health of her patients. She used her class connections to write to bureaucrats and politicians, for example, to improve conditions such as poor air quality in the workhouses in which she nursed. Nightingale pioneered the development of nursing curriculum, which introduced the importance of addressing the broad determinants of health.

Later in North America, Lillian Wald founded what came to be known as the Henry Street Settlement among the impoverished, largely immigrant tenements on the lower east side of New York City. She took up residence in the tenement neighborhoods, evidence no doubt of Wald's belief that the nurse should have an "organic relationship with the neighbourhood" (Reverby, 1993, pp. 1662–1663) and thus be well located to be connected to groups working for social change (Rafael, 1999). Apparently, what she saw motivated her to lobby for change. Wald fought for health care for the poor, for tenement reforms, and for changes to labor laws, including the abolition of child labor.

By many accounts, Wald understood that income and education were fundamental to improving people's health. She is reported to have found jobs for unemployed men, insisted that poor children be sent to school, and arranged for unemployed women to earn money as charwomen, with wages paid by local charitable organizations (Silverstein, 1985). Wald believed

that if only people *knew* about the squalid conditions people endured, such conditions would be remedied. She wrote, "to my inexperience it seemed certain that conditions such as these were allowed because people did not *know* [emphasis Wald's], and for me there was a challenge to know and to tell" (Wald, 1915, p. 8). Here, Wald articulates the politically naïve belief held by many of her modern-day successors: that articulating the existence of poor conditions is sufficient to bring about political changes.

During the same era, settlement of the Canadian western frontier required an expansion of health care, and nurses began to migrate west. Lady Ishbel Aberdeen, wife of Canada's then Governor General, began to identify emerging health and social needs in remote prairie areas. Although opposition from physicians (apparently worried about losing economic revenues) reduced political support for the VON, Aberdeen worked with the National Council of Women to establish the organization in 1896. The establishment of the VON made homesteading more survivable by providing outreach nursing services to isolated, impoverished farm families across the prairies. VON nurses provided prenatal care, well baby care, school health services, and home visiting nursing.

Outreach nursing continued to spread with the burgeoning frontier borders (VON, 1996). In 1898, the VON sent nurses to the Klondike to meet the health needs of the huge influx of people to the Yukon during the gold rush. Cottage hospitals were built in rural areas for pioneers and early settlers by the VON, the Canadian Red Cross, and various churches. During this era, the Red Cross provided maternity care, care of tuberculosis and venereal diseases as well as public health education (Duncan, Leipert, & Mill, 1999), largely in small isolated villages and outposts.

Social reform and public health

The turn of the 19th century heralded an often zealous social reform movement that positioned churches, middle-class women, nurses, and doctors as advocates of reforms that sought to "cleanse the nation of ill health, immorality and indolence" (Strong-Boag, 1991). A belief evolved that introducing nursing to settings where people had significant health risks (read: impoverishment) would reduce those risks. In 1917, the Ontario Board of Health developed a plan to hire a public health nurse (PHN) for each Ontario Health district with the intent of reducing infant and child mortality rates through the education of

mothers. In creating the Rural Child Welfare Project, “it was widely believed that the special power of one woman—the PHN—would literally save Canadian babies from the jaws of death and ensure the stability of the family unit,” (Stuart, 1989, p. 112).

Exemplifying the hidden agenda of public health as a means of social control of the working class, Chief Medical Officer Dr. McCullough believed that PHNs were needed to visit pregnant women and new mothers at home because “ignorant, careless women” and especially immigrant women and those who could not read English would not attend Infant Welfare Centres (Stuart, 1989, p. 118). Essentially, public health authorities were arguing that low income and immigrant women were unfit mothers and thus needed PHNs to intervene to improve the health of their children, all the while ignoring the profound risks posed not by poor parenting but by their poverty. In the end, mortality did decline, not due to teaching, but due to increased immunization rates (Stuart, 1989). Regardless of how “health education” was delivered, it “would not erase the effects of poverty nor replace the lack of expert care in the treatment of morbidity and the prevention of mortality. It was a facile solution” (Stuart, 1989, p. 126). This era also witnessed the establishment of hospitals and nursing services to Aboriginal people in remote areas by Christian missions and the Canadian government. It is perhaps a perverse aspect of this history that, in conjunction with the legacy of residential schools, modern-day Canadian street nurses continue to provide care to homeless aboriginal survivors of these systems who have been deeply traumatized by the cultural appropriation that resulted.

Some nurse leaders apparently understood the limitations of public health in ameliorating the ravages of poverty. Although suggestive of middle-class biases, Eunice Dyke, superintendent of Public Health Nurses at the Toronto Department of Health, recognized that “poverty gives rise to sickness . . . well educated and well disciplined folk would find it difficult to maintain health in poverty conditions” (Dyke, 1919, p. 288). In Alberta, Edmonton’s Chief PHN noted that, for district nurses, “. . . in most cases . . . a shortage of food and clothing with the accompanying despondency was at the root of the trouble” (City of Edmonton, 1933).

In the early 20th century, there was a gradual assumption of control of public health by medicine that resulted in physicians displacing nurses from

many health-promotion activities. This dominance was complete by the 1950s (Rafael, 1999). During the 1960s, development of a national health insurance plan across Canada theoretically allowed all citizens regardless of social class to have access to medical care. However, it eventually became apparent that access to health care was not equal, and more importantly, access to the basic health determinants was even more elusive.

Modern-Day Street Nursing

In the late 20th century, this inequity of access to health care and to the basic determinants of health led to the origins of “street nursing” in large urban centers. The term refers generically to the provision of nursing care, often through outreach to nontraditional locations, to homeless and otherwise marginalized people. While it is impossible to track precisely the beginning of homeless outreach nursing, one can look to nursing literature for early documentation. In the United States, a group of emergency room nurses from Boston City Hospital opened a nurses’ clinic in a large urban men’s shelter in 1972 at the Pine Street Inn. They initially agreed to a 1-month trial clinic (Lenahan, McInnis, O’Donnell, & Hennessey, 1985) but the needs were apparent and the initiative has evolved into an extensive health service that today includes infirmary care (Lenahan et al., 1985). In Britain, nursing literature contains information on homeless health issues dating as far back as 1981 (Blackburn, 1981).

Canadian street nursing origins: Vancouver, British Columbia

Although the history of street nursing is largely undocumented, Vancouver, British Columbia, would appear to be its Canadian birthplace. Anecdotal evidence gathered from nurses currently practicing on the streets of Vancouver suggests that the figurative matriarch was a PHN, the late Grace Donald (L. James, personal communication, March 29, 2005). As far back as 1946, when antibiotics began to be used, Donald provided venereal disease (VD) treatment and contact tracing. She began to realize that marginalized people were not attending the hospital-based VD clinic.

At that time, prostitution was controlled by vagrancy laws so many street prostitutes, whose living situations would have been no doubt precarious,

ended up repeatedly in jail. This gave Donald the idea of taking her services to the Vancouver City Jail in order to reach those being missed by the clinic. She started a "VD Clinic" behind bars during which she would see 40 to 50 people in a morning. In the afternoons, she would go into the hotels and bawdy houses searching out sex trade workers and their contacts to provide testing and treatment. Although most people avoided jails when they could, Grace Donald was apparently so well liked and trusted that clients of hers who were not incarcerated would ring the buzzer to get into the jail just to see her (L. James, personal communication, March 29, 2005). It is very likely that many of those cared for by Donald would have been living under insecure and transient living circumstances—that is, they would have been homeless.

During the 1960s and 1970s, the sexual revolution witnessed increased sexual health needs regarding both disease treatment and contraception. "Street nurses in bluejeans" (Ruiterman & Biette, 1973) arose out of a joint project of the B.C. health department's division of VD control and the Vancouver health department. Four nurses began carrying backpacks in 1971 from which they dispensed oral contraceptive pills and sexually transmitted disease (STD) treatment on the streets, beaches, and in the squats to what was largely a transient youth population. These nurses had to be young, flexible, and *married* [emphasis mine], "to provide stability lacking in the work situation" (Ruiterman & Biette, 1973, p. 34)—apparently reflecting the belief that "the streets" were not considered appropriate places for single young women to be spending time. The nurses describe treating many of the same conditions familiar to today's street nurses, including lice, scabies, and viral hepatitis, and note the same prevalence of pejorative attitudes toward their clients on the part of middle-class health providers (Ruiterman & Biette, 1973). The 1973 Ruiterman and Biette article in *Canadian Nurse* may well be the earliest documented use of the colloquial term "street nurse."

As a port city with a long history of drug availability, it was not surprising that HIV/AIDS issues would arise in Vancouver early on. In 1988, the AIDS Prevention Street Nurse Program was created in the lower east side neighborhood of inner-city Vancouver with a focus on HIV and sexually transmitted disease prevention (Hilton, Thompson, Moore-Dempsey, & Hutchinson, 2000). This project has grown significantly with many more staff and a primary focus on

street outreach. While clearly committed to providing hands on nursing care including prevention education and assistance to clients to navigate the health care system, the nurses' role in political advocacy is described as less clear (Hilton et al., 2000).

Canadian street nursing origins: Toronto, Ontario

In Toronto, the late 1960s and 1970s also witnessed the beginnings of outreach to transient young people living in abandoned buildings (known as squats) who were considered at risk for health problems as a result of their homelessness and drug use. Although largely undocumented, according to anecdotal evidence, this outreach was mainly focused on helping youth deal with "bad trips" on drugs or treat STDs (C. Newman, personal communication, April 5, 2005). It was conducted on an ad hoc basis variously by visiting nurses, public health, and staff from a large downtown hospital (C. Newman, personal communication, 2005).

Such outreach was not explicitly recognized as "street nursing" in Canada until 1985 with the creation of an organization called Street Health by a group of formerly homeless people and community allies, including registered nurse Dilin Baker (Judd & Forgues, 1989). When this group of people who had experienced homelessness articulated that they had experienced difficulty getting their health problems adequately addressed because of systemic barriers to the health care system, or due to the inability of homeless people to attend to their health because of their poverty, the result was the creation of community-run nursing clinics. The first nursing clinic opened in January 1986 in a large Toronto drop-in center using volunteer nurses. In 1989 Street Health became Ontario's first autonomous nursing organization funded by the provincial Ministry of Health.

By this time in Toronto, there were also outreach nurses beginning to be affiliated with various drop-in centers and inner-city community health centers (CHCs). Working mostly alone, an attempt to overcome this workplace isolation prompted the origins of the Street Nurses' Network, which originated with nurses from ten different agencies and that continues to meet today with members from across the Greater Toronto Area. Today, Street Health is a large organization with many staff. There are an astonishing 40 or more street nurses in Toronto, working in CHCs, shelters, and drop-in centers. They run nursing

clinics, conduct street outreach, and provide care from mobile vans and buses.

Canadian street nursing origins: Montreal, Quebec

In Montreal, the health needs of homeless people began to be seriously acknowledged in the late 1980s (Thibaudeau & Denoncourt, 2000). A network of social service providers created an informal drop-in center known as *Dernier Recours Montreal (DRM)*, which began to recognize serious health issues among its clientele and also issues such as poor continuity of care, poor treatment by mainstream health services, and the phenomenon of “dumping” sick homeless people from hospitals at drop-in centers (McKeown & Plante, 2000). In 1988, a downtown community service center responsible for primary health care (CLSC), known at the time as CLSC Centre-Ville, set up a “homeless team” to provide care to homeless people coming in to the clinic (Thibaudeau & Denoncourt, 2000).

In 1989, a needle exchange program known as CACTUS (Centre Action Communautaire des Toxicomanes Utilisateurs de Seringues) began operating in the same general geographic area as the CLSC Centre-Ville, with nurses being part of the earliest staff mix (H. Denoncourt, personal communication, February 25, 2005). In 1990, the CLSC’s team began sending a nurse and a social worker out to hold outreach clinics in shelters and day centers in the area surrounding the CLSC. Today, the project has grown to include a large multidisciplinary team based at the CLSC des Faubourgs (which arose when CLSC Centre-Ville and CLSC Centre-Sud merged in 1993).

Street Nursing and Political Advocacy

Political advocacy as nursing intervention

In Canada, it would appear that Baker was the first to create a written practice model of street nursing that could be readily articulated and taught. Baker had studied primary health care models with a view of working in the developing world. Her initial exposure to poverty and homelessness in Toronto led her to believe that a model of grassroots community-based health care could work in inner-city North America. As Baker developed her nursing model, she described the role of the street nurse as three-fold: providing hands-on nursing care, advocating for clients within

the health and social service systems, and advocating politically for the changes needed to eliminate homelessness (Baker, 1988). At the same time, she described the need to use strategies to build relationships with clients, including “hanging out” in drop-in centers and shelters, to allow homeless people to become familiar with the nurses in a nonthreatening way. This is not dissimilar from one of the nurses working at Boston’s Pine Street Inn, who in turn echoed Wald when she said “overall, I consider myself organic with the environment—visible, neutral, and safe to approach. Sometimes that means fetching sandwiches or finding a pair of pants in the clothing room. Sometimes, it means ‘hanging out . . .’” (Ferguson, 1989).

Less common, and much more radical in Baker’s nursing model is the idea that political work is an essential component of street nursing: “If we do not link the urgent survival needs to adequate income, housing, food, etc., (street nursing) is a bandage, a part of the community’s problem.” (Baker, 1989, p. 1). Baker’s notion of the importance of political advocacy has gained support in the nursing literature. For example, what is called “activist primary care nursing” argues that nursing activism “promotes exposing, provoking and unbalancing the social power that maintains people in a state of disease” (Hagedorn, 1995, p. 2).

However, political analyses are unusual in most discussions of street nursing in the literature, and are often limited by the same naivete characterized by Wald, who believed that if nurses simply articulated social problems to political powers they would be remedied. An example can be found in a 1985 editorial in the *American Journal of Nursing*, which calls upon its readership to speak out (italics Mallison’s):

What if each of us wrote our own city council member or state legislator . . . describing what we’d seen that week? Describing the scabies that caused the impetigo that led to glomerulonephritis? . . . The debilitation of tuberculosis? The apathetic faces of anemic toddlers? . . . We could bear witness until what is already intolerable to the sick poor becomes intolerable to our local governments . . . We are *nurses*. We can decide that such human suffering in our midst *must* be relieved . . . (Mallison, 1985).

While poignant, I believe this exhortation is steeped in the politically unsophisticated notion that homelessness exists because of ignorance. Its suggestion that “bearing witness” until governments find

poverty intolerable frankly underestimates the tolerance for poverty exhibited by most governments. Despite more than a century of inefficacy, nurses working amidst poverty seem deeply wedded to this strategy of “bearing witness.”

What has been the outcome of such witnessing? Certainly in the almost 20 years I have been street nursing in Toronto, Canada, I have seen much more homelessness, poverty, illness, and poor access to health care as time goes on. How can one explain the continued belief that speaking out will bring about changes? Is it simple political naivete? It is a lack of knowing our history? Is it because, among political strategies, it involves minimal personal risk? Is it because middle-class professional nurses are imbued with a strong although fallacious belief in their own influence?

Political advocacy: Inquests and disaster relief

Fortunately, we have some examples of political nursing activities that combine “witnessing” with action. Strategies exploiting high-profile events like homeless deaths to create public debate on homelessness sometimes provide better outcomes. In 1996, three homeless men froze to death in Toronto, Canada. Homeless advocates including street nurses lobbied the provincial coroner for an inquest, which was held later that year (Sibbald, 1996). The inquest jury developed a series of recommendations to prevent further deaths including the since-implemented “wet hostel” for men, which provides safe shelter for chronically alcoholic older men (Sibbald, 1996). After three homeless men died from tuberculosis, which they contracted in Toronto’s shelter system in 2001, another inquest helped to focus attention on poor shelter conditions. Canadian West Coast street nurses in British Columbia fought courageously alongside other advocates for a much-needed safer injection site on the lower east side of Vancouver (Gold, 2003). While improvements undoubtedly resulted from all of these efforts, most are limited to making homelessness safer, not to eradicating homelessness.

One exception is the Toronto Disaster Relief Committee, a political organization dedicated to bringing about a national housing strategy in Canada, and co-founded in 1998 by a street nurse and a community worker (Toronto Disaster Relief Committee, 2006). Notably, political action is the focus perhaps because there is no expectation to provide nursing

care, a balancing act for most street nurses in which all too often the downstream service side outweighs the upstream advocacy side. It is this fundamental dichotomy that perhaps must be addressed if street nurses are to truly work for improved health for our clients. Discouragingly, many street nurses do not see a role for themselves in the political realm, even if they were given time to do this work. Many employers fail to recognize and value upstream advocacy. Street nurses must push health and social agencies, as well as government bodies, to respond to upstream health determinant issues, and must educate and support each other to work collectively on systemic issues.

Street Nursing in Canada in the 21st Century

Decades after the origins of street nursing in Canada, there are street nurses working in most major Canadian cities from Vancouver to Halifax, as well as British Columbia’s rural Interior (Self & Peters, 2005) and smaller cities such as Sudbury, Ontario. One could argue that the exponential growth of street nursing is actually a stark reflection of governments’ abject failure to address the exponential growth of poverty and homelessness across the country.

How far have we really come? Nightingale’s workhouses and Wald’s tenements sound unmistakably like modern-day shelters. Today’s street nurses are dealing with many of the same problems—infectious diseases, premature deaths. While looking back on our accomplishments, we must also acknowledge the perverse growth of a nursing specialty, which, in a country of Canada’s wealth, should not exist. We must guard against embracing strategies that do not address basic health determinants for low-income people, and reject those strategies that may, albeit inadvertently, result in little more than glorifying nurses who “tend the poor” such as media stories that make governments look progressive for funding street nurses in shelters while poverty continues to grow and poor people continue to die prematurely. While it is right to honor our historical nursing sisters with pride, let us be inspired by their passion but not perpetuate their biases and naivete. Let us reach out to vulnerable people who need help with their health problems, but let us also make “systematic efforts to alter destructive structures and systems” (Chalmers & Kristajanson, 1989, pp. 572–573) so that when some-

one writes the history of the next century of nursing, it does not sound as if nothing at all has changed.

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