A 20th Century Witch Hunt: A Feminist Critique of the Grange Royal Commission into Deaths at the Hospital for Sick Children

ELAINE BUCKLEY DAY

The witch hunts of the late fifteenth and early sixteenth centuries were the result of a concerted effort by the Church and the emerging medical profession to eliminate women as lay healers among the peasant population.
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Women’s knowledge and experience were deemed inauthentic and invalid, and thus attacked. As Barbara Ehrenreich and Deirdre English point out, “The real issue was control.”¹ In a similar vein, the 1983 Grange Royal Commission of Inquiry into deaths at the Hospital for Sick Children in Toronto can be labelled a witch hunt. Nurses became scapegoats for events that could not be easily explained, and their voices were considered inauthentic both because they were women and because they were nurses. This paper summarizes events leading to the creation of the Commission, provides evidence from Commission proceedings that demonstrates the differential treatment nurses endured, and offers several explanations for an event which has been perhaps justly characterized as “the highest priced, tax-supported sexual harassment exercise that we’ve ever witnessed.”²

Beginning in June 1980, thirty-two children died during a nine month period on the cardiology wards of the world famous Hospital for Sick Children. In the spring of 1980, the unit had been newly renovated, expanded and relocated from its former fifth floor location. It was divided into two sections, known as wards 4A and 4B, which shared a common nursing station. Each ward had its own head nurse and four teams of nurses. The members of the nursing teams worked twelve hour shifts, alternating between long day shifts (7:15 am to 7:45 pm) and long night shifts (7:15 pm to 7:45 am). A team consisted of a team leader who was a registered nurse, at least one but usually two registered nurses, and one or two registered nursing assistants. Each team worked on either ward 4A or 4B, although they did help each other out in emergency situations, when wards were short-staffed, and they shared meal and coffee breaks.

The sudden death of an infant on the last day of June 1980 was followed by the deaths of five children in the following month. Consequently, by early August the nurses who worked on the team on which the majority of deaths were occurring approached their head nurse, the clinical nurse specialist and some of the doctors to seek answers to explain the increasing death rate. Registered nurses Susan Nelles and Phyllis Trayner of ward 4A addressed their concerns to clinical specialist Carol Browne. Browne discussed the death rate with 4A head nurse Liz Radojewski and 4B head nurse Mary
Costello. By the end of July, cardiology fellow Dr. Carlos Contreras and cardiologist-pathologist Dr. Robert Freedom had held discussions with the nursing staff concerning the deaths. In addition, Chief cardiologist, Dr. Richard Rowe, had assured Mary Costello that the children were dying as a result of their anatomical conditions. The majority of deaths were occurring on the night shift, and nursing supervisors on duty during that period also spoke to surgical staff concerning the terminal events. After hearing from the nursing staff and nursing administration, Dr. Rowe organized two “Mortality and Morbidity” Conferences, the first of which was held September 5, 1980. A proposal was made to establish an intermediate intensive care unit on wards 4A and B, a kind of “stepdown” unit for patients discharged from the main Intensive Care Unit, but who were in need of additional care prior to being admitted to the ward. No action resulted from this suggestion. A second conference was held on September 26 and despite the nurses’ forebodings, the doctors once again reasserted their position that children were dying as a result of their clinical conditions. By January 1981, the number of deaths had reached twenty-two, and the Director of Cardiovascular Surgery, Dr. George Trusler, informed Dr. Rowe by letter of his concerns regarding the high numbers of children who survived surgery and subsequently died on the ward. Accordingly a third conference was held, which resulted in five possible theories being offered to explain the deaths. These may be summarized as follows:

(1) The phenomenon known as clustering was occurring. This is an unexplained cyclical pattern of deaths according to the type of heart malformation present. During a certain period a particular condition is seen frequently, and then is not seen again, for several months. Some of the doctors believed this explained the increasing death rate and its sudden occurrence.

(2) Due to the expansion of wards 4A and B, which replaced the smaller former cardiology ward 5A, an increased number of sick infants would result statistically in an increased number of deaths.

(3) The number of infants undergoing surgery was increasing. Thus the surgical risk was higher because the procedures
were newer, and therefore the statistical probability of death was higher.

(4) A higher number of very ill children were being referred from Western Canada, especially from Winnipeg, whose children's hospital had lost its cardiac surgeon. (In fact, only one child of the twenty under review was from Winnipeg.)

(5) Some suggestion was made that there was a shortage of nursing staff at night, which might account for the death rate, although no actual shortage could be established.\(^5\)

An alarming number of issues were not discussed at this meeting, which, had they been raised, might have substantially altered the course of future events. No examination was made of the fact that the deaths were occurring at night. There were no representatives at the review session from the Departments of Pharmacology, Epidemiology or Pathology. No toxicological results were reviewed. It was not until after this meeting when the minutes were distributed, that the Chief of Pediatrics, Dr. David Carver, or any of the Hospital administration became aware of the problems existing on ward 4A.

Ironically, the day before the committee met, eighteen week old Janice Estrella died on the cardiology wards. Through a sequence of events still not clear today, Estrella became the first patient upon whom a post mortem test for digoxin was carried out. Digoxin is a drug prescribed routinely for patients of all ages with a variety of cardiac disorders but chiefly congestive heart failure. It acts by slowing down the heart rate, thus improving circulation. If the heart beat slows dramatically, or slows to the point of not beating at all, the patient will die. Altering the dosage even slightly may have lethal consequences, and therefore policy at the Hospital for Sick Children required two nurses to check the patient's heartbeat. If the rate is too low the medication is withheld. The drug may be given by mouth (to young children and infants in syrup form, to older children by tablets) and this is the most common method of administration. If the patient is unable to take nourishment by mouth or is receiving medication by intravenous line, it will serve as the method of administration. A nurse may not administer digoxin by the intravenous line. Digoxin is rarely given by injection into the muscle as it is quite painful.
Dr. Glen Taylor, the resident doctor who performed the autopsy on Estrella, was performing his first such procedure at the Hospital, and forgot to obtain the digoxin level as was requested of him. Thus he had to return to the morgue with a fellow pathologist, re-open the autopsy incision and obtain the required specimens. One sample was taken from the stomach cavity and a second specimen was produced from an artery in the infant’s leg, the blood being squeezed or “milked” by the application of pressure to the leg muscle. The results recorded later that day indicated a level of 72 nanograms per millilitre, nearly thirty times that of an acceptable therapeutic level (a nanogram is a billionth of a gram). The level was so outrageously high that it was attributed to an error in calculation, a laboratory error or a result of the fact the specimen from the stomach cavity was contaminated with fecal matter. The pathologist, Dr. Freedom, believed that the specimen was contaminated and ordered the level rechecked, but this was never done. The level was thought to be an error, and thus no follow up took place.

During the month of March 1981, the wards experienced ten sudden deaths. The death of twenty-five day old Kevin Pacsai on March 12 profoundly changed the course of events within the Hospital, and resulted in the commencement of investigations from outside the Hospital. Pacsai had a structurally normal heart, and was diagnosed as having a malfunction of his conduction system (which controls the heart’s electrical impulses). He was in stable condition when his nurse, Susan Nelles (who normally worked on ward 4A but was relieving on ward 4B that night) left his bedside to assist in the resuscitation effort of another patient. Following that unsuccessful attempt, Nelles returned to Pacsai and found that his condition had deteriorated. She made several unsuccessful attempts to persuade the resident doctor on call and a cardiac specialist of the seriousness of the patient’s condition. Finally the chief pediatric resident, Dr. Colm Costigan, was summoned, whereupon the infant was immediately transferred to the Intensive Care Unit. He died later that morning, and post mortem blood digoxin tests revealed levels six times the normal limit. Dr. Costigan suspected digoxin poisoning and informed his supervisors, Dr. Carver and senior cardiologist Dr. Rodney Fowler of his suspicions. Coroner Dr. Paul Tepperman was
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notified of the elevated digoxin levels after their discovery at the autopsy. Then by coincidence, on March 20, the pathologist who performed the Pacsai autopsy communicated his elevated digoxin level findings to the Estrella pathologist, who recalled similar findings the previous January. Accordingly the Estrella pathologist informed Dr. Tepperman of his earlier findings, a link was established and the next day the police investigation began.

The same day the coroner was notified of the deaths of Pacsai and Estrella, three-and-a-half month old Justin Cook was admitted via the emergency department from Owen Sound. He was born with his heart on the right side of his body, and following cardiac catheterization, was scheduled for emergency surgery on Sunday, March 22. The scheduling of surgery on a Sunday indicates the serious nature of Cook's illness. Following his catheterization, Cook experienced several blue spells, one of which was nearly fatal. He was given medication to control his blue spells, maintained on oxygen and placed under constant nursing care. His condition stabilized for approximately nine hours whereupon he suffered cardiac arrest. Resuscitation efforts were unsuccessful. Cook was not prescribed digoxin and in fact his condition would have contraindicated its use. However, blood samples taken after death revealed the presence of high levels of digoxin. That evening (Sunday, March 22) the nursing team led by Phyllis Trayner was relieved of duty, being informed by their head nurse that the Hospital administration was reacting to the stress they had been under. The ward nurses were not aware of the police presence in the hospital nor of the police suspicion that digoxin was responsible for the deaths.

Three days later, one of the registered nurses on the Trayner team, Susan Nelles, was arrested and charged with the murder of Justin Cook. Although they had no motive and no additional evidence, forty-eight hours later the police charged Nelles with the additional murders of Kevin Pacsai, Janice Estrella and Allana Miller. The date set for the preliminary inquiry was October, but the Crown asked for and was granted a delay until January 1982, chiefly because of the difficulties with the testing of digoxin and digoxin results. Prior to the Grange Inquiry, knowledge about the drug and its effects on the body after death, about the methods available to test for
its presence, and about the interpretation of test results was minimal. It has been asserted that more was learned about digoxin in the three-year period culminating in Mr. Justice Grange's report than in the previous three-hundred years of its use in the treatment of heart disease.

It is necessary to discuss several facts concerning digoxin testing before addressing the question of the treatment of nurses, as the lack of knowledge in the area played a significant role in the Commission proceedings and in the dismissal of the voice of nurses. It is difficult to measure the quantities of digoxin present in the blood because the levels are not normally high. During the course of digoxin therapy, the level of medication present in the body may be determined by testing blood samples. At autopsy, levels may be determined only by blood or tissue samples. Testing for digoxin levels in the blood of patients at the Hospital for Sick Children began in 1975. Although there may be slight variations, the normal, therapeutic level in blood specimens is between two to three nanograms per millilitre (ng/ml). A reading above 3.5 ng/ml would indicate possible toxicity or overdose.

During the epidemic period of deaths on wards 4A and 4B digoxin tests were not among those routinely ordered by a physician. As noted, the first test for a digoxin level done at autopsy was that performed on Janice Estrella. Testing during the review period was done by a procedure known as radioimmunoassay (RIA). The patient's blood is combined with animal antibodies to detect digoxin. Difficulties arise because the blood may contain substances which are structurally similar to digoxin, thus producing digoxin level readings higher than they possibly are. Three other methods of testing existed but the RIA method of testing was the only one used by the Hospital during the period of the deaths. In addition, the Hospital had only carried out post mortem blood levels on four infants—Cook, Miller, Estrella and Pacsai—and when the police decided to widen their investigation, the lack of diagnostic analysis became a serious liability. Consequently the Hospital and the police turned to the Centre for Forensic Sciences for assistance. So little was known about digoxin testing that the Centre's Chief of Toxicology, George Cimbura, at first refused the Hospital's request. Cimbura, in fact, had himself never done a digoxin test when he was asked to perform tests on blood
and tissue samples from the body of Justin Cook. It was due to the fact Cimbura needed extra time to devise procedures to test for the presence of digoxin in the blood and tissues that Nelles' preliminary inquiry was postponed. Cimbura had to invent a test to measure digoxin levels in tissue samples.

Even then problems existed. For many of the infants, samples of blood or tissue were non-existent since their deaths occurred before any suspicions had been aroused. In preserved tissue specimens, the preserving solution aided in digoxin breakdown and made results inaccurate. For exhumed tissue samples, from bodies which had been embalmed, Cimbura could not say in what quantities digoxin was present. Thus before Nelles' preliminary inquiry ever began, much controversy surrounded the scientific evidence.

The preliminary inquiry commenced on January 11, 1982, presided over by Judge David Vanek. On May 21, Susan Nelles was discharged, the Judge ruling that there was insufficient evidence to bind her over for trial. In his eighty-three page judgement, Vanek concluded that the police evidence against Nelles was entirely circumstantial, there was no motive, she was not on duty for the deaths of Janice Estrella and Stephanie Lombardo, and that she was an excellent nurse with an excellent reputation among her peers.

With the release of Nelles, public pressure grew, particularly from the parents of the deceased children. The Ontario government initially responded by appointing a review committee chaired by Mr. Justice Charles Dubin to look into procedures and practices at the Hospital. The Dubin Report was completed in January 1983 and made ninety-eight recommendations for changes within the Hospital, many of which have since been implemented. However, probing the deaths was not in its mandate, and thus the report provided no answers for the parents or public. At the same time as the Dubin review was taking place, the Hospital instituted its own investigation into the infant deaths. The former Chief of Pediatrics, Dr. Harry Bain, prepared a study on the causes of death during the epidemic period. "I was unable to attribute death to other than natural causes in 34 of 36 patients," concluded Bain. The two exceptions were Jordan Hines, who Bain believed died of Sudden Infant Death Syndrome (SIDS), commonly known as "crib death", and Kevin Pacsai who he believed died
of transient adrenal insufficiency, a controversial diagnosis as the condition is quite rare and may be undetectable at autopsy. It was Dr. Bain's opinion that Justin Cook might have received a dose of digoxin but he was not sure the medication caused the death, and moreover he believed the digoxin level test results to be unreliable.

Dr. Bain and several other Hospital doctors then requested the Centre for Disease Control in Atlanta to undertake an investigation into the deaths, which the Centre began in the fall of 1982. The Atlanta group's findings were reviewed at the Hospital's invitation by Dr. R.B. Haynes of McMaster University, who was critical of the American team's methodology but did agree that a significant increase of deaths had occurred between July 1980 and March 1981. The Haynes Report concluded that the question was not whether there was an unusual increase in mortality, but what was the cause of that increase. The provincial Attorney General, Roy McMurtry, withheld the Atlanta Report from the public and even from the Hospital for several months, claiming it would hamper the ongoing police investigation. The public and members of the legislative opposition continued to apply pressure to the government to provide answers, which three major studies and a preliminary inquiry by now had failed to do. Finally on April 21, 1983, McMurtry announced that a two phase Royal Commission of Inquiry under Mr. Justice Samuel Grange would re-examine the baby deaths. Phase one would determine "how and by what means the children on wards 4A and 4B came to their deaths", while phase two would examine the conduct and actions of the police relating to the arrest of Susan Nelles.

The Grange Inquiry commenced on May 31, 1983, in Toronto and lasted one hundred and ninety-one days at an estimated cost of three million dollars. The proceedings began by hearing testimony from doctors who presented evidence in the capacity of expert witnesses. This was the manner in which their credentials were submitted before the Inquiry, and the spirit in which they were questioned. The nurses were called as witnesses because some of them had been present when infant deaths occurred, not because they were regarded as having any expertise. On the opening day of the proceedings the Commission Counsel, Paul Lamek, justified this position:
My present inclination, Mr. Commissioner, is not to call any of the nurses, nursing assistants and so on. Their evidence was taken at the Preliminary Inquiry in the Nelles case. Many of them, and I certainly mean no criticism of any, but many of them frankly had little to say that was helpful in unravelling the mystery. They will all be re-interviewed by the Commission's staff to the extent they're available and if any of them has anything relevant to say, we will certainly hear evidence. I do intend, however, to call any doctor, registered nurse, registered nursing assistant, ward clerk or anyone else present on the wards at or shortly preceding the time of the significant number of deaths.  

Media coverage of the Commission did not focus on the testimony of the doctors. Cable television only began broadcasting live daily when Susan Nelles began to testify. As a result the public did not see and hear the doctors' testimony. At least six of the nurses who testified during the Grange proceedings reported that they were approached by strangers who recognized them as a result of their television exposure and asked them when doctors could be expected to testify. This left the public with many false impressions. First, it confirmed the popular view that doctors are "scientific experts" whose knowledge would be too difficult for the average person to understand. Secondly, testimony such as that of the clinical pharmacologist, Dr. Stephen Spielberg, as to the possibility of medication error received little attention, as did the disagreement among the "experts" as to causes of death, flaws in testing methods used to detect the presence of digoxin, and the fact that it was the nurses who first began to raise questions concerning the increasing number of deaths.

One of the chief factors responsible for nurses becoming scapegoats during the Inquiry lay with the police investigation. Staff Sergeant Jack Press and his partner, Sergeant Tony Warr of the Metropolitan Toronto Police Homicide Squad were called to the Hospital on Saturday, March 21, 1981. At that time they met with coroners Dr. Paul Tepperman and Dr. Peter King, Hospital doctors Rowe, Fowler and Carver, and two members of the Hospital Administration. No members of the nursing staff were present. The police were informed of the deaths of Janice Estrella and Kevin Pacsai, and of the presence of an elevated digoxin level in Baby Estrella. They were also told that the Hospital had undertaken what Dr. Rowe referred
Staff Sergeant Press was the first of the investigating officers involved to make a hasty yet confident judgement that the babies' deaths were the result of murder. He later admitted that he had come to this conclusion a mere thirty minutes after being on the case. Moreover, prior to this meeting he had never heard of digoxin, and had never had any dealings with hospital cardiology departments. Secondly, the police mistakenly believed that wards 4A and 4B were separate entities and that there would be no contact between personnel of the two units. This misunderstanding followed a tour of the cardiology wards given to Sergeant Warr by the Senior Cardiologist, Dr. Rodney Fowler. Warr reported his observations to Sergeant Press who summarized the police perception of the ward structure in this way:

I remember a particular something that was quoted to me, a phrase that Dr. Fowler used, he said the wards were a mirror image of each other. I understood it to be two different separate entities, the only thing that was common to them was the nursing station where the ladies [sic] would have their coffee and the records were kept, but beyond that they were two separate wards and they had separate drug cabinets... These wards were totally independent of each other.14

Asked by Commission Counsel Paul Lamek whether he considered the possibility that nurses from one ward might, during the course of a shift, visit the opposite ward for any number of reasons from friendship to curiosity, the officer replied: "I didn't have that impression at all. If I had that impression I would have wondered why they had two separate wards instead of one complete."15 It was not until the preliminary inquiry that Staff Sergeant Press realized that nurses moved freely between the wards, visiting, helping each other with patient care, consulting with one another, sharing meal breaks.

Initial inquiries concerning the functioning of nursing teams were not directed to any nurses but rather to Dr. Colm Costigan, the chief pediatric resident. This is but one of the numerous examples of the way in which the police investigation treated all of the nurses' knowledge as irrelevant and
inconsequential. How easy it would have been to ask a nurse what nurses do!

Believing they were dealing with murder, the police needed a suspect. Further, believing that the wards were separate entities, a suspect who could be placed on both wards during nights when deaths occurred would strengthen their conviction in that suspect's guilt. It was these two false assumptions and misunderstandings of charting procedure which convinced Press that Justin Cook had been murdered by a deliberate overdose of digoxin, and that Susan Nelles was the murderer because she was the nurse assigned to care him. The police believed at first that "constant" care meant Nelles never left Cook's bedside. Then they realized that other nurses might relieve Nelles, the officers mistakenly assumed that a written indication of such an action would be noted on the patient's medical chart.

Sergeant Press operated by a principle he referred to as the "Benz Axiom". "This is something I learned a long time ago at a homicide seminar. There was a professor up from the States and he said, 'Think dirty and 90 per cent of the time you will be right' and normally that is the way we will think," testified Press. It never occurred to Sergeant Press, chiefly because of his ideological conditioning as a member of the Homicide Squad, that he could be dealing with anything other than murder. This basic preconception governed all his future actions and accordingly, events during the Commission itself. He maintained throughout the investigation and the Inquiry that he believed Susan Nelles had murdered Justin Cook. Moreover, "I (also) felt she was responsible for the other three deaths [Pacsai, Miller, Estrella] ... (that was) a strong belief. That is something we learn early in our police training. It is a set of facts and circumstances that would lead a person of ordinary care and judgement to have a strong belief." Another factor which convinced the police of Nelles' guilt was her presence on ward 4B the night of Kevin Pacsai's death. The police appear to have interpreted what they considered to be an inability to follow orders as suggestive of incrimination. Press concluded that Nelles' behavior was somewhat deviant.

I don't really know what goes through somebody's mind when they are murdering babies. I guess I am a died-in-the-wool policeman
and over the years I have to work by routine, I have to do certain things. If somebody tells me to work in a particular area, I work in a particular area, because if I am found out of that area somebody will want to know why.¹⁸ (emphasis added)

Prior to Nelles' arrest, the homicide officers interviewed pediatric nurse specialist, Carol Browne, who knew members of the Trayner team quite well. She told the police that Nelles was an excellent nurse; she had only positive statements to make concerning Nelles. The police, however, destroyed the notes of that interview. When asked to explain this, Press answered, "...the notes were made in point form and I can recall that Warr was sitting there and he was doing what he usually does, when we are listening to something that is not of very great importance, he was scribbling."¹⁹ (emphasis added) The police also interviewed team leader, Phyllis Trayner, and their description of the encounter demonstrates several of the criteria used to determine guilt or innocence. The officer who spoke to Trayner reported "she was acting as an innocent person. She was crying and upset."²⁰ Nelles, however, did not cry. She believed the officers were from the Coroner's office and had come to interview her concerning a possible inquest into the death of Kevin Pacsai. Consequently when they informed her, 'Justin Cook died of an overdose of digoxin, a drug he wasn't supposed to have. We believe you gave him that drug and we'd like to know why,"²¹ Nelles replied she would like to speak to a lawyer. It was at this point that Press decided to arrest her.

I had that very strong belief when I was there and I did not waver from that for a second. The fact that she did not protest, tell me about her innocence in this matter just supported my belief.²²

It strengthened my belief that she was the person responsible because I believed that an innocent person would cry to the heavens and say, 'I didn't do it' or something of that nature.²³

The police had put Nelles in a classic double bind situation, by cautioning her that she did not have to say anything while taking her silence to be additional evidence of her guilt.

Police also displayed their insensitivity and disrespect towards nurses by their interviewing procedures. Police arrived
unannounced while nurses were on duty and expected immediate response to the specific questions they asked. Nursing supervisor, Lynn Johnstone, after finishing a night shift, was asked specific questions regarding Justin Cook. She was offered no copy of the patient's medical record, which might have assisted her in answering police questions. She was not asked about constant nursing care, team nursing, nor how nurses were relieved for meal and coffee breaks. She was asked no questions about any nurse other than Nelles, and no doctors were mentioned. Johnstone informed police she did not believe Nelles was guilty; however, a subsequent transcript of the interview did not contain that statement. Kathleen Coulson, also a night nursing supervisor, told Sergeant Warr that Nelles could not have committed the alleged murders because she was not on duty when some of the deaths occurred. The police notes of the interview made no mention of her reference to Nelles' absence from duty. Bertha Bell was questioned by police while she was on duty caring for three infant patients in a room of six young children which required a nurse to be present at all times. She was taken away from her nursing responsibilities and presented with forty patient charts and asked "what she could recall." She was not asked specific questions about specific patients or specific medications.

The police were not the only ones who appeared to be convinced that they were dealing with a case of murder. After six months of hearings, Mr. Justice Grange could still respond to a submission by Nelles' attorney, John Sopinka with: "Well, it would certainly be difficult because you can't have a murder without a murderer, that's the problem. It is something that faces me." Sopinka pointed out to the Commissioner: "Nor should you determine, with respect, whether it is murder because to say it is murder you have come to a conclusion of law as well as fact." Lawyers also presupposed that they were dealing with murder. Douglas Hunt, counsel for the Attorney General, made the statement to Phyllis Trayner that every time she was there a baby died (implying she murdered it), or every time someone was "killing a baby", she was also there (implying she knew, or was working with, the "murderer"). Earlier Liz Radojewski was confronted with: "now carrying on with this
I have been living with this thing for three years," to which Paul Lamek replied, "It is entirely understandable, it is difficult to isolate exactly what you knew at one particular time in light of what you have learned since."

Doctors were not chastised in the same manner that nurses were for not detecting a pattern as ward deaths continued to escalate. Because of concerns raised by the nurses, the doctors were aware by July an assumption that it was a nurse who administered an overdose of digoxin to the children."29

The Commission proceedings demonstrated the extent of the differential treatment of nurses from doctors by attorneys and the Commissioner. Nurses were repeatedly asked personal questions, which doctors were not. Bertha Bell was asked how often she went out socially with Susan Nelles and Phyllis Trayner, whether their husbands (Bell's and Trayner's) accompanied them, and whether she had ever been to Belleville (Nelles' hometown). Registered nursing assistant, Janet Brownless, was asked whether she socialized more with Phyllis Trayner or with Susan Nelles, and if she had any reason to prefer one to the other. Sui Scott was asked, "Did you go to Phyllis Trayner's wedding? Were you invited?" "Did you prefer Susan Nelles to Phyllis Trayner?"30

Nurses were intimidated by frequent interruptions while attempting to answer hostile questions. "Oh ma'am is that the answer you want us to accept. . . ." and subsequently, "Mr. Commissioner, might it be a useful time to have our mid-morning break and then Miss Kiteley (counsel for the Registered Nurses Association of Ontario) may be able to help the witness answer the questions properly?" At one stage even Mr. Justice Grange was finally moved to comment on lawyer Barry Percival's constant badgering of witnesses, "If I could just ask you, perhaps, to pause an instant before you go at her."31

No doctors were asked to undergo the methods suggested to nursing staff in order to illuminate the events which had occurred three years previously. Lynn Johnstone was asked by police if she would undergo hypnosis; Susan Nelles was asked to submit to a lie detector test; and attorney Douglas Hunt asked Phyllis Trayner whether she would be willing to take sodium amytal (truth serum). Yet when Staff Sergeant Press testified, he began by indicating, "I might as well tell you right now, I am going to have problems with remembering, because I have been living with this thing for three years," to which Paul Lamek replied, "It is entirely understandable, it is difficult to isolate exactly what you knew at one particular time in light of what you have learned since."33 Doctors were not chastised in the same manner that nurses were for not detecting a pattern as ward deaths continued to escalate. Because of concerns raised by the nurses, the doctors were aware by July an.
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August that the death rate was increasing. The doctors attributed this to the patients' physiological conditions. No physician was subjected to the condescending level of questioning that members of the Trayner nursing team were. Douglas Hunt made this statement to Susan Nelles: “I don't mean to be discourteous but I think the evidence has shown that you are not a shrinking violet when it comes to expressing your opinion and views and given...what happened to you...my question is why at that time were you not screaming at somebody to get in there and find out what was going on.”34 No doctor was confronted with statements such as “you are not a shrinking violet”. Other counsel went further, as this exchange indicates: “Now is it a question that we should say you (Phyllis Trayner) and Miss Nelles, ... WERE STUPID. You were not as clever as all these other witnesses who apparently recognized the pattern long before you did.”35 Barry Percival, moreover, encouraged the misperception that the infant deaths were somehow the nurses’ fault when he provided his definition of the nursing role: “and they must effectively and successfully give good nursing care so that those babies will survive while in the Hospital, to the best of the nursing team's ability...so they will leave the Hospital alive.”36 Does the doctor not play some role in ensuring the child's survival? If a child dies in hospital, does that imply the contributing factor was inevitably inadequate nursing care?

Although nurses were accused of not recognizing the existence of a pattern early and thus, in the view of several counsel, preventing certain deaths, no doctor or any member of the Hospital administration raised any concerns of the type nurses were expected to have had regarding a pattern of deaths, and similarly no accusations were made against them for their “stupidity” or “lack of cleverness”. No doctor was asked the question put to the 4A team leader, “On your oath to God, Mrs. Trayner, did you kill any of those babies?”37

Why were women, especially nurses, treated differently from doctors throughout the Commission proceedings? The argument presented here is that this treatment bolsters and sustains male dominance through the suppression of women's knowledge. By not listening to nurses, the Commission did more than dismiss their evidence. It defined a particular view of reason and expertise. Armed with these definitions and the
power to make them hegemonic throughout the hearings, it proceeded to attack women not as knowledgeable participants in events but as potential purveyors of evil acts. Seen in this light, the Commission was indeed a witch hunt.

Viewed in historical context, the history of healing documents the subordination of women to men as healers. This subordination is based on both gender and class. Feminist scholars Barbara Ehrenreich and Deirdre English have traced the long history of women as healers. By the nineteenth century, men had successfully appropriated the “curing” function, leaving women the “caring” role. The emergence of secular nursing in Britain in the nineteenth century took on a class dimension which further subordinated it to medicine. Women of the lower classes were forced by economic necessity to seek what limited wage work was available to them. The dominant ideology effectively barred middle and upper class women from medicine, but at the same time allowed women of the working class to practice nursing. The typical nurse was portrayed by Charles Dickens (e.g., Sairey Gamp and Betsy Prigg) as a sloppy, careless and babbling old woman.

It was this image which Florence Nightingale sought to reform. Nightingale’s influence on nursing cannot be overestimated, as she advanced nursing practice yet simultaneously perpetuated its subordination to medicine. On the one hand, she transformed the popular image of nursing. She lobbied tirelessly, wrote endless reports, and established guidelines for nursing education which remain the core of much nursing practice today. Unfortunately, some of Nightingale’s actions had lasting and detrimental effects on nursing in its struggle to achieve recognition as an independent profession. Her staunch insistence that the nurses during the Crimean War not undertake even the most basic patient care without a physician’s order aided in defining the nurse’s role as subordinate in all areas of health care, including nursing care.

Medicine achieved professional status by creating a white, male, middle class monopoly, and established a division of labour in which women as nurses were and continue to be subordinate. The close association between medicine and the ideology of a male-dominated society has had many crippling effects on nursing. The sexual division of labour, which is socially determined, is justified by the belief that it is a natural
division. Journals published at the turn of the century provide examples of this belief. "The best nurse is that woman whose maternal instincts are well developed...The connection between mothering and nursing is very close." That nursing should be so closely allied with mothering reinforces an ideology which portrays its most central relationships as mirror images of the nuclear family. The sexual division of labour has reinforced the nurses' subordination to doctors within the health care system, by virtue of doctors' exclusive control over diagnosing and determining what constitutes illness. Nursing cannot take place until after some intervention by a physician has occurred.

The subordination of the profession of nursing and nurses themselves can be seen by the pervasive stereotypes that exist. Janet Muff has outlined six of these as follows:

(a) The nurse as Angel of Mercy—Florence Nightingale (the lady with the lamp) is the prototype: putting others first, being dedicated.

(b) The nurse as Handmaiden to the doctor—The nursing role is an extension of the woman's role within the family; she becomes a surrogate wife to the physician and surrogate mother to the patient.

(c) The nurse as the woman in white—Particularly in the media, the nurse is the woman in virginal white, typifying virtue, cleanliness and purity.

(d) The nurse as Sex-Symbol—Based on the male myth of the woman as seducer and temptress, this portrays the nurse as a woman with loose morals.

(e) The nurse as Old Maid or Battle Axe—The nurse is seen as the bitch—the Nurse Ratched of movie fame.

(f) The nurse as Torturer—In pornographic publications (and even on greeting cards) nurses are depicted as people who inflict pain and suffering on helpless victims.

These images have been perpetuated by novels, children's books, television and films. The stereotypes are reinforced until they become unquestioned assumptions, and ultimately an integral part of the mass culture of the society.

The dominance of medicine over nursing implies that male doctors are seen as having more expertise than female nurses.
One of the basic reasons for the differential treatment that women received throughout Commission proceedings is their lack of social recognition as "rightful knowers". Genevieve Lloyd has established the equation of knowledge and reason with "male" since the time of Plato. She argues that the "maleness of the Man of Reason...lies deep in our philosophical tradition" and that in our quest for rational knowledge, male characteristics have been associated "with a clear, determined mode of thought, femaleness with the vague and indeterminate." Sandra Harding has described what she terms the difference in the distribution of rationality in the following way:

From antiquity to the present day, women have been claimed less capable of abstract and systematic thought than men, less capable of developing a mature sense of justice than men, more ruled by the emotions, the passions and the appetites than men, and more inclined toward subjective assessments and less toward objective ones than men...a lesser, immature, or defective rationality consistently has been attributed to women.

Biological arguments have been used in the past to deny women access to knowledge by preventing them from obtaining higher education. It was even alleged in the nineteenth century that brain work would lead to a generation of women incapable of bearing children. Thus, due to the opposition to training nurses encountered by Florence Nightingale, and the opposition to women as "knowers", nurses have had a double obstacle to overcome.

During the Grange inquiry the knowledge possessed by nurses was discounted, deemed irrelevant, or simply ignored. Even before the inquiry, the dismissal of nursing knowledge was illustrated by the fact that nobody listened seriously to the nurses' warnings that something was wrong on the cardiology wards. During the inquiry, the way the opinions of nurses were regarded was demonstrated most clearly in a response by Dr. Rowe to a question by Hospital counsel, Ian Scott. Asked "Who would you want to talk to, to find out about a baby who died, its condition prior to death?" Dr. Rowe replied, "Well you would want to talk to both the pediatric resident, the general pediatric resident who is the sort of first line physician, the Cardiology fellow and the associate resident
who would be the member of the team that came to do the pa resuscitation.”44 There was no mention of asking a nurse, the person who would have spent the most time with the patient.

Nurses were assumed to have no knowledge even concerning their own jobs. Barry Percival asked Susan Nelles if she was “aware of the rules of the Hospital with respect to constant nursing care, what you were supposed to do and what you were not supposed to do?”45 No doctor was asked, “Were you aware of what you, as a cardiologist, were supposed to do and what you were not supposed to do?” The discounting of nurses as women who possessed knowledge was a crucial factor in Commission proceedings insofar as many of Mr. Justice Grange’s final decisions were based on the testimony of expert witnesses, and nurses were not considered experts.

The doctors who testified as “expert” witnesses had varying theories to explain the increased mortality rates. These theories ranged from death due to the patients’ underlying cardiac conditions, to the possibility of digoxin intoxication. Biochemist Dr. Steven Soldin informed the Commission that he had detected a material produced in the body known as substance X, which is present in all humans. The substance is excreted in the urine; however, in infants with underdeveloped or impaired renal systems, or those who are suffering from congestive heart failure, the amount of substance X in their blood will increase. Thus a child who has never had digoxin may test positive for the presence of digoxin in their system under the RIA method of testing, which was the method employed at the Hospital. Therefore, according to Dr. Soldin, the high ante mortem digoxin levels may not necessarily have been indicative of digoxin poisoning.46 Clinical pharmacologist Dr. Stephen Spielberg attributed the deaths to medication error. In the case of Allana Miller, Spielberg pointed out that she received the diuretic lasix and five minutes later her heart stopped. Thus he concluded she was the victim of a medication error, she received digoxin instead of lasix. Other patients to die from medication error included babies Inwood, Pacsai, Cook, Miller, Hines, Belanger, Estrella and Lombardo, according to the pharmacologist’s theory.47 Many such conflicting theories were put forth.
Noticeably lacking was the voice of nurse expert witnesses. The Registered Nurse's Association of Ontario (RNAO) spent a great deal of time attempting to persuade Mr. Justice Grange and Commission counsel to allow a nurse expert to testify. Finally, on the last day of Phase One during which witnesses gave evidence, Dr. Marion McGee, Associate Dean of the Faculty of Health Sciences and Director of the School of Nursing at the University of Ottawa, testified on nursing procedure and related nursing matters. So little credence was given to Dr. McGee's testimony that the only attorneys who questioned her were those from the RNAO, counsel for the Hospital, and a lawyer for the Attorney General's department. In his final report, Mr. Justice Grange includes Dr. McGee under "other experts" and wrote, in his only mention of her in the entire document, "We also heard from Dr. Marion McGee, Associate Dean, Faculty of Health Sciences, Schools of Medicine, Nursing and Human Kinetics, University of Ottawa, who gave expert advice on nursing matters and procedures." McGee said at the conclusion of the proceedings that she was doubtful about Grange's ability to recognize the implications for nurses resulting from the Inquiry.

The dismissal of nurses' knowledge was facilitated by the fact that the Commission proceedings were rooted in the adversarial paradigm. Psychologist Carol Gilligan believes that the hierarchical, achievement oriented, universal abstract principles recognized by theorists as predominant human characteristics overlook "a different voice". She emphasizes that this voice has been associated with women but is in reality characterized not by gender but by theme. Gilligan concludes from her study that the morality associated primarily with women is based on responsibilities to oneself and others, an ethic of care. The contrasting morality is one based on abstract rights, property and law. It is based on concepts of equality and fairness, while the ethic of care "relies on the concept of equity, the recognition of differences in need." Equality may "fracture society and place on every person the burden of standing on their own two feet."

Gilligan suggests that women in societies based on the Western philosophical tradition are uncomfortable with a judicial system based on rights, hierarchy and adversarial behavior. "The adversary system of justice impedes not only the
supposed search for truth' but also the expression of concern for the person on the other side." Susan Sherwin has suggested that this is primarily due to the fact that the rights-based system is rooted in principles of abstraction and emphasizes individuality. In this system, people are analogous to isolated, autonomous atoms and need laws and moral principles to guide their actions. Sherwin argues that this system should be replaced by one which: "views co-operation and concern as normal, not an aberration... This would differ significantly from the approach which the dominant theories reflect where pure self interest and competition is defined normatively as 'rational'."

The dangers inherent in the adversarial paradigm have been examined by Janice Moulton. Firstly, all participants in an adversarial debate just share certain assumptions, and "for the sake of argument, premises which might otherwise be rejected must be accepted." Secondly, the adversarial method may restrict the scope of argument. It aids in determining which questions will be asked and which type of answers will be deemed most acceptable. It must be emphasized that the feminist critics of the adversarial paradigm, particularly Gilligan, do not suggest that only women are uncomfortable with this approach and prefer an ethics of care.

Scientist Ursula Franklin pursues a similar path when she describes the existence of two competing but incompatible value systems. One is organized hierarchically and emphasizes personal achievement; it equates rank and authority with competence, and the maximization of gain is its main strategy. The second value system is based on cooperation, is non-hierarchical and holds that the minimization of loss is more important than the maximization of gain. These value systems have led to different perceptions of certain problems, differing solutions to those problems, and different long-term ways to manage them. One of the key features of the second value system is its emphasis on context. This approach stresses that problems cannot be dealt with in isolation from the surroundings in which they occur. Secondly, in this system, experience is highly valued. This is completely at odds with Western philosophical heritage, which firmly believes that "mere" experience is inferior to knowledge. Franklin is thus led, like others, to argue for the replacement of the current order with a new
non-hierarchical social order stressing cooperation, and hence for change in our current institutional structures.

The Grange Commission proceedings illustrated how vastly different these two worldviews can be, and how, in our society, the paradigm which embraces the values of expert knowledge, masculinity and adversarial procedures does indeed dominate. It became blatantly obvious during the Commission hearings that male doctors were assumed to possess expert knowledge and nurses were assumed to have experience but no expertise. They were treated differently from men in the questions they were asked and in the assumptions that were made.

The methods used throughout the Commission proceedings significantly affected the results. Certain arguments were suppressed, particularly during the testimony of "expert" witnesses. Certain assumptions were shared by the chief participants, namely that murder had occurred and that the murderer was assuredly a nurse, in spite of the fact that no acceptable evidence for this assumption was produced. Because nurses were not seen as having "expertise" and not seen as full professionals, their work was deemed unimportant. The disadvantages of adversarial methods are even greater in the case of a Royal commission where witnesses have fewer rights and protections than they would in a court of law. Speculation, hearsay evidence, unfounded accusation and innuendo, which would be ruled out in a court, are frequently accepted in an inquiry, as they were here. The adversarial system impeded the search for truth by setting issues in dualistic terms. Mr. Justice Grange admitted as "a fellow trained in law" that he "intended to conduct it [the inquiry] as much like a court of law as I can. Judges are to take both sides and to say I accept one side of it and not the other."57 The destructiveness and detrimental effects of such thinking are evident in the manner in which nurses were treated during Commission proceedings, which one observer claimed "sometimes resembled a kangaroo court."58

The reasons for that treatment are rooted in capitalist patriarchy, "a sexual system of power in which the male possesses superior power and economic privilege. . . . The male hierarchical ordering of society.59" Theorists such as Gilligan, Lloyd and Harding have, as we have seen, documented historically and empirically the silencing of the voice of women.

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For Gilligan, moreover, this silencing is linked to the concept of women's different voice. Indeed, an increasing number of studies are providing evidence that women's ways of knowing are different. A new study co-authored by Mary Field Belenky builds on the work of Gilligan. Among the findings are that the "voice of reason first appears to men as 'separate knowing'...while many women achieve the different kind of objectivity represented by 'connected knowing' but even though this epistemological voice is valued in some areas, the dominant tendency is to think of it as a less rigorous, less objective, less rational mode of thought—in short...as feminized...A number of women in the study reported they lived...in 'the world of silence' in the past."

The Grange Commission ignored the different voice of women. Nurses were treated as non-knowers, ridiculed, accused and threatened. The hospital administration, the police, the lawyers and the Commissioner did not hear what nurses were telling them, and attempted to silence them. In so doing the truth was obstructed, and the Commission's results satisfied almost nobody, not the parents, not the public, not the police, not the attorney general's office, and least of all the nurses. Although there is some evidence that these proceedings have radicalized nurses to a certain degree, it is not inconceivable that such an event could take place again. Given the history of the suppression of women's knowledge and the attempts to define and confine women as non-knowers, the Commission events were almost predictable. Only one member of the Trayner team still works on the cardiology wards at this time. Some of them have left the profession altogether. The doctors' lives remain virtually unchanged. The lawyer for the Hospital, Ian Scott, is now the attorney general in the Ontario government. Former Attorney General, Roy McMurtry, is now Ontario's High Commissioner in London, England. Officers Jack Press and Tony Warr remain as detectives with the Metropolitan Toronto Homicide Squad. Bob McGee, who prosecuted Nelles in the preliminary inquiry, left the Crown Attorney's Office and began work as a criminal defence lawyer with a prestigious firm. The Assistant Crown Attorney at the time, Jerome Wiley, took over his former boss's job. The males emerged dominant and victorious again.
The words of Virginia Woolf, in her now classic work *A Room of One's Own*, written over sixty years ago, appear prophetic: "It is fatal for a woman to lay the least stress on any grievance; to plead even with justice any cause; in any way to speak consciously as a woman."62 The nursing staff at the Hospital for Sick Children learned the truth of those words in an agonizingly painful way.

Notes

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3. Committee meeting activities summarized from The Honourable Mr. Justice Charles L. Dubin, Chair, "Report of the Hospital for Sick Children Review Committee (January 1983), pp. 138-139.
4. A cardiac catheterization involves the introduction of a thin tube or catheter into a vein in the leg. The tube is manipulated through the circulatory system to the heart, a procedure which is observed by the cardiologist on an X-ray screen. Once in position, dye is injected through the tube in order to determine blood flow and heart function. There is risk involved in the procedure especially in very young children with small veins.


15. Ibid., p. 1093.

16. Ibid., p. 1053.


18. Phase 2, Volume 7, pp. 1424-1425.

19. Ibid., pp. 1405-1412.

20. Phase 2, Volume 6, p. 1281.


22. Phase 2, Volume 6, p. 1309.

23. Phase 2, Volume 7, p. 1507.


27. Exchange between John Sopinka and Mr. Justice Grange, Phase 1, Volume 44 (4 October 1983), pp. 9061-9062.


31. Barry Percival to Bertha Bell, Phase 1, Volume 101, pp. 2845 and 2880. Mr. Justice Grange, Ibid., p. 2879.


34. Phase 1, Volume 123 (4 April 1984), pp. 8437-8438, 8426.


38. Ehrenreich and English, Witches, Midwives and Nurses (see n. 1, above). Also: Barbara Ehrenreich and Dierdre English, For Her Own Good—150 Years of the Expert's Advice to Women (New York, 1979).


41. Janet Muff, “Handmaiden, battle ax, whore: An exploration into the fantasies, myths and stereotypes about nurses,” in ed., Janet Muff Socialization, Sexism and Stereotyping: Women's Issues in Nursing (St. Louis, 1982), p. 120. These are Muff's categories.


44. Phase 1, Volume 20 (17 August 1983), p. 3544.

45. Phase 1, Volume 126 (5 April 1984), p. 8644.

46. Phase 1, Volume 50 (17 October 1983), pp. 1355-1364.

47. Phase 1, Volume 54 (24 October 1983), pp. 2061-2162.


51. Ibid., pp. 164, 167.

52. Ibid., p. 135.


55. Gilligan, In A Different Voice, p. 2. (See n. 50, above.)


61. Sarah Spinks, Cardiac Arrest, chapter eighteen. (See n. 6, above.)