

fig. 1 Montreal General Hospital (largely demolished),
c. 1848. (Photo: Montréal, Osler Library of the
History of Medicine, McGill University)

THE ARCHITECTURE OF THE MONTREAL TEACHING HOSPITALS OF THE NINETEENTH CENTURY

Our pedestrian understanding of the hospital is that it is a place to turn for assistance for our bodies and minds. The hospital of today, in symbolic terms, brings to mind images of corridors and beds saturated in whiteness and light, instruments of technology, and a purifying and redeeming antisepticness. In another sense, however, the hospital can symbolize despair. At worst, it is a site of distance, desolation and ultimate detachment of body and soul.

This paper will provide a closer inspection of some hospitals, primarily teaching institutions, in nineteenth-century Montréal. A study of the architectural agendas of these institutions in Montréal is not, therefore, of merely antiquarian interest, and I want to begin with a few questions that will be considered in terms of the historiographical material and the social architectural history of that city.

When did a hospital change from being a place to die, to a place to live? How did the concept of “hope” shift from a spiritual and ecclesiastical vision of resurrection to a dependence on the scientific machine as a *bona fide* substitute? And, how did we arrive at the hospital of today, at once both the life-line to sustaining life *and* the instrument of our own destruction as sympathetic beings? When did *hope* become an operative notion in the history of science? And how, today, is all this rooted in architecture?

The concept of hope is what transformed hospital planning from one of thinking in terms of a place to die to one of a place to live, but, in this change, one which linked architecture with science and withdrew from art. As the human body became the locus for classification and diseases were subject to grouping by order, genres and types, the hospital as spatial articulation of human needs became empirical, functional and rational. In the face of miserable and deteriorating eighteenth-century hospital conditions, new hospitals of the nineteenth century had to be seen as the *best* and *only* places to survive. They would have to embody the most innovative approaches to architectural design in keeping with the current trends but, as well, synthesize current hospital design theory propounded by such medical professionals as Jacques Tenon in France or John Howard in England. Strategic placement of such buildings within a geographic location was portentous as scientists grappled with such hygienic considerations as the effects of air currents and light on recuperation.

One has only to provide description of the Hôtel-Dieu in Paris at the end of the eighteenth century to see just how important it was to change the existing

hospitals. There is no better architectural image than the one created by Thompson and Goldin in their seminal book, *The Hospital: A Social and Architectural History*, where they describe the infamous Salle St. Charles which held one hundred large beds and nine small ones. What this implied was a horizontal arrangement of three to six patients lying crosswise, with the feet of one person wedged between the heads of the two on either side. These hellish conditions existed during routine days. During pestilence, the hospital crowded to capacity with the same number of patients per bed but now squeezed onto the upper berth that formed the canopy of the bed below, so that the hospital ward held four hundred and four fever patients (male) and nine others in the smaller beds. These figures reflect the condition of only one ward in the hospital. Others were equally cramped: the St. Roch ward for young boys aged three to fourteen years old had thirty-five beds which held one hundred and fifty patients. Latrines, according to the *Mémoires* of Tenon, were so backed-up with filth clear to the door that patients were required to use the *chaise percée* beside the individual beds. Nightly, the contents were dumped into a larger vessel and kept in the middle of the ward. Windows aligned only one wall so that any hope of cross-ventilation was dashed. Two narrow staircases in the centre of the building doubled as open wells, drawing air from the fever wards on the ground floor to the surgical wards and operation room on the second floor. And, of course, there were beds for the 'mad,' the pregnant and a crèche for children — all three housed in the same ward. The staircase well, drawing air from below, continued to rise to the fourth floor where men and women held fevers and smallpox. In the very same room were located the anatomical theatre and the depot for bodies. Clearly, the staircases were messengers of disease.¹

When the idea of a teaching hospital was introduced in Montréal, nothing but scientific soundness would accompany the design. All the ghastliness of the Parisian hospital and other similar examples in Europe, particularly the Royal Infirmary of Edinburgh, would be avoided at all costs. To mark the importance of the British on the once-French colony of Montréal, science, as the modern and efficient system of operation, would be introduced by the time of the arrival of British medicine within that city. In Montréal, hospitals would literally climb the mountain in a quest to dominate the city, and thereby ostensibly control, making sure that life would dominate over death. In this city, during the formative years of teaching hospitals, such institutions vied for primacy over the existing French-style system of health care.

The first mention of a hospital there was in 1643 and by 1644 preparations were made for a larger, more official one outside the fortifications. This was a Jesuit hospital (Religieuses hospitalières de St-Joseph) where the chapel played a central role, as it did for the religious order itself, founded by the Society of Notre Dame “for the purpose of conversion of the natives.” According to

archival records, the first building was designed as a central pavilion of grey masonry construction, 60' x 24', with five rooms attached: a kitchen, a room for the founder with another for her maid, a room for the nurse and the Mother Superior and (between 1657-59 at least) a room for the priests. There was a stable with grazing area, courtyard and main gate. Some furnishings for the chapel and hospital were shipped from France. Sometime between 1654 and 1695, the nine- to ten-foot stone chapel was converted into a parlour and a wood frame chapel was added, 80' long by 30' wide and 20' high.²

In 1826, when conditions deteriorated with considerable acceleration as space constraints were increasingly restrictive, rumblings of discontent were heard concerning the drawbacks of the existing facilities, stirred up by a latent but direct competition from the Montreal General Hospital. Indeed, the Hôtel-Dieu and the Montreal General Hospital were the two major health-care facilities at that time. Faced with a continual conflict of religious and language differences, French-Catholic and English-Protestant physical and intellectual domination of the city, Montréal necessarily developed a split image that registered not only the tension between these Catholic and Protestant traditions, but the deeply embedded cultural differences of immigrants from France and Great Britain.

The history of the Hôtel-Dieu, founded by Jeanne Mance and eventually expanding to thirty beds, parallels the history that is Montréal. The hospital, symbol of healing activities, was controlled and guided by the faith and spirituality which was the nexus of French Catholic society of the time. Now it had to be measured against a fresh ideological departure: a spanking new, English-based, Protestant-oriented *teaching* hospital with twenty-four beds, the *Montreal General Hospital* (fig. 1), founded in 1821 by four young and proud scientists. The impertinence of these young men exacerbated any hope of consolidating the conflicting groups (French- and English-speaking). More to the point, this was perceived by those affiliated with the Hôtel-Dieu as a means of certain disgrace to what they had built over the last one hundred and seventy-eight years. In such a competitive climate and, perhaps predictably, Sœur Lacroix, who served as architect and director of the *Hôtel-Dieu* (Montréal), ordered her (existing) hospital to be demolished to make way for a new monastery and health-care facility to open its doors in 1861 (fig. 2). But, let me return to the Montreal General Hospital.³

On May 3, 1822, the Montreal General Hospital officially opened and teaching began almost immediately. At the same time, those who founded the Montreal General Hospital also founded a medical school, the Montreal Medical Institution, which took in its first students in 1823.⁴ With science abounding and religion abating, it is clear that, as Foucault said, a new experience for the patient was in the process of being born, and “ medicine as



fig. 2 Victor Bourgeau, Hôtel-Dieu, Montréal, 1861, Montréal, Archives des religieuses hospitalières de St-Joseph. (Photo: Montréal, Novelty Manufacturing and Art Printing Co.)

a clinical science appeared under conditions which defined the domain of its experience and the structure of its rationality.”⁵ The use of anatomical pathology tempted scientists to seek out ways to classify and to attach names in Latin important to the validity and efficiency of the system. The hospital as “techno-machine” equated science with the defeat of disease. This high-tech art form of the nineteenth century must be understood, then, as a masterly project equal to the wizardly work in iron in engineering and architecture of the late eighteenth and early nineteenth centuries. One thinks of the Forth or Coalbrookdale Bridges or mathematical exercises in rigid forms of applied geometry in courses taught by J.B. Rondelet at the *École Centrale des Travaux Publics*⁶ or J.-N.-L. Durand at the *École Polytechnique*.⁷ Indeed, the new concept of “hospital,” — an intricate scientific machine — had a clear objective to convey to the Board, the patients and the patrons that this practical, rational and well-ordered hygienic environment could only promote health and rehabilitation as a logical outcome of internship. If death would result from a stay within this environment, it was something altogether unavoidable and perhaps had been significantly delayed due to treatment in such a place.

The four young graduate doctors, founders of the Montreal General Hospital, were intent on developing an institution for clinical studies as they put it in a clinical lecture later recorded in the Minutes of the Montreal Medical Institution:

Being convinced of the advantage which would result from the establishment of a medical school in this country, and considering that the Montreal General Hospital affords the student a facility of acquiring a practical knowledge of Physic never before enjoyed in these Provinces, an advantage which will be greatly enhanced by the establishment of lectures on the different branches of the profession.⁸

This can be read, of course, as the architectural programme. Considerations of wards and contemporary clinic distribution of space were thoughtfully broached in order to define the purpose of the institution. As a result, a distinction could be drawn between the well-established French institution of health — which embodied all that the Church represented, and which had made its mark upon Montréal society at least until the defeat of the French in 1759 — and the newly-developed English health-care institution which was clearly operating on a premise of one-upmanship to the existing French system. In the Minutes of the Montreal Medical Institution (1823):

Medical officers appointed by the president and Director of the Montreal General Hospital having seen the great difficulties which the student of Medicine within the country has to encounter before he acquires a competent knowledge of his profession... are further encouraged to attempt the formation of a... medical seminary where they reflect that of the medical school of Edinburgh, the basis of which they would adopt for the present institution... (as it has been)... more than one hundred years since medical lectures were first delivered in that city. And the early history of the Royal Infirmary of Edinburgh is not dissimilar (sic) to that of the Montreal General Hospital.⁹

This notion of *difference* from the French community would underscore all the existing tensions created in the city from the time of the British invasion to the present day. And, for the teaching institution, the architectural forms the hospitals would assume from this time on would persist, coupled with the geographic quest for the top of the mountain.¹⁰ Mount Royal, described by Newton Bosworth in the first English-language history of the city (1839), portrayed the mountain as “a very conspicuous object, [that] consists of two distinct hills, between which passes one of the leading avenues into the city... which, from the many charms of its scenery, is a very favourite drive.”¹¹ Struggles for control of life and life-enhancing institutions would mark the topographical conquest of the mountain where hospitals would leapfrog up its hills by relocating outside of the fortifications throughout the nineteenth century and

well into the twentieth. A competitive campaign continued to be waged for the administration of life or the conquest of death.

In this context, part of the image of the existing nunnery hospitals was one of moving through a zone of passivity that focused on the world beyond, as the patient awaited death. The aspect of “hope” that the Scottish doctors attempted to disseminate addressed a departure from the current practice to an aggressive commitment to experimentation, where life would indeed transform the patient to a *subject* of science. Whereas both states point to the body as an idle vessel, in the first instance the submitting body joins the crowd in the hereafter; in the latter, the body acquiesces to become a museum piece. Ivan Illich refers to the hospital of the nineteenth century as the “museum of disease,” designed to accommodate students in order to facilitate their study of patients as clinical examples.¹²

Because the four Montréal doctors were trained at the Royal Infirmary of Edinburgh, it would seem logical that their inspiration for hospital design emanated from much of the thinking that went into preparing this two hundred-bed Scottish hospital, designed by William Adam in 1738. At Edinburgh, open walk-through wards housed twenty-four beds in each room, in a symmetrical arrangement. Surgery and surgical cases were kept at the top of the building where an operating theatre was illuminated by a cupola.¹³ This space was given three functions: operative surgery, observation tower and chapel. This confusion of function inevitably impaired hygienic conditions. Doctors who were trained there in the first twenty years of the nineteenth century were struck by a considerable deterioration of the conditions of “sanitary” quarters. A series of pamphlets of heated disputes levelled accusations at the managers of the Royal Infirmary of Edinburgh concerning diet and hygiene with charges of “Patients being fed like wild beasts in cages, having their meat thrown upon their beds when raw” and criticisms about “uncleanness of sheets, sheets imperfectly washed.”¹⁴ Even earlier (1800) Dr. Robert Jackson commented that the Infirmary:

is not situated advantageously for ventilation: confined on one side by a wall, on another by lofty homes, the air of it can only be preserved sweet and wholesome by the operation of strong causes, acting within.... The air of the wards is thus heavy, in damp weather it stagnates, and frequently is offensive.... The bottom part (of the bed) is formed of thick and spongy rope, disposed to receive and to retain every kind of contagious mischief... that the Inspector of a Military Hospital would... condemn... to flames.... There ought to be a command of water in every apartment, a water closet, a boiler for heating water, and a bathing vessel for the use of the patients of the ward, covered from the sight by a curtain.¹⁵

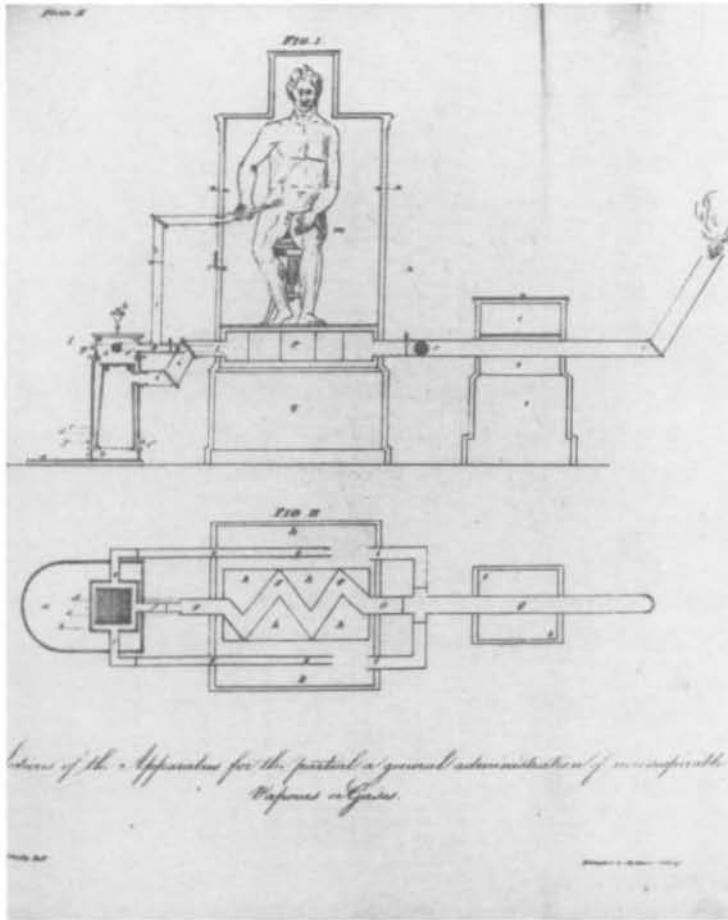


fig. 3 Sections of the Apparatus for the Partial or General Administration of Non-Respirable Vapours or Gases, from Charles Sylvester's, *The Philosophy of Domestic Economy*, 1819, n.p. (Photo: Edinburgh, Medical Archive Centre, Edinburgh University Library)

These remarks would make a tremendous impact on physicians training there so that when they left for Montréal, the doctors saw to it that architecture and design became a physician's art. They sought rectification through innovative hospital design, known to them either in Edinburgh or perhaps from the Massachusetts General Hospital, constructed at the same time.¹⁶

Engineer-inventor extraordinaire, Charles Sylvester (fig. 3), in a book entitled *The Philosophy of Domestic Economy*, expounded his laudable ideas about inventions for institutions, such as for the Derbyshire General Infirmary. "High situation" is suggested as the most healthy location for a health-care facility. This has direct import for the Montreal General Hospital as it moved up and out beyond the fortifications. Perhaps there was a covert political

agenda: the English-language population was to take possession of the city beyond its original French boundaries. Further, Sylvester's recommendations and designs included roasters for meat and baking, steaming tables for bodies, laundry and washing machines (remarkably similar to our present ones), ventilating and heating machines, baths (with water now changed every 14 days) and elaborate water closets.¹⁷

Although it is still unclear to me whether or not any of these inventions were introduced into the Montreal General Hospital, I believe the *desire* to implement these enlightened design features is important. The primary sources of December 27, 1820, state that it was "resolved that Mr. Becket be requested to send out from England as early as possible Sylvester's book on the recent improvement in Hospitals together with such plans of the most improved Hospitals as he can procure."¹⁸ We have no information on the identity of Mr. Becket, although we do know that Thomas Phillips was chosen as the architect. Just how much Phillips contributed to the design of the hospital is highly debatable.

Regardless, there can be no doubt that a sweeping strategy of change from previous health-care systems was mapped out for Montréal and English-language subjects. There was no further place for existing architectural forms in hospital design. New programmes and hospital concepts firmly rooted in British culture were the only suitable models for the gentry doctors and Board of Governors.¹⁹ The most noteworthy of all in what can be called metaphorically an architecture of domination, was the physical lack of a chapel. Concurrently, however, the French-Catholic culture persisted in its traditional approach to hospital design and concepts.

Not far from the foot of the mountain (although significantly modernized since its days within the fortifications), the new Hôtel-Dieu on Pine Avenue and St. Urbain Street perpetuated even in 1861 (forty years after the Montreal General Hospital was begun) a cross-axial plan where the church formed the central axis and all wards were extended from and connected to it. Designed by the prominent Montréal architect, Victor Bourgeois, the Church was the most noticeable feature from the street, in fact, more so than ever before. This new building endeavoured to meet the challenge of the Montreal General Hospital by reinstating the necessary presence of the Church as centre of an institution, but an enlarged institution that could compete by combining with religion a teaching philosophy in medicine.

Even the Royal Victoria Hospital (fig. 4), opened in 1892, designed by H. Saxon Snell of London, England, would once again confirm the Scottish/English presence. It covered twenty-three acres and was carved into a niche of Mount Royal (the mountainside), while looming slightly above the new Hôtel-Dieu of 1861, further downhill. This can be read as a political championing by

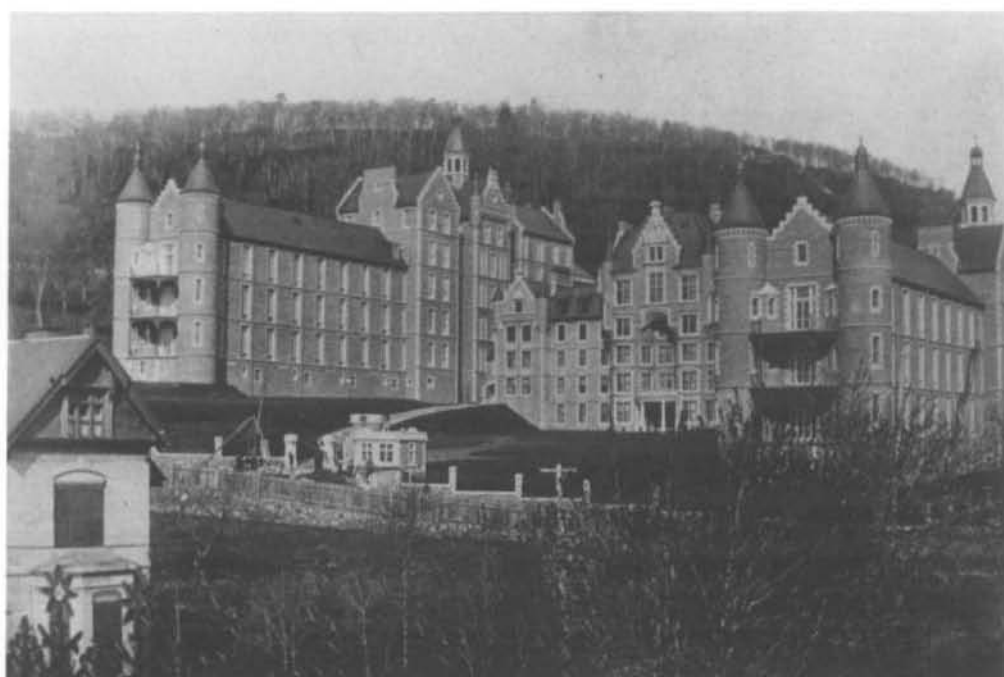


fig. 4 H. Saxon Snell, architect, Royal Victoria Hospital, c. 1891. (Photo: Montréal, Osler Library of the History of Medicine, McGill University)

way of an architectural choice designed to illustrate the defeat of science over religion; of hospital technology (otherwise known as “hope”) in the conquering of life over death.

Whereas at the early part of the nineteenth century Montréal hospitals provided a fertile subject for debate centred on language and cultural differences, what emerged towards mid-century was as a question of *control* and *authority* for the preservation of the sick-poor. With a greater attention to the “germ theory,” changes in morbidity patterns affected the way in which the middle- and upper-classes began to enter hospitals as patients. Technology and multiplying ideas in the scientific community sparked an unavoidable bureaucratization of hospital staff. The outbreak of cholera, for example, in Montréal in 1832 put the germ theory to the test. Between June 8 and September 2 of that year, 2,218 people died. Subsequently, a quarantine station was established on Grosse Isle, known as the St. Lawrence Quarantine Station (1832-1837). In its conclusion on the status of the epidemic, the Central Health Board claimed that it was impossible to prevent the importation of disease to this country. Only drainage, sewerage, ventilation, a pure water supply, attention to cleanliness

and the prevention of over-crowding would help mitigate the intensity of the epidemics and obviate recurrences.²⁰

A half-century later, this appreciation of sanitary conditions is echoed by Dr. Starkey in his inaugural address to the Montreal Branch of the Royal Sanitary Institute (founded in England in 1872), and composed of civil engineers, architects, doctors, chemists and bacteriologists, all engaged in the practical application of "sanitary science." Starkey pointed out, in an article entitled "Not Wholly Due to Bad Water," sections of Montréal where disease (especially intestinal) is most prevalent: low class property, narrow lanes, blind alleys, back-to-back houses, an abundance of filth from house refuse, bad drainage and sanitary arrangements, small shut-in courtyards, poor soil conditions upon which houses are built, no provision for efficient drainage, poor ventilation, a marked absence of sunlight.²¹

This dramatic contrast between religious and secularly informed programmes for architecture has a wider relevance as we look at medicine and hospitals today; that is, at palliative care and its new promise of respectable death in environments conducive to humane activity — an aspect of health care which is rebuilding strength within contemporary communities disenchanting with medicine as we know it in the Western world. This can be contrasted with the promise of cure through scientific expertise, where the test provides a rational approach to sustaining life — perhaps, however, in locations we find particularly inhumane.

At this juncture, I return to the substantive portion of this paper which purports that although I can create a link between sanitary deficiencies, advancing medical theory and technology, and architectural change, some essential methodological problems have still not been addressed. What has resulted from largely selective readings of the history of medicine, economics, architecture and science is largely an uncritical use of the term "science" that obscures a vast array of difference in nineteenth-century thought. And, in this way, science is seen as perfectly linear. Consequently, only that which can be proven to be "true" is recorded in the annals of medical science.

What must be looked at anew is context — individual community — to legitimate a scientific "truth." What was "true" for Montréal's bifurcated population was that science provided a validation, a liveable, manageable, rationale for coherency within a severed municipality. It provided a framework, even a superstructure, to empower the British gentry. Science, and science alone, in the face of a potentially overwhelmingly pious French constituency, possessed the requisite features to announce a new focus and explanatory structure for the dominant (English-language) class.

The nineteenth-century architectural choices made by each of the city's two major cultural groups for academic hospital-care reveal their place within,

and their responses to, the complex social, political and cultural conditions within an expanding, developing urban community. Their choices allow us to better comprehend the construction of our own concept of a place to die.

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Notes

- 1 John D. THOMPSON and Grace GOLDIN, *The Hospital: A Social and Architectural History* (New Haven and London: Yale University Press, 1975), 122-24.
- 2 Sœur Marie MORIN, *Annales de l'Hôtel-Dieu de Montréal* (followed by two other annalists), 1642-1757, 19ff. et seq.
- 3 For further information, please see the archival anthology assembled by the archivists of the Religieuses Hospitalières de Saint-Joseph, under the direction of Sœur MONDOUX, *L'Hôtel-Dieu, premier hôpital de Montréal, 1642-1763* (Montréal: Thérien Frères, 1942). Additional discussion is available in Michel ALLARD, ed., *L'Hôtel-Dieu de Montréal (1642-1973)*, Collection Histoire, Les Cahiers du Québec (Montréal: Hurtubise HMH, 1973).
- 4 *By-Laws, Regulations and Statutes/Minutes, Board of Directors, Montreal General Hospital, 1822-23*, McGill University Archives. It is useful to mention the first comprehensive volume on the hospital by Francis J. SHEPHERD, *Origin and History of the Montreal General Hospital* (Montréal, 1925). This small work was enlarged by H. E. MacDERMOT, *A History of The Montreal General Hospital* (Montréal, 1950), 19-20. However, much of what Shepherd and MacDermot documented is more anecdotal and requires a thorough review of primary archival material.
- 5 Michel FOUCAULT, *Naissance de la Clinique; une archéologie du regard médical* (Paris: Presses Universitaires de France, 1972), 74.
- 6 Author of a major treatise on the art of building, particularly construction techniques, entitled, *Traité théorique et pratique de l'art de bâtir* (1802-1817).
- 7 Durand served as Professor of Architecture at Napoleon's new institution, the École Polytechnique, a school devoted to various sciences and technics, but clearly sympathizing with engineering as the forerunner to architecture. Although he had published in 1800 *Recueil et parallèle des édifices en tout genre, anciens et modernes*, it is his second publication, *Précis des leçons d'architecture données à l'École Polytechnique* (1802-5), that addresses structural systems of building.
- 8 Montreal Medical Institution. Minutes, 27 September, 1823. McGill University Archives, Montréal. File RG 38 (c.1).
- 9 Montreal Medical Institution. Minutes, 1823. McGill University Archives, Montréal. File RG 38 (c.1).
- 10 Although the Hôpital Général, founded by the Charron brothers in 1696, existed between the dates of the Hôtel-Dieu and the Montreal General Hospital, the first was created as a hospice and never functioned as a teaching institution. See Gilles JANSON and Michel LALONDE, "Guide des sources d'archives concernant la médecine sur l'île de Montréal, des débuts jusqu'en 1900," in *Archives* (1980): 29.
- 11 Newton BOSWORTH, ed., *Hochelaga Depicta; The Early History and Present State of the City and Island of Montreal* (Montréal: William Greig, 1839), 88-9.

- 12 Ivan ILLICH, *Némésis médicale: l'expropriation de la santé* (Paris: Editions du Seuil, 1975; Collection Points, 1981), 170-71.
- 13 The authoritative text is A. Logan TURNER's *Story of a Great Hospital; The Royal Infirmary of Edinburgh, 1729-1929* (Edinburgh: Oliver and Boyd, 1937).
- 14 Alex. BOSWELL, clerk, *Note by the Ordinary Managers of the Royal Infirmary of Edinburgh* (Edinburgh, 7th March 1817). Dr. Mike Barfoot, Archivist, Lothian Health Board, University of Edinburgh Medical Archive Centre, was invaluable in bringing this document to my attention.
- 15 Robert JACKSON, M.D., *Memorial Addressed to the Managers of the Royal infirmary of Edinburgh* (Edinburgh: Mundelle & Son, 1800), 12-14.
- 16 Paul STARR, in *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 150-51, elaborates on the idea of the voluntary hospital as a privately funded enterprise and the involvement of doctors in soliciting donations. By extension, doctors would have direct say in the articulation of space.
- 17 Charles SYLVESTER, *The Philosophy of Domestic Economy; as exemplified in the mode of Warming, Ventilating, Washing, Drying and Cooking, and in various Arrangements contributing to the Comfort and Convenience of Domestic Life, adopted in the Derbyshire General Infirmary, and more recently on a greatly extended scale, in several other Public Buildings, Newly Erected in this Country; Together with an Explanation of the Principles on which they are performed* (Nottingham: H. Barnett, 1819).
- 18 MacDERMOT, *A History of The Montreal General Hospital*, 7.
- 19 The Register of Proceedings of the Board of Governors of the Montreal General Hospital recorded on December 27, 1820, the following resolution:
Resolved unanimously, that a subscription be opened for contributions toward building a permanent Hospital to be called the Montreal General Hospital upon the ground in the St. Laurence [sic] Suburb lately belonging to James Marshall [,] Gardener [,] and that the said Hospital be provided and constituted upon the following principles (viz) to be for the reception of patients of all diseases usually admitted into such Hospitals in Great Britain without distinctions of religious denominations, that contributions of seventy five pounds and upwards shall entitle the contributors to have, during their lives, voices in the management of the General Hospital, in the ratio of the sums they do contribute respectively they shall be denominated Governors or Directors of the Montreal General Hospital or such other appellations as may hereafter be agreed upon.
- 20 Report of the Central Board of Health in *Act 12 Victoria*, Cap. 8, (Québec: John Donaghue & Co., 1855).
- 21 Dr. T.A. STARKY, "Not Wholly Due to Bad Water", Montréal, Feb. 15, 1906 in *Album of Newspaper Cuttings*, Osler Library Holdings, McGill University.

ARCHITECTURE DES PREMIERS HÔPITAUX UNIVERSITAIRES DE MONTRÉAL AU XIX^e SIÈCLE

Cet article vise à faire ressortir les différences dans l'architecture hospitalière de Montréal, caractérisée par la présence d'établissements de santé français et anglais, et dans la façon dont ils se sont développés au cours du XIX^e siècle. Je m'intéresserai aux différences systématiques entre les deux types de constructions hospitalières qui ont transformé profondément le visage social, économique, politique et culturel de Montréal.

Les hôpitaux français étant un prolongement de l'action de l'Église, les congrégations religieuses qui en assuraient le fonctionnement prodiguaient des soins destinés à apaiser les souffrances des malades. Cette approche (aujourd'hui appelée «soins palliatifs») se traduit, sur le plan architectural, par la conception de salles d'hôpital avec un plan prévoyant toujours une chapelle au centre, et qui en général respecte un ordonnancement symétrique.

À la différence de l'hôpital français type, le premier hôpital anglais fut aussi le premier hôpital «universitaire» en Amérique du Nord où l'enseignement était dispensé dans les deux langues. Ce facteur subtil mais pourtant décisif révèle un changement radical dans le cours de l'évolution des soins de santé et partant, dans les installations réservées à cette fin. Du jour au lendemain, l'Église n'exerce plus une emprise aussi forte. L'émergence de la médecine en tant que science est le facteur clé prouvant au malade qu'il est désormais possible de croire en la science médicale plutôt qu'en Dieu. En contrepartie, le médecin accède à un rôle nouveau et unique, et a le pouvoir de décider de la vie ou de la mort de ses semblables. La construction du premier hôpital universitaire supprime donc le plan central au profit d'un nouveau type de bâtiment, inspiré de certains hôpitaux universitaires, en particulier le *Royal Infirmary* d'Édimbourg.

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