“A solider in the service of his country”:
Dr. William Rees, Professional Identity,
and the Toronto Temporary Asylum,
1819–1874

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The first medical superintendent of the Toronto Lunatic Asylum, physician Dr. William Rees, found his tenure from 1841 to 1845 marked by financial struggle, extensive administrative conflict, and physical injury. His personality along with these events have given rise to negative portrayals of Rees as an inept administrator. Less known are his social contributions beyond his asylum work. A more extensive assessment of Rees suggests the value of his biography as a study of Upper Canadian professional and class status. While Rees’s occupational endeavours before 1841 enhanced his status, negative experiences at the asylum changed this pattern and caused an ongoing decline in his social status after 1845.

Le mandat du premier directeur médical du Toronto Lunatic Asylum, le médecin William Rees, de 1841 à 1845, a été marqué par des difficultés financières, un important conflit administratif et une blessure corporelle. Ces événements ont eu pour effet de dépeindre Rees comme un administrateur inepte. Ses contributions sociales au-delà de son travail à l’asile sont moins connues. Un examen approfondi de Rees témoigne de la valeur de sa biographie en tant qu’étude du statut à l’égard des professions et des classes dans le Haut-Canada. Bien que les activités professionnelles antérieures à 1841 de Rees aient doré son blason, les difficultés de l’asile ont changé les choses et entraîné un déclin continu de son statut social après 1845.

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IN SEPTEMBER 1869, physician Dr. William Rees wrote a memorial to Governor General Lord Lisgar imploring the Canadian government to answer compensation requests he had made to the Province of Canada in the years prior to Confederation. Rees expressed his fear of “the humiliation of dying in debt” because of obligations to friends who had “made him advances in the expectation that the Government would soon grant him relief.”¹ In 1845, as medical superintendent of Toronto’s Temporary Lunatic Asylum, Rees had sustained injuries that left him unable to work. Dismissed from the asylum in consequence of his illness and other administrative conflicts, he continued to face deteriorating health. By the 1850s he was in debt and unable to do physically demanding work. The letter to Lisgar was the last in a long series of correspondence between Rees, medical colleagues, and government officials that unsuccessfully sought financial recompense for his troubled situation. Although at the time of the asylum’s opening in 1841 Rees had firmly established himself within Toronto’s professional social circles, by the 1860s he had little to show for his earlier success. Debt, physical frailty, and social isolation eradiated much of his social status as a professional, middle-class man.

William Rees’s social and financial position by 1869 stands in sharp contrast to historians’ portrayals of doctors’ occupational status in Canada. Most studies of nineteenth-century physicians have examined doctors from a group perspective, focusing on their ongoing struggles for authority over education, licensing, and professional associations.² While offering important insights, these studies portray professionalization as a largely progressive process whereby doctors’ status increased as they closed ranks and became self-regulated. Yet, as case studies of individual physicians have shown, professional achievement did not always move in a forward trajectory, nor was the associated social identity wholly stable.³

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Instead, the professional, social, and economic status of nineteenth-century physicians varied depending on the location of their practice, their field of medicine, whether or not they received remuneration for services, the presence of alternative sources of income, their health, and their specific working circumstances. By demonstrating the instability of nineteenth-century medical practice, these case studies have provided insight into doctors’ experience of social mobility. They also indicate that a man’s professional status developed within a broad cultural context, involving the political climate, the type of work he performed, his social activities, and his personal circumstances.

The relevance of socio-political context to the formation of professional identity has been recognized by R. D. Gidney and W. P. J. Millar through their conceptualization of the “professional gentleman.” Gidney and Millar argue that professional status required a man to have particular educational qualifications, social attributes, and behaviours aligned with middle-class values, requirements that shifted over time as cultural class expectations changed. Despite their choice of the masculine term “gentleman” to describe expectations of the nineteenth-century professional, Gidney and Millar do not address masculinity as a factor in the social element of professional status. This absence is striking given demonstrations by Cecilia Morgan, Joy Parr, and John Tosh of the influence of work on men’s gender identity and the relevance of marital and family status to their occupational and social positions. Rees’s experience of masculinity was central to his position as a “professional gentleman,” and his story suggests the importance of gender as a key element in determining professional identity and social status.

William Rees’s career in Canada from 1819 to 1874 reveals shifting trajectories of social status and professional identity over the course of his life. His upward social mobility during the 1820s and 1830s was a consequence of occupational pursuits, social activities, and friendships that enhanced his status as a gentleman professional. In 1840 Rees took

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charge of the Toronto Lunatic Asylum, formally becoming its medical superintendent the following year. The administrative conflicts he experienced there during his five-year tenure compromised the social identity he had established in the 1830s. Rees’s situation worsened in 1845 when he was injured by a patient; leaving him unable to work, the injury led to deteriorating health and increasing poverty that eroded his social status through the remainder of his life. Yet Rees’s circumstances were also complicated by Toronto’s and Ontario’s changing political atmosphere, his bachelorhood, and character traits that some colleagues perceived as unmanly. To this extent, political culture and gender expectations were also pivotal factors in his identity as a professional and as a man. While the doctor’s professional identity did not fully disappear as a result of his problems, he was less able to maintain the masculine attributes required of a nineteenth-century gentleman, demonstrating the precariousness of masculine professional status in colonial Upper Canada.

Little is known of William Rees’s life before his arrival in British North America. Born circa 1800 in Bristol, England, he studied medicine as an apprentice of Sir Astley Cooper, a prominent surgeon and anatomist at St. Thomas and Guy’s Hospital in London, before immigrating to Lower Canada in 1819. Although not as prestigious as a university medical degree, apprenticeship was a common means of entry into medicine during the early nineteenth century, and Rees’s education under Cooper gave him a solid foundation for future professional elevation. While it is unclear from his emigration at age 18 or 19 whether Rees had completed the apprenticeship before departing for British North America, his education was sufficient for him to become an immigration health officer at the port of Quebec after arriving in Lower Canada. He remained in this position until 1822, when he was commissioned to take medical charge of transport to England. Rees apparently made no attempt to become licensed in Lower Canada during this period; perhaps he wanted practical experience before doing so, or his immigration positions may have offered sufficient pay for a young, unmarried man. Whatever his reasons, Rees did not become licensed until January 1830 after moving to York, Upper Canada, and passing the Medical Board of Upper Canada’s (MBUC) licensing examinations. Upon receiving his medical licence, he purchased the practice of Dr. John Porter Daly, which he operated for the next decade.7

6 Historical sources about Rees to date have provided no information on his family background, and most have suggested he had no family in North America. Just prior to this article’s publication, however, I located a family genealogy website suggesting that he came to Canada from England with his parents and eight siblings. While this information has not been verified, the site clarifies certain aspects of Rees’s biography noted here. Website accessed April 15, 2010, from http://www.knology.net/~qed/R-G-Rees.htm (copyright Lew Zerfas, 2008).

Rees’s success at securing a medical licence was no small accomplishment, given the restrictions on medical practice during this period. Medical status in Upper Canada generally followed British patterns, and rankings within the profession were determined by a combination of education, licensing, government appointments, and practical experience. “MD” physicians with medical degrees from universities within the British Empire had the highest status and were automatically eligible for licensing by the MBUC. Those who held military commissions or were licensed as “surgeons” by the Royal College of Surgeons in London or Edinburgh had secondary ranking. A Georgian cultural association developed between military service and “enhanced masculine virtues” following the revolutionary wars of the late eighteenth century; enlistment demonstrated commitment to British governance and values, a sentiment that strengthened in Upper Canada following the War of 1812. For these reasons, military surgeons typically had little difficulty passing the MBUC’s examinations. Practitioners like Rees, with apprenticeship training or more limited medical education, could be licensed after passing the examinations set by the MBUC; however, without the prestige of a degree or military service, such candidates were frequently rejected by the Board members for “deficiency” and “incompetency.”

Founded in 1818, the MBUC consisted of a small number of prominent Upper Canadian physicians who were established members of the colony’s professional class. With power over licensing, these individuals also controlled which candidates would become colleagues and enter their professional social circles. To limit entry, examinations were rigorous and required knowledge of anatomy, medical science, chemistry, midwifery, pharmacy, and Latin; apprenticeship candidates often lacked skills in at least one of these areas, explaining the high failure rate. While it is unclear whether Rees had all of these skills, his training under a renowned surgeon and his ten years’ experience as a health officer probably convinced the Board he had sufficient knowledge and skills. Some may

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10 Canniff, _The Medical Profession_, pp. 56–60. At the time Rees received his licence, the MBUC had a changing membership of five or six, although candidates were frequently assessed by only three members. Members of the MBUC between 1828 and 1832 included such men as Dr. William Warren Baldwin, Dr. Peter Deihl, Dr. Charles Duncombe, Dr. James Horne, Dr. John King, Dr. Grant Powell, Dr. John Rolph, and Dr. Christopher Widmer.
have had reservations, however; several years later, MBUC member Dr. Christopher Widmer questioned Rees’s competence and strongly criticized his professionalism. It is unclear when and why Widmer had formed his opinions, but they may have dated back to the time of Rees’s licensing.11

Restrictive licensing policies were only one factor contributing to physicians’ occupational struggles. The professional image of licensed doctors in private practice partly relied on the clientele’s acceptance and approval of the treatment received. In this period, tenets of medicine associated illness and disease with toxicity in bodily fluids; to restore the body’s systemic balance, treatments often involved the elimination of toxins through bloodletting, purging, blistering, and administering emetic compounds.12

Physicians struggled to gain the confidence of colonists who often vehemently avoided these painful and sometimes fatal practices, turning to alternative healers when they required medical care. While middle-class clients tended to have greater faith in licensed doctors or “regulars,” the public’s low confidence in scientific medicine meant many general practitioners were viewed as skilled tradesmen rather than educated professionals. The low level of public trust and the presence of alternative practitioners meant that colonial doctors did not experience the same level of professional security as lawyers, who, once called to the bar, had the exclusive right to practise in the courts. The constant presence of unlicensed competitors placed doctors in a precarious financial and professional position.13

Even if a physician found colonists willing to trust his treatment methods, he faced the challenge of obtaining sufficient numbers of patients able and willing to pay for his services. Work opportunities and income varied greatly depending on the location of a doctor’s practice. Unpopulated regions had a dearth of licensed practitioners, since life in the Canadian backwoods was unappealing to physicians emigrating from urban Britain. The minimal penalties for unlicensed practice were rarely enforced, and physicians who did work in these areas faced competition from a variety of other healers including homeopaths, eclectics, and midwives.14 Toronto doctors faced the opposite problem; the city’s population density and active political and cultural life made it highly attractive to physicians wanting to run a private practice. Eventually the number of licensed practitioners exceeded requirements, making it difficult for

11 Toronto Reference Library [hereafter TRL], Robert Baldwin Papers [hereafter RBP], Widmer to Baldwin, January 16, 1843 and January 1843.
some Toronto doctors to find patients. Since physicians rarely received full financial remuneration for their services, it became almost impossible for most to live without a supplemental source of income.

The need to generate money by increasing patients or finding an alternative income placed physicians within the professional sector of the “entrepreneurial class” identified by Michael Katz in his study of Hamilton, Ontario. Although Katz did not extensively analyse professionals, the descriptor “entrepreneur” accurately describes physicians’ position in the colonial middle class, for it shows them to be business-minded individuals whose professional success partly rested on their ability to generate and sustain a living. Many Upper Canadian men engaged in two or more forms of work to maintain a middle-class standard of living. Income was not the only motivation behind this “occupational dualism,” however; when successfully balanced, it also demonstrated rationality, tenacity, and industriousness, qualities that enhanced masculine social status.15

Alternative sources of income proved especially important for many Upper Canadian physicians whose medical practices did not provide adequate financial security. Wentworth County’s Dr. Harmaunus Smith and Richmond Hill’s Dr. James Langstaff both invested in real estate and operated farms to generate income separate from their medical practices; their land and property holdings formed a substantial basis of wealth that supported their identity as professional men. While Rees attempted to find employment more lucrative than private practice, compared to those of Smith and Langstaff, his efforts were minimal and much less practical, involving somewhat unrealistic attempts to secure a salaried government position. The practicality of his efforts was less of a concern for Rees since, unlike Smith and Langstaff, he was a bachelor without a family to support. Although the absence of family labour or financial assistance placed limits on the type of work he could do, without dependents the need for extra income was probably less urgent than it might have been for his married colleagues.16

Bachelorhood was beneficial and detrimental for Rees in other ways during the 1830s. To be perceived as a professional, a physician had to reinforce occupational skills with appropriate interests, hobbies, family background, religious affiliation, and circle of acquaintances. Young men without family responsibilities were “ideal intellectuals” since they had


unlimited freedom to learn and socialize with like-minded men. Youth and ambition promised upward social mobility and material security, while offering ample time for future marriage and family. Single life thus enabled Rees to become an active participant in Toronto’s middle-class cultural life in ways that fostered the development of his professional identity.\(^{17}\)

Gender factored significantly in constructing such an image, since professional identity required that a man’s activities and behaviours adhere to colonial codes of middle-class masculinity. Although gender divisions in the 1830s were not as distinct as they would become by mid-century, British social discourses were already instituting distinct social roles for middle-class men and women. Manliness was characterized by self-control, independence, and rationality; to be identified as a professional gentleman, a doctor had to reflect these qualities in his social activities and private life. Although marriage supported masculinity by symbolizing a man’s independence through his establishment of a household and position as head of a family, the freedom available to young bachelors meant that they were not necessarily disadvantaged by their single status. Historian John Tosh has acknowledged that bachelorhood “was always an ambivalent status,” which could be beneficial or detrimental depending on a man’s personal circumstances and stage of life.\(^{18}\)

Rees used his position as a young, aspiring professional without family ties to participate in activities that elevated his professional image. During the 1820s and 1830s, he pursued a variety of occupational and intellectual endeavours. Science was a primary interest, closely related to his medical work, that brought him into contact with York’s male intellectual circles. Intellectual study and scientific research were socially valued in the post-Enlightenment world of early-nineteenth-century Europe, and Upper Canadians transplanted these views into their own culture. Before settling in York, Rees had travelled through Nova Scotia and the Canadas researching physical geography, climate, environmental influences on human disease, and the medicinal uses of plants; he subsequently petitioned Upper Canada’s Legislative Assembly in 1834 to publish his findings in a book on “medical topography.” In 1835 Rees petitioned Lieutenant-Governor Sir John Colborne for assignment to the Baddeley-Carthew land survey north of Lake Huron, hoping to provide a botanical complement to Lt. Frederick H. Baddeley’s geological assessments of the region.\(^{19}\)


Rees’s scientific interests were further evidenced through his participation in the York Literary and Philosophical Society (YLPS). He cofounded the society in 1831 with physician and Canada Company warden William “Tiger” Dunlop and amateur naturalist Charles Fothergill to advocate a natural history inventory of the British North American territories. Later, in 1836, the three men petitioned for a provincial natural history museum with zoological and botanical gardens. As an intellectual voluntary association, the YLPS enabled Rees to present his scientific research and give it social relevance. Operated and dominated by men, such associations provided a platform for the generation of intellectual and social ideas. Public debate at association meetings and in the colonial press cultivated a masculine intellectual culture that gave credence to shared views, advancing the social and occupational ambitions of male participants. Participation in such voluntary associations supported professional men by giving them visibility and demonstrating their ability to engage in rational discussion.

The value of these associations was not limited to their professional benefits. They also provided men with leisure space away from responsibilities of work and family, promoting fraternal ties with other members. While working in Lower Canada in the 1820s, Rees benefited from this familial environment, finding accommodation at a Freemason’s Hall. Masonry’s democratic ideals and acceptance of internal political and religious diversity were complemented by formal pledges of brotherly support, be it economic or emotional; for a young immigrant like Rees with professional ambitions and limited income, such friendships were ideal. In the 1830s, no longer needing the protection of Masonry’s strict allegiances, elaborate rituals, and exclusivity, the doctor pursued social and occupational advancement through the YLPS with its greater opportunities for professional growth. With his medical licence giving him a degree of professional recognition, Rees focused his interests...
more intensely on intellectual connections with men supportive of his scientific ideas and philanthropic motivations.

Scientific research was not the only avenue followed by Rees in applying his medical knowledge to Upper Canada’s social and cultural betterment. He developed a strong interest in health and social welfare because his observations of patients, first as an immigration health officer and later as a general practitioner, led him to identify the social problems contributing to illness and disease. These experiences motivated him to engage in numerous philanthropic endeavours throughout the 1830s that aimed at improving the health of socially marginalized people. His interests in the insane asylum date back to this period, and he participated in the 1830s campaign to construct this institution. Rees also offered free medical clinics to the poor, helped establish a provincial board of prison inspectors, and promoted the development of various other welfare institutions including an orphans’ home, a female aid society, sailors’ homes, a juvenile reformatory, and a humane society. Drawing on his knowledge of immigration and recognition of the relationship between hygiene and health, he constructed a dock and public baths on the waterfront near his home in 1837. Known as “Rees’ wharf,” the port became a common point of entry for Toronto’s immigrants.

It is unclear whether Rees’s charitable work benefited his social status as a middle-class gentleman. Colonial social mores viewed voluntarism and philanthropy as a middle-class responsibility, and an individual’s participation in such work certainly solidified a position within middle-class social circles. Yet voluntarism was also structured according to gender. Women increasingly headed religious and benevolent societies, particularly those supporting women and children; in contrast, temperance, Sunday school, and intellectual associations were typically headed by men. These divisions were far from absolute; names of men and women appeared on membership lists of many organizations, and economic necessity often required men’s financial involvement in women’s organizations. Yet even when both men and women were involved, gendered ideas remained about the type of work performed. The extent of Rees’s philanthropic endeavours clearly situated him within middle-class society, but his work with women, orphans, animals, and the poor may have detracted from his ability to present himself as a masculine “gentleman.” In contrast to scientific research, intellectual engagement, and advocating on behalf of institutions, working with women and children had maternal

24 Although there was no medical specialty of “general practitioner” during this period, in this paper I use the term in a similar way to mean a doctor in private practice who worked outside an institution, treating a variety of illnesses.

25 Ormsby, “Rees, William,” DCBO; Anna Brownell Jameson, Winter Studies and Summer Rambles in Canada (1838; Toronto: McClelland & Stewart, 1990), March 5 and April 1, 1837, pp. 100, 154–155.
qualities. Bachelorhood may not have helped Rees in this regard, for it meant he could not position himself as the paternal supporter of a wife’s charitable work.26 To this extent, Rees’s welfare interests may have compromised his masculinity and altered perceptions of him as a professional gentleman.

It was not only Rees’s charity work that may have worked against his desire to project a professional image. He made various attempts at self-improvement that failed due to their implausibility. In 1834 he advertised a lecture series, hoping to initiate the formation of a medical school. Nothing came of it, probably because MBUC member Dr. John Rolph, a prominent Upper Canadian physician, had already been giving medical instruction at York since 1832. Given York’s small population and his limited experience, Rees could not have feasibly competed with Rolph. That same year he ran unsuccessfully for a seat in the Legislative Assembly as a Tory candidate in York. Election to the Assembly signified success and social prominence, benefits that almost certainly motivated Rees. Yet his social reform advocacy was probably not appealing to many of Toronto’s staunchly Tory citizens, and, again, his limited experience in the city probably worked against him during this decade when the Assembly’s political balance shifted continuously between Tory and Reform majorities. J. K. Johnson has remarked that, in Upper Canada, social prominence was developed over the long term and that physicians elected to the Legislative Assembly were usually Reformers. Rees fit neither of these situations, and the improbability of success in his various endeavours may explain why he was frequently characterized as irrational and foolhardy.27

Rees did achieve some success when he was appointed surgeon to the guard-ship at Toronto and assistant surgeon to the Queen’s Rangers regiment during the 1837–1838 Rebellions. Local appointments, they were less prestigious than war-time service, but probably gave some additional income while legitimating his professional status.28 Financial remuneration had also no doubt motivated his 1835 petition for a government appointment to the Baddeley-Carthew land survey at Lake Huron. Government salaries were not typically large, yet “[e]ven an apparently small but certain income was attractive,” and public service appointments were much sought after by men seeking social advancement. Stable payment, however small, would have brought Rees greater personal and


professional security. The level of priority he placed on income while engaging in his various pursuits is unclear, however. Opinions given of him by colleagues and friends, whether positive or negative, suggest that it was not his primary aim. Though some praised his benevolence, Rees was also described as flighty and impractical, descriptors not characteristic of a man ambitiously seeking financial self-improvement. Part of the issue may have been his limited access to more lucrative and reliable forms of income. Rees did not have family near him to support an endeavour such as farming or to provide initial investment capital through gift, loan, or inheritance. Government posts were probably his only hope, yet many of his proposals were unlikely to succeed. Coupled with charitable interests that suggested maternalism, these failures created an impression of him as impractical and positioned him on the edge of acceptable masculine behaviour. This perception of Rees undercut his intellectual pursuits and made his professional identity vulnerable.

Opinions of Rees varied greatly, however, and not everyone perceived him this way. His social activities connected him to individuals of diverse backgrounds, including members of the Upper Canadian elite and men already connected to these privileged circles. Fellow YLPS founder William “Tiger” Dunlop’s superior medical education at the University of Glasgow and subsequent work as an assistant military surgeon in the War of 1812 gave him an elevated social status in the colony; at the time the YLPS was founded in 1831, the Canada Company’s “Warden of the Woods” had access to government officials and other politically and socially influential men. Dunlop’s political connections enhanced the merit of Rees’s scientific proposals in the Assembly, making Dunlop a reliable source of political support.

Rees also had long-lasting friendships with Toronto Sheriff William B. Jarvis and Robert Jameson, Vice-Chancellor of the Court of Chancery. On one level these relationships are interesting since, as members of the city’s Tory elite, both men had a higher class status than Rees. Personal relationships, however, were not rigidly defined by class position, and social interaction was common among men and women with similar political and cultural values. Lt. John Henry Lefroy’s


30 According to the genealogy website described in note 6, Rees’s father had been a rope maker (tradesman), and the only family Rees had left in Lower Canada by the mid-1830s was his widowed mother and two sisters. Website accessed April 15, 2010, from http://www.knology.net/~qed/R-G-Rees.htm.

31 Critics of the Upper Canadian elite often use the term “Family Compact” to suggest a group with unchanging membership and inflexible social alliances. This label is problematic, for, while these individuals often formed an alliance, they thought and behaved as individuals. When they closed
friendships during the 1840s were markedly similar to those of Rees. Leaving England in 1842 to conduct a magnetic survey in the colonies, Lefroy had by 1844 settled in Toronto, where he forged relationships with many of the city’s elite families. The well-educated bachelor’s scientific pursuits, reform interests, and Anglican Church affiliation made him “a prime candidate for social invitations” from Tory political leaders. Shared interests and the colony’s flexible social networks enabled men like Rees and Lefroy to forge friendships with politically prominent men.

The circumstances of Rees’s initial contact with Jameson and Jarvis are unclear. Sources do not indicate whether Rees ever provided medical treatment to their families. They may have met through the YLPS or through church; like Jameson and Jarvis, Rees was Anglican, and, given their places of residence, all three men probably attended St. James parish. Rees’s intellectual endeavours adhered with the Tory elite’s valuation of social order and material progress, and Jameson and Jarvis thus probably shared many of the doctor’s interests. They both respected Rees’s attempts to improve social welfare in the colony. Corresponding with the government, Jameson described Rees as a man “without a moral imputation upon his character,” whose devotion to welfare was one of “benevolent ardour.” As Toronto’s Sheriff, William B. Jarvis witnessed much of the misery caused by poverty and crime, often due to inadequate welfare resources. He similarly identified Rees as a man whose labours were “unceasing,” whom he always considered a “public benefactor.” Among those defending Rees’s work in later years were Anglican Bishop John Strachan, lawyer William Henry Boulton, businessmen Sir Allan MacNab and Isaac Buchanan, and physicians Drs. William Beaumont, William C. Gwynne, and Wolfdred Nelson. They consistently emphasized his kindness and efforts to better the lives of people less fortunate than himself.

109 ranks, it was typically in an effort to secure their individual social positions by working as a group. See Graeme Patterson, “An Enduring Myth: Responsible Government and the Family Compact” in J. K. Johnson and Bruce G. Wilson, eds., Historical Essays on Upper Canada: New Perspectives (Ottawa: Carleton University Press, 1989), pp. 491–492.

32 Lefroy married Chief Justice John Beverley Robinson’s daughter Emily in 1846, and in the late 1840s and early 1850s became involved with Egerton Ryerson’s educational reforms. See Zeller, Inventing Canada, p. 131.

33 Zeller, Inventing Canada, p. 133.

34 Report of the Select Committee of the Legislative Assembly in the Case of Dr. Rees with an Appendix (Quebec, 1861), p. 8; AJLAPC, 1841, Appendix L.L., p. 1, “Report by the Honorable the Vice-Chancellor . . .”

One view of Rees’s character that provides some insight into his masculinity relative to other professional men in Toronto is that offered by Jameson’s wife Anna in 1837. Anna spent one year in Upper Canada before obtaining a separation agreement from Robert and returning to England. She found colonial life intolerable, describing Toronto as “a fourth or fifth rate provincial town,” and particularly disliked the “petty gossip ... mutual meddling and mean rivalship” characterizing those seeking social prominence. Experiencing first-hand the difficult adjustment to colonial life and observing the problems of less privileged and socially marginalized people, Anna was particularly impressed with Rees’s attempts to assist women and children. While she criticized colonial society at large, she made a conscious acknowledgement of the effort of her “good friend” Rees, praising him as a “benevolent physician.” Anna evidently saw him as operating outside the colony’s masculine political sphere, which she believed sacrificed women’s interests for the benefit of a few elite men.  

Anna’s opinion of Rees is significant, not because it was of any practical benefit to him, but because it suggests he had certain characteristics that might have led some male colleagues to perceive him as irrational and unmanly.

Rees’s unique personality and active participation in public life meant that by the late 1830s he was well known among Toronto’s professional and privileged social classes. Yet it is difficult to define him precisely as a “professional” due to the term’s fluidity, medicine’s continuing instability during the period, and Rees’s own personality and behaviour. Many colonial middle-class men existed at the margins of power and prestige, and Rees was certainly no exception. Nevertheless, in light of Gidney and Millar’s definition of the “professional gentleman,” Rees’s activities during the 1830s may be understood as helping to enhance his occupational status from ordinary physician to professional. His more questionable traits only began to have serious significance after he began work at the asylum, an experience that demonstrated the true instability of his social status.

The Temporary Asylum began operation in the former Toronto Home District Gaol during the spring of 1840. As its name indicated, this jail location was intended to be provisional until a permanent facility was built. In May 1839, pressured by District Magistrates to address the problematic presence of destitute insane persons in local jails, the Upper Canadian Assembly passed an Act authorizing the construction of an asylum with plans for the facility’s future funding and

36 Errington, Working Women, p. 159; Jameson, Winter Studies and Summer Rambles, February 17 and 21, March 5, and June 13, 1837, pp. 65,72–73,100, 194.

administration.\textsuperscript{38} When it became apparent that the asylum would take several years to build, the former jail was sanctioned temporarily to house the insane. This measure lasted nearly a decade until the permanent structure opened on Queen Street West in January 1850.

Weak administrative structures throughout the 1840s caused ongoing conflict between the Temporary Asylum’s medical superintendents and its government-appointed Board of Commissioners, leading to successive dismissals of Superintendents Drs. William Rees (1841–1845), Walter Telfer (1845–1848), and George Hamilton Park (1848–1849). Previous studies of the temporary asylum have focused attention on these conflicts, examining the 1840s as a singular unit and assuming that similar problems recurred for each physician.\textsuperscript{39} Although the conflicts proved problematic for each superintendent, Rees’s story demonstrates that particular circumstances were also significant to the asylum careers of these men.

Like many of Rees’s endeavours, his interest in mental disease began during his years in Lower Canada. Recounting his observations years later, he recalled:

\begin{quote}
While practising my profession successfully at Québec, I was led to observe the very inefficient, objectionable, and inhuman mode of treatment of pauper lunatics, for whom no provision could be found but incarceration in the Common Gaols, with a treatment infinitely worse than that of convicted felons, and I took a great interest in endeavouring to ameliorate their condition, and at my own expense visited England and other countries to examine into the mode of conducting institutions for the insane and the mode of treatment.\textsuperscript{40}
\end{quote}

He later found conditions similar in Upper Canada’s jails. Making use of his new authority as a licensed physician, Rees became active in the efforts to establish a lunatic asylum in Toronto. With the passing of the 1839 Asylum Act and the opening of a permanent facility allocated to the
distant future, he remained committed to finding a solution for the lunatics incarcerated in the overcrowded jail.41

Having already applied in January for the position of medical superintendent in the future asylum, Rees came to the jail in the spring of 1840 offering voluntary care to its “16 or 17 insane persons.” He likely wanted to improve the living conditions of these inmates while also obtaining experience to better his chances for the superintendent’s position. When the jail relocated a few months later, the four newly appointed asylum commissioners — Robert Jameson, William B. Jarvis, physician Dr. William C. Gwynne, and architect John Ewart — had yet to appoint a medical superintendent. As sheriff, Jarvis was responsible for the jail’s lunatic inmates; with Board chair Robert Jameson’s approval, he left them in the old facility under Rees’s temporary care. The Board of Commissioners formally accepted Rees’s application at the end of the year.42

The appointment was controversial. Dr. Christopher Widmer would later angrily claim Jameson had “smuggled” Rees into office, and another adversary described it as “setting a madman to watch a madman.”43 Given these negative views of Rees, there seems little doubt that his appointment was a patronage decision directly influenced by his friendships with Jameson and Jarvis. Nevertheless, all four commissioners acknowledged that living conditions inside the former jail had greatly improved since Rees’s arrival. His position was formalized when the temporary asylum officially opened on January 21, 1841.

Following his appointment, Rees relinquished his private practice.44 Why he did so is unclear, since most physicians receiving government appointments maintained their practices for supplementary income and enhancement of their professional status. Rees seemingly had idealistic visions of becoming a full-time “alienist,” the term applied to nineteenth-century asylum medical superintendents in Britain and North America. While travelling in Britain in the 1820s, Rees would have seen physicians working exclusively as asylum superintendents in the numerous private asylums and few charitable and state institutions operating there. In North America, asylum construction was a more recent development, however; while the United States had several institutions built by 1840, the British colonies only had only a few temporary facilities in New Brunswick,
Upper Canada, and Lower Canada. Given the slow progress of welfare facilities in British North America, asylum management alone was unlikely to provide a physician with a livable income. 45

Indeed, the decision to sell his practice proved to be the biggest mistake of Rees's career. His five-year tenure at the asylum was marked by numerous financial and administrative problems that negatively affected his professional reputation. While Rees tried to remedy these difficulties, his efforts earned him a reputation as foolish and lacking in administrative skills. To some extent, such characterizations were legitimate, since Rees did make certain unwise decisions. Many of the asylum’s problems, however, remained beyond his control, and negative opinions of Rees formed by some individuals in the 1830s served to make him a convenient scapegoat by 1845. 46 While a dispute in 1844 with the Board of Commissioners precipitated his departure, this incident should be viewed as a culmination of several problems that arose between 1841 and 1844 rather than the main reason for his dismissal, as other historians have suggested.

Upon arriving at the asylum, Rees immediately began implementing a modern “moral treatment” programme similar to those he had observed during his tours of asylums in Europe and England. Developed in France and England from the ideas of physician Dr. Philippe Pinel and philanthropist William Tuke, moral treatment aimed at eliminating physical restraints and promoting self-healing through good nutrition, rest, work, exercise, and recreational activities. Unfortunately, the Toronto jail was “wholly unfit” for insanity treatment and lacked the facilities for moral treatment such as space for an exercise yard and a well for clean, accessible water. Rees, however, made the most of the limited resources, placing patients in “purified and airing debtors’ rooms — carefully washed, clothed and placed under Medical care” with “food critically adapted to their physical state”; for exercise, he allowed patients to go off-property with asylum-keepers to fish or walk by the lake. 47


46 Brown, “‘Living with God’s afflicted,’” p. 139; Canniff, The Medical Profession, p. 572; Ormsby “Rees, William,” DCBO.

It was difficult to improve the inadequate facilities given that the passing of the Asylum Act had coincided with a period of financial constraint in Upper Canada following the collapse of one of its major British creditors. With the union of Upper and Lower Canada in February 1841, the newly created Province of Canada inherited Upper Canada’s substantial debt load. Hoping to stimulate economic development, the Executive Council placed priority on the completion of canals, roads, and other public works projects, directing government spending and taxation away from social welfare projects.48

This situation proved inauspicious for asylum development. Cultural valuations of penal institutions and concerns about a growing crime rate meant that any available welfare funds were directed to expanding the Provincial Penitentiary, which had opened at Kingston in 1835. The insane were more of a social nuisance than a threat to public safety, and the government hesitated to impose further taxes on colonists for welfare purposes. As a result, construction of a permanent asylum was delayed, as were improvements to the temporary facility. While criminals were given specialized accommodations that met their basic needs, the insane were dehumanized and left to wallow in the cramped, filthy, ill-equipped jail.

The lack of money and poor facilities placed Rees in a difficult situation since he was expected to implement a sustainable treatment programme that would “cure” patients. As early as November 1841, William Dunlop appealed to the Provincial Secretary, identifying Rees as “quite out of funds” with “creditors clamourous, and the servants in a state of mutiny.”49 Although some paying patients were admitted during this period after local families petitioned the government to accommodate their insane relatives, these payments were insufficient to meet the asylum’s financial needs. The problems were partially disguised by Rees’s adaption of the jail and partial implementation of moral treatment methods. Only later was it learned that he and certain commissioners were assuming personal debts to keep creditors at bay.50 To our current perspective this action seems foolish, yet in the nineteenth century it was not uncommon for men to become financially over-extended, accumulating

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49 *Report of the Select Committee of the Legislative Assembly in the Case of Dr. Rees*, p. 14, Dunlop to Hon. S. B. Harrison, Provincial Secretary, November 22, 1841.

large debts to support entrepreneurial and other business projects. According to historian Peter Oliver, the Kingston Penitentiary suffered similar financial constraints, with its warden and inspectors also assuming such personal debt. Assumption of debt was a risky practice given the instability of the colonial economy; if not properly handled, it could have financially disastrous results, explaining the frequency of downward social mobility. With the asylum now his only source of income and his professional reputation at stake, Rees was particularly vulnerable to undertaking such personal risk; next to giving up private practice, bankrolling the asylum was undoubtedly Rees’s second major professional error. Rees’s self-sacrifice at the asylum proved particularly inexpedient once the government began reducing his salary along with the asylum’s operating funds. The 1839 Asylum Act stipulated that the medical superintendent would receive an annual salary “not exceed[ing]” £300; while Rees assumed he would receive the full amount, the language of the Act was carefully worded to allow the government to reduce his pay at will. Although he seems to have received close to this amount in a lump sum sometime in 1842, by July 1844 his yearly salary was £200. By 1843 Rees had appealed to both the commissioners and the Provincial Secretary for a pay increase and a residence near the asylum, living arrangements that were standard practice in American and British asylums during the period. Despite the commissioners’ support for these requests, he received neither.

Rees’s appeals were not unreasonable. Since the opening of the penitentiary in 1835, its head administrator, Warden Henry Smith, had received his legislated salary, which by 1841 had reached £300 and would rise to £375 in 1844. Rees probably believed his asylum position gave him a professional status equivalent to Smith’s, particularly with his additional qualifications and skills as a physician. His salary and administrative authority suggested otherwise, however. While an 1834 Act had made disbursement of penitentiary salaries and wages a responsibility of the warden, no such regulation existed for the asylum, living arrangements that were standard practice in American and British asylums during the period. Despite the commissioners’ support for these requests, he received neither.

salary in the way that Smith did. Rather, Rees depended on the government and the Board to remunerate him fairly. The inadequate funding provided for the asylum caused his salary to decrease, making it difficult for him to maintain a middle-class lifestyle and portray a gentlemanly image. His assumption of debt was likely an effort to salvage his social identity and disguise what was quickly proving to be a professional failure.

Administrative changes made after his appointment further complicated Rees's difficulties. In 1842, under orders of the Lieutenant Governor, the Board created a new “Code of Rules and Regulations” clarifying the duties of the “officers of the institution.” Although the commissioners were required to work with Rees to manage the asylum, the Board implemented a new position of asylum steward that complicated this relationship. The steward resided at the asylum and supervised the treatment of male patients, an arrangement that was meant to align the Toronto facility more closely with administrative structures of American asylums. Although most American institutions had a separate treasurer, Toronto's asylum commissioners made business and financial matters an additional duty of the steward, seemingly as a cost-saving measure.

As long as relationships among the commissioners, medical superintendent, and steward remained harmonious, this system was sufficient, and there were few problems during the first year. In 1843, however, the Board expanded to twelve commissioners to adhere to the number legislated in the 1839 Act and give it a broader range of skills and expertise. Its members now included physicians, businessmen, clergy, the sheriff, and an architect, diversity that made it a more bureaucratic body. No longer dominated by Rees's friends, the new Board included many members who did not share his medical and welfare interests, largely eliminating Rees's collegial relationship with the commissioners.

Administrative relationships became particularly strained after Robert Cronyn became steward sometime in 1843. As with Rees, patronage had

55 While Smith complained frequently to the government about insufficient funds to pay waged employees, he had considerable control over payments, and the penitentiary records show all salaried employees were properly remunerated. Oliver, “Terror to Evil-Doers,” pp. 148–152; Statutes of Upper Canada to the time of the Union, vol. 1, chap. 37, p. 690, An Act ... Maintenance and Governance of the Provincial Penitentiary... , March 6, 1834.

56 The steward was typically a married man hired jointly with his wife, who was appointed matron with charge of the female patients. AJHAUC, 1836, Appendix No. 30, p. 12, “Report on Lunatic Asylums”; AJLAPC, 1842, Appendix U, p. 1, “Annual Report, for 1842, of the Commissioners”; George Hamilton Park, A Narrative of the Recent Difficulties in the Provincial Lunatic Asylum, Canada West (Toronto: Examiner, 1849), pp. 3–4.

played a role in Cronyn’s hiring. Commissioner Martin J. O’Beirne was an Irish-Catholic clothier and founder of the city’s St. Patrick’s Benevolent Society (1832); committed to helping Irish immigrants like Cronyn, O’Beirne remained his fervent supporter despite mounting evidence that Cronyn wasted funds, drank to excess, and verbally abused patients and staff. Cronyn’s administrative control over finances and business matters muddied the managerial waters. Confusion was compounded by his full-time residence at the asylum and connections to Toronto’s professional circles through O’Beirne and other commissioners. Desiring social elevation himself, Cronyn used his greater presence and visibility at the asylum to assert his authority over Rees. As a result, confusion soon developed over seniority and management, causing conflict between the two men.

The first recorded incident occurred in October 1844 when it was necessary to hire a male keeper. Keepers, who were responsible for daily care, kept patients clean, fed, clothed, and exercised and ensured they had appropriate medical treatment when necessary. Because they were essential to patients’ health, Rees believed the medical superintendent should have charge of hiring keepers. Accordingly, he selected a man by the name of Roche for the position, telling him to submit his paperwork to visiting Commissioner William B. Jarvis, who, after consulting with fellow Commissioners Grassett and Jameson, subsequently approved Roche’s appointment. Unfortunately, when Roche arrived at the asylum, he found the position occupied by a man Steward Cronyn had hired. Rees and Cronyn argued over the matter, with both officers declaring their right to have charge of hiring. Infuriated, Rees approached the chairman of the Board, who stated: “[I]t is your duty, and yours alone, to obtain a fit person to act until the pleasure of the Commissioners be known to rescind or confirm your choice... if [the steward] has again behaved with insolence... all I can say is, bring the matter before the Board.” Unfortunately, at the Board’s next meeting on October 22, only physician Dr. William Beaumont supported Rees’s choice of keeper, and charge of future hiring was given to Cronyn.

Rees believed individual Board members supported Cronyn out of patronage because they had business contracts with him for asylum supplies. It was a reasonable claim, since the private businesses of Martin O’Beirne and John Eastwood profited from asylum supply orders. The commissioners’ individual decisions to side with Rees or Cronyn were strongly related to their own occupations and backgrounds.

58 See AILAPC, 1849, Appendix G.G.G., “Return – all papers... relative to the removal... of Dr. Telfer...”

59 AILAPC, 1849, Appendix E.F.F., pp. 6, 9, “Return – ‘Copies of all Correspondence between the Commissioners...’”
and formed the basis for divisions on the Board and between Rees and the commissioners. From late 1844, conflicts between Rees and the more business-oriented commissioners increased, with both sides appealing to government officials for guidance and blurring the truth to suit their own ends.

Although the 1839 Act legislated that official complaints of the medical superintendent were to be addressed to the Board, by the spring of 1845 it was evident to Rees such appeals were pointless given the Board's internal divisiveness. Frustrated, he made the decision to break protocol. On April 4, 1845 he wrote an exasperated letter to Attorney-General and government leader William Henry Draper, complaining of the “gross neglect” of patients by keepers over whom he had little authority. He identified most of the issues as rooted in “the great want of harmony” on the Board of Commissioners regarding the asylum’s management. 60

The letter greatly angered the commissioners, who believed Rees had undermined their authority. They subsequently appealed to Governor General Charles Metcalfe with copies of Rees’s letter to Draper and their asylum reports from August 1844 and April 1845. They identified Rees as “[thinking] proper, on many occasions, to disregard the instructions of the Board” and wanting in “soundness of judgement, and command of temper,” as exemplified by the various distortions presented in the letter to Draper. Although Rees’s identification of the Board’s “want of harmony” was legitimate, the Board saw this assertion as untrue and “very mischievous.” Members dismissed his letter as the latest in a series of “false and hurtful communications” by Rees and stated that most of the asylum’s problems were due to his ongoing misconduct. 61

In June Rees made his situation worse. In a bid for further support and again reacting emotionally, he hastily solicited two character references from Robert Jameson (temporarily off the Board) and George Gurnett, foreman of a Grand Jury that had inspected the asylum in 1844. The tone of these requests implied the references would be used as weapons against the objecting commissioners. Neither Jameson nor Gurnett wished to be dragged into the conflict, saying as much in their replies, but also offering positive comments about the institution and its management at the time they had seen it. Despite their friendship, Rees’s erratic behaviour was such that Jameson probably hesitated to help him for fear of losing credibility by appearing similarly irrational and unprofessional.

At the end of June, Rees wrote a lengthy letter to Provincial Secretary Dominick Daly responding to the Board’s comments to Metcalfe in April. In this letter, he suggested eliminating the steward’s position altogether,

60 AJLAPC, 1849, Appendix F.F., p. 2, “Return – ‘Copies of all Correspondence between the Commissioners’.”
61 Ibid., pp. 3–4.
contracting for supplies, and instead employing an assistant physician who would work under the medical superintendent. Rees believed that doing so would eliminate the existing conflicts over management, placing the medical superintendent (himself) in charge, while obtaining a physician to reduce his own workload.\footnote{Ibid., p. 5.}

By the summer of 1845, this dispute was largely a power struggle between Rees and the commissioners. Rees's frustration was fully understandable, since the undermining of his managerial authority made it difficult for him to present himself as a professional. Yet his barrage of letters expressing anger and frustration only exacerbated any prior perceptions of him as irrational and unmasculine. In Upper Canada, emotion and hysteria were synonymous with effeminacy, particularly in the conservative circles with which Rees aligned himself.\footnote{Morgan, Public Men and Virtuous Women, p. 71.} His emotion and rashness did not adhere to social expectations of professional gentlemen, and his reactive letters undermined his efforts to present himself as such.

Rees's professional reputation was further challenged by scrutiny of his medical practices at the asylum. He frequently used depletive methods such as bleeding and emetics to treat patients. These anti-inflammatory practices were debated widely in the medical profession at this time, with many physicians questioning whether they offered physical benefits to patients. Their usefulness for treating mental disease was particularly uncertain, fuelling controversy in Toronto over Rees's use of bleeding and purging and leading to inquiries into his asylum medical practices between 1834 and 1844.\footnote{Tomes, A Generous Confidence, pp. 79–83; AJLAPC, 1851, Appendix O.O., “Report of the Special Committee . . . relating to the Petition of William Rees . . .”; Appendix No. 1, March 17, 1843, “Dr. Spear’s Report on the Management of the Temporary Lunatic Asylum . . .”; Brown, “‘Living with God’s afflicted,’” pp. 141–142.}

Although this investigation should be understood as part of wider medical debates, personal and professional attacks on Rees's character were also involved. After reviewing Rees's work in the winter of 1843, Dr. Robert Spear of the Royal College of Physicians in London submitted a positive report to Board chair Robert Jameson, defending Rees and commenting that most of the criticism came from one “dishonest man” who questioned the doctor's general medical competency. James Moran’s account of this investigation suggests the involvement of Rees’s successor, Dr. Walter Telfer; at this time objections to anti-inflammatory practices were also voiced by asylum Commissioner Dr. William Gwynne.\footnote{Moran, Committed to the State Asylum, pp. 82–83; Canniff, The Medical Profession, p. 405.} Yet letters from Dr. Christopher Widmer to Reform leader Robert Baldwin in January 1843 indicate it was Widmer who was directly responsible for the review. Certainly Widmer's English gentry background,
service as a military surgeon, and long-term leadership on the MBUC gave him a high professional status with the power to initiate such an investigation. Complaining about Rees’s competence, Widmer proposed an inquiry be instituted to “lift the film from Sir Charles [Bagot] vision” as to the patronage circumstances of Rees’s employment and his lack of medical skill. Wanting Rees to “make his bow” and leave the asylum, Widmer further claimed that “care of the Insane should certainly be consigned to a practical man, with a philosophic knowledge of the treatment of insanity.”

Throughout Rees’s career, Widmer had harshly criticized his professionalism; while he targeted Rees’s medical knowledge, Widmer’s objections were more likely rooted in his negative perception of Rees’s character as a masculine gentleman. The letters to Baldwin suggest that Widmer consistently argued Rees lacked the rationality and practicality befitting the professional class. Widmer thus took malicious initiatives to exclude Rees from these circles.

Although Spear’s report wholly defended Rees, stating he had raised the asylum “to nearly a level with the most favored of similar institutions in Europe,” Rees’s position at the asylum was on shaky ground by 1844. A second investigation of his practices that year by a Board of Physicians created at the Lieutenant Governor’s initiative determined Rees’s treatments to be excessive and often inappropriate. Combined with his strained relationship with the commissioners, Steward Cronyn’s administrative interferences, and Widmer’s attempts to remove him from the institution, Rees was professionally vulnerable and risked losing the government position he had worked so hard to obtain.

Tragically, that summer, Rees’s administrative complaints faded to the background when he was attacked twice by violent patients. The first incident involved a severe blow to the head by a patient named Dempsy, which caused Rees to stagger for a period of time. He subsequently complained “at different times . . . of the effects of the injury.” Five or six weeks later, a patient named Fitch kicked him in the groin, leaving him faint and pale. Rees developed a severe infection from this injury and became confined to his house. Months later, the head injury still caused dizziness and “giddiness,” while Rees also suffered ongoing chills and fever from the groin infection. His attending physician, Dr. George Grassett, commented, “The exercise of walking cannot be performed without pain, nor is it desirable that bodily exertion should be used.”

66 TRL, RBP, Widmer to Baldwin, January 16, 1843 and January 1843.
These injuries accelerated the downward trajectory of Rees’s career over the remainder of his life. Coupled with the administrative disputes, they sealed his fate at the asylum, and in October 1845 he received notification from Dominick Daly terminating his employment as medical superintendent. Although Rees’s physical incapacity at the time of the dismissal no doubt contributed to this decision, Daly’s correspondence cited the conflicts between Rees and the Board as the cause:

His Excellency in Council has perused [the Memorial of the Commissioners together with your observations] with an earnest desire to discover some circumstance by which to avoid the necessity of removing you from your office of Medical Superintendent, but he regrets that the consideration of your letter of the 24th June last, confirms His Excellency in the opinion that there is no alternative, but either to dispense with your services or to lose the benefit of the services of the Commissioners of the Asylum.⁶⁹

The emotionally charged tone of the complaints and appeals that Rees made to maintain his position at the asylum ironically gave the government an excuse to dismiss him by characterizing him as irrational and unsuited to management.

That Rees’s injuries almost certainly influenced Daly’s decision is evidenced by the doctor’s ongoing ill health and indications that animosity between him and the Board may not have been as severe as the documents suggested. In the midst of the conflicts over Steward Cronyn, the commissioners supported Rees in a bid to the provincial government for the unpaid portions of his originally promised £300 salary.⁷⁰ They also defended Rees after his dismissal, asking Daly to reinstate him since he had made “ample apology to the Board.”⁷¹ No further action was taken, however, probably because of Rees’s physical incapacitation.

Immediately after his dismissal, Rees filed a second appeal to Governor General Charles Metcalfe for salary compensation: “Your Memorialist earnestly prays that you will be pleased to take into consideration your Memorialist’s long services; that he is now thrown back, with impaired health and personal embarrassments, originating in his quitting his general profession to dedicate himself to that part which had been his particular study, to re-establish himself in life with every disadvantage to obstruct his advancement.”⁷² His bid was supported by character

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⁶⁹ AJLAPC, 1849, Appendix F.F., p. 10, “Return – ‘Copies of all Correspondence between the Commissioners’.”
⁷⁰ AJLAPC, 1846, Appendix K.K.K., pp. 2–3, “Return to an Address … respecting the claim of Dr. Rees.”
⁷¹ AJLAPC, 1849, Appendix F.F., p. 10, “Return – ‘Copies of all Correspondence between the Commissioners’.”
⁷² AJLAPC, 1846, Appendix K.K.K., p. 1, “Return to an Address … respecting the claim of Dr. Rees.”
references from a number of very prominent men, including Jameson, Allan MacNab, John Strachan, J. B. Macaulay, and John Beverley Robinson. Medical certificates from Drs. Beaumont and Gwynne testified to the extent of his injuries, which included a leg fracture, ankle dislocation, severe groin infection, and dizziness.

In February 1846 Rees submitted a third appeal, asking for a portion of paying patients' asylum fees since the commissioners had previously provided Rees with these fees to compensate for his inadequate salary. Nothing came of this appeal, since the Select Committee reviewing Rees's case viewed it as a private arrangement having nothing to do with the government. “Totally different,” however, was the Select Committee’s opinion of compensation for incidental “injuries received from the unfortunate and irresponsible class of our fellow beings.” Committee Chairman William B. Robinson stated such compensation could “no more be denied to [Rees] than to a soldier wounded in the service of his country.” Nevertheless, the Select Committee still hesitated to offer Rees a long-term pension or retroactive payment since it “was not shewn to them that the injuries . . . [would] affect him for life.” Instead, they recommended £100 be given to the doctor until they received evidence of the permanency of his ill health.73

The injuries made Rees somewhat of a martyr for the medical profession, and recognition of the personal risks associated with care of the insane increased sympathy for his plight among friends and supporters.74 Dr. Francis Arnoldi, one of Rees’s examining physicians, made a point to acknowledge in his report that Rees “had many of the worst cases to manage.”75 Robinson's comparison of Rees to a wounded soldier was echoed by several of Rees’s supporters over the next 20 years, demonstrating continued admiration for his sacrifices, long-term commitment to welfare, and willingness to deal with patients few others wanted to treat. Dr. Arnoldi argued that “a pension was undeniably his right” since his situation was “precisely the same as that of an officer in the army.” Similarly, Robert Jameson described Rees as standing “in light of an

74 Although severe injuries to staff occurred infrequently, patient violence was problematic in nineteenth-century asylums. Violent behaviours were usually symptoms of a patient's illness or acts of resistance against confinement. Most incidents were minor and controllable; yet the potential for serious injury was always present, particularly from male patients whose physical strength made them more dangerous when riled or delusional. At the Kingston Asylum, Dr. William Metcalf died after being stabbed by a delusional patient in 1885, and his successor Dr. Charles Clarke once nearly drowned after a patient fought with him, pushing him into the rough waters of Lake Ontario. It must also be noted, however, that at the Temporary Asylum Rees's successor Dr. Walter Telfer complained that Robert Cronyn and his wife (the matron) physically abused patients, no doubt inciting them to violence by requiring them to defend themselves. See AJLAPC, 1849, Appendix G.G.G., “Return – ‘all papers . . . relative to the removal . . . of Dr. Telfer.”
75 Report of the Select Committee of the Legislative Assembly in the Case of Dr. Rees, p. 6, Arnoldi to Hon. John Rose, May 8, 1860.
officer maimed in battle,” while military surgeon Dr. Delmage also argued that Rees should be awarded the same type of life pension granted to army personnel.\textsuperscript{76} The military comparisons are literally misleading since a colonial physician’s class status was higher than that of an ordinary soldier, but lower than that of an army officer; whatever his injuries, Rees had never faced the degree of ongoing, immediate physical threat of military personnel in battle. Yet these men were of a generation that understood military service as symbolic of masculine patriotism, making it a meaningful metaphor to emphasize Rees’s fortitude. It strategically drew the government’s attention to the undesirable nature and danger of his work and the sacrifice he had made while carrying out his duties.

In the end, Rees did not see money from any aspect of his 1845–1846 claims. Unable to re-establish his private practice and greatly in debt from investments in the asylum, he faced a bleak situation. He did not pursue the issue again until June 1850, when he submitted a petition specifically focused on his injuries. A special five-member committee was formed to investigate the claim, comprised of former Assembly members Sir Allan MacNab, John Prince, John Ross, and Drs. Wolfred Nelson and Thomas Boutillier. After reviewing documents provided by Rees and his physicians, they concluded in July 1851 that the doctor’s claim was legitimate since supporting evidence now showed his health problems to be permanent and worsening. During the late 1840s, Rees had travelled to Bermuda and “other places” hoping to restore his health through “sea voyages” and warmer climates.\textsuperscript{77} Medical certificates showed these efforts were in vain. Not only had his condition not improved, but he was now afflicted with heart, liver, and kidney problems. Dr. Francis Badgley, one of the examining physicians, informed Rees that his health was such that “no Life Assurance Company would undertake a risk upon your life.” All medical certificates indicated that the doctor was unlikely ever to return to full-time practice. Badgley made the further comment that public stigma against insanity and asylum physicians made the re-establishment of a remunerative medical practice even less likely for Rees. Because Rees’s ill-health was confirmed to be the result of attacks by his asylum patients, the committee recommended the government give him “such provision as they may deem fit to award to him.”\textsuperscript{78}

\begin{itemize}
\item \textsuperscript{76} Report of the Select Committee of the Legislative Assembly in the Case of Dr. Rees, pp. 6–7, 19, Arnold to Hon. John Rose, May 8, 1860; Jameson to Allan MacNab, May 12, 1852; Delmage to the Executive Council, March 21, 1851.
\item \textsuperscript{77} According to the family genealogy site discussed in note 6, one of Rees’s brothers became a dentist in Bermuda, while another was a physician in Antigua. They may have paid for his ship passages and provided accommodation, explaining his ability to seek recovery in such locations. Website accessed April 15, 2010, from http://www.knology.net/~qed/R-G-Rees.htm.
\item \textsuperscript{78} AJLAPC, 1851, Appendix O.O., pp. 1, 6, “Report of the Special Committee … relating to the Petition of William Rees.”
\end{itemize}
Although the committee subsequently prepared a recommendation based on its report, nothing was resolved, and once again Rees was left without compensation. He felt it was an oversight caused by the absence of Sir Allan MacNab, who had “the case in hand,” but had suddenly taken ill, leading the parliamentary session to close “without any action being had upon it.”

Rees’s faith in MacNab’s ability to influence the Assembly seems excessive given that the case was being presented to a Reform government. Like most of Rees’s supporters throughout his career, MacNab was a Tory; although his political position was more moderate by 1851, he continued to be firmly associated with Tory ranks. As the Legislative Assembly had been led by Reformers since 1848, Rees’s confidence in the political power of his conservative supporters was overly optimistic. While alliances with such men had secured the asylum position for him during the Tory leadership of the early 1840s, these connections no longer had benefits in the Assembly of the 1850s. Perhaps Rees’s misguided hope was a way of protecting himself emotionally by denying the bleakness of his future.

Rees’s failure to obtain compensation was increasingly problematic. His ongoing inability to work led to a growing debt load. Rees also owed money to friends, since many had “made him advances.” Although financial failure was not uncommon among men of Rees’s class, it may have proved more socially problematic for him than for the average professional man. Indebtedness and financial reliance on others signified feminine dependency, exacerbating Rees’s already questionable masculinity.

Literary scholar David Anthony has identified “debtor masculinity” as a popular theme in antebellum American gothic literature, with “fiscally irresponsible, emotionally mercurial” professional male characters at the centre of many popular fiction stories. Anthony suggests the period’s unstable economy led the male debtor to symbolize the increasing instability of the professions, thus redefining masculine professional identity.

Within this social context, however, men experiencing financial ruin could survive their indebtedness with their masculine identity relatively intact if they otherwise demonstrated rationality and self-control. Such was not the case for Rees, whose history of emotional and eccentric behaviour unfortunately caused him to resemble the feminized fictional male described by Anthony. His circumstances and unmanly behaviour...
apparently continued to irritate Christopher Widmer, who, when approached to provide medical testimony for Rees’s 1851 petition, flatly refused, commenting to Premier Robert Baldwin that he had “nothing to say in [Rees’s] favour” since the claim was a waste of public money and “the most impudent effort ever projected.”83 While seemingly unfair, Widmer’s comments may be understood as an extreme representation of broadly held attitudes about men and debt. With self-improvement forming a key element of middle-class male identity by the late 1840s, Rees was clearly in a precarious social position.84

His unmarried status had further complicated his social position by the 1850s. While it was relatively common for young middle-class men to be single, it was uncommon for them to remain bachelors beyond age 40.85 Opportunities for social mobility and increased personal security through marriage and family life therefore also decreased with age. Now in his fifties, Rees was no longer young, and, given his poverty and various health problems, he was an unlikely candidate for marriage. Bachelorhood left him with a lack of family support as his health and finances deteriorated through the rest of his life.

Many of Rees’s friends and former colleagues sympathized with his plight. Recognizing that he had no family to assist him and believing him still to be a valuable professional who simply ran into great misfortune, they petitioned government officials on his behalf throughout the 1850s and early 1860s. In May 1852 Robert Jameson wrote Allan MacNab and Henry Sherwood (respectively the current and former Tory leaders) asking for their “proper moral influence” to assist with Rees’s case and expressing his fear that compensation would come too late to be of any use to Rees. Prolonged financial assistance was rarely granted in the province, and such pension appeals were unlikely to succeed, however legitimate a man’s plight; middle-class Victorians believed “free handouts” promoted idleness and destruction of moral character. The moral valuation of a man’s work ethic meant charitable assistance was typically offered only in exchange for labour, making a government position a more likely compensation option for Rees.86

MacNab and Sherwood subsequently corresponded with Premier Francis Hincks on the subject, as did Dr. George Herrick, a member of the medical board. Herrick suggested to Hincks that Rees would be an appropriate candidate to be an “Inspector of Gaols and Lunatic

83 TRL, RBP, Widmer to Baldwin, July 9, 1851.
84 Morgan, Public Men and Virtuous Women, p. 215.
Asylums” for the western section of the province. Canada East (formerly Lower Canada) already had such an inspector, and Herrick argued that it would be an ideal post for Rees, given his expertise, experience, and physical limitations. A letter in 1852 from Tory MP William Cayley to Hincks concerning the welfare of the country’s “unhappy aborigines” in the face of government resettlement requested the selection of “some competent party to devote his whole time and attention” to their spiritual wants and temporal needs. Cayley mentioned Rees as a possible candidate due to his expertise and “peculiar idiosyncrasy which render him eminently qualified for this all-important charge.” This last suggestion was probably more practical than the inspectorship, since it would be less physically demanding, but it was unlikely the government would fund such a position when William B. Robinson had already been appointed as a Native settlement negotiator in 1850.87

Hincks apparently had his own ideas as to how Rees might best be employed. In October 1852 Sherwood wrote to Rees about his discussion with Hincks:

[Hi rents] seems quite disposed to recognize your claim and requests me, as I shall do, to place it before the Government in the shape of a Bill for the establishment of Institutions for the imprisonment and correction of juvenile offenders, one of which is to be erected in Toronto, and if the proposition meets the approbation of Parliament, and becomes a law, that he will give you the management of it at a respectable salary. If this arrangement, however, should fail, I feel justly confident that I can get your just claim answered in some other way.88

It is strange that Hincks would think Rees was sufficiently fit to manage such an institution given his physical disabilities, particularly one that would likely house violent inmates. Since provision for a juvenile reformatory was not made until the 1857 Prison Inspection Act, Hincks’s suggestion did not materialize into a position for Rees.

Rees tried to help himself by staying professionally and politically active during the 1850s, although his efforts did little to improve his financial situation or repair his professional identity. As in the 1830s, he wrote several petitions to the Legislative Assembly concerning urban infrastructure and welfare. Examples included comments on an ice bridge and breakwater at Quebec, a petition to incorporate a humane society for the protection of animals, proposed amendments to the Toronto “Esplanade ‘Act’” for the routing of the Grand Trunk Railroad, and measures “to secure free

87 Report of the Select Committee of the Legislative Assembly in the Case of Dr. Rees, pp. 10–11.
88 Ibid., p. 8, Sherwood to Rees, October 6, 1852.
[smallpox] Vaccination to the inhabitants of [the] Province.” Yet, in the context of the United Province’s larger government, increased responsibilities, and location away from Toronto between 1852 to 1859, petitions no longer drew attention to Rees as a professional. His ideas were read in the legislature, but did not bring the same level of political and social prestige as they had in the small world of 1830s Toronto. Rees’s deteriorating health prevented greater participation on government committees, and his pen remained his only tool of activism.

Following Herrick’s proposal two years earlier, in 1854 Rees approached the government himself about forming a Provincial Board of Inspectors to supervise and investigate all “institutions in which the Public Health may be more or less deeply affected.” He did not directly request to head such a Board, but asked Dr. Wolfred Nelson to support the proposal and recommend his appointment. Nelson had already been appointed inspector of welfare institutions in Canada East, and he acknowledged to Provincial Secretary A. N. Morin, that a “Sanatory [sic] Board” was very much required, with few men better qualified than Rees to assist with the project.

Because the provincial government did not act on any of these proposals, Rees’s former colleagues continued to make employment requests throughout the 1850s and early 1860s, imploring government officials not to “forget our old friend Dr. Rees and his services.” These character references and efforts to secure compensation for him were published in reports of Select Committees formed to investigate Rees’s appeals in 1858, 1861, and 1862. Against his friends’ efforts, the government countered that there was no fund established for such compensation. In 1864 Rees did finally obtain some remuneration, although it was only a lump sum of £1,000. This payment, equal to approximately three years’ salary as a superintendent at the originally promised £300 per year, was not much to show for a 20-year struggle, particularly with the expenses he had incurred through “journeys to and detentions at the seat of Government” at Quebec through much of the 1850s and 1860s. Undoubtedly the sum was insufficient for him both to pay his accumulated debts and to live the remainder of his life comfortably.

89 AJLAPC, 1853, Appendix L.I.L.L.L., p. 13, “Report of the Select Committee . . . the formation of an Ice Bridge over the St. Lawrence at Quebec”; JLAPC, October 3, 1854; May 12, 18, 23, and 29, 1857.
90 The legislature was located at Quebec during this period.
91 Report of the Select Committee of the Legislative Assembly in the Case of Dr. Rees, pp. 8–9, Rees to Morin, December 4, 1854; Nelson to Morin, November 23, 1854.
92 Ibid., p. 20, Isaac Buchanan to Hon. George Sherwood, August 17, 1859.
Rees’s final appeal to government came with his 1869 memorial to Governor General Lord Lisgar. He requested that his appeal be given to the arbitrators appointed to settle financial matters between the new provinces of Ontario and Quebec, separated following Confederation in 1867. Briefly reviewing the details of his career, Rees stated he was by then completely blind in one eye, with sight in the other similarly threatened. Burdened with “obligations to friends,” he feared humiliation from “dying in debt in the midst of a people who have so largely benefitted from his courage, patience, and humanity.” Once again, no further action came of this final appeal. Rees’s fears of dying a debtor were realized in early 1874 when he suffered a stroke. He died in Toronto’s General Hospital on February 5 at age 73. The absence of an obituary in either the Toronto newspapers or the medical journals suggests he died alone without family or friends. His death certificate and an executor’s notice for claims on his estate were the only records of his passing. It was a sad ending to an extremely difficult and undoubtedly lonely life.

A variety of factors contributed to the failure of Rees’s appeals between 1845 and 1869. His injuries and worsening poverty negatively influenced his ability to maintain his identity as a middle-class gentleman professional. Although supported by numerous Tory colleagues and acquaintances, his case became lost in the political shifts of mid-nineteenth-century Ontario. Slow implementation of welfare legislation meant few new social welfare or medical institutions where he might have worked were constructed. Little came of the numerous efforts to find him an alternative position suitable to his occupational and physical abilities. By 1867 Rees faced the further disadvantage of trying to claim compensation in the midst of arbitration to settle financial matters between Ontario and Quebec following Confederation. Although he received professional support through the publication of his 1869 memorial in the recently created *Dominion Medical Journal*, this venue of professional advocacy came too late in his life to have any real influence. By the mid-1860s, many of his friends and colleagues had died, leaving him virtually alone to struggle with the government while in a precarious state of health until the time of his death.

Despite all his misfortunes, William Rees made numerous contributions to the development of science and welfare in Upper Canada,
demonstrating that he is undeserving of the historical portrayals of him as a weak administrator and vulnerable victim of perpetual bad luck. Such characterizations merely perpetuate nineteenth-century attitudes about masculinity and professionalism that contributed to the downfall of his career after 1845. Rather than being viewed as representing professional “failure,” his problems at the temporary asylum should instead be seen to highlight the cultural factors that made it difficult for Rees to sustain a middle-class identity as a “professional gentleman” given his injuries, temperament, and personality. A study in downward social mobility, his story demonstrates the instability and fluidity of social and class status in early Victorian Canada. While Rees’s physical injuries indicate the necessity of bodily health for occupational achievement and suggest the importance of focusing historically on disabilities, the collegial support evidenced in his appeal cases shows that illness and inability to work did not wholly erode his professional identity as a physician. Intellectual activity and philanthropic endeavours early in his career helped Rees to earn the respect of several members of the colonial elite. These social bonds subsequently helped him preserve some of his professional reputation during a time of personal crisis, underlining the importance of collegial support for professional success, though they were less helpful when the political climate changed. Formerly pushed to the historical sidelines, William Rees’s story should serve as an invitation for more complex studies of physicians and other professionals to further consider how bodily health, occupational reputations, and collegial friendships have variously created, sustained, and destabilized professional identities.