

Edited by Dianne Dodd
and Deborah Gorham

Caring and Curing

Historical Perspectives on Women
and Healing in Canada



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Caring and Curing

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For Michael Moher and Toby Gelfand

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Dianne Dodd and Deborah Gorham
Ottawa, April 1994

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1

Introduction

DIANNE DODD AND DEBORAH GORHAM

This collection of articles on women and health care in Canada from the 1880s to the present, which grew out of the 1991 University of Ottawa Hannah Lecture Series, contributes to an understanding of the complex role women have played in the history of health care, as workers and as consumers.

Until quite recently, much of the historiography on gender and health care accepted the gendered medical hierarchy, which conflated medicine with the physician's role alone, and either ignored or subordinated the experience of nurses and other health care workers. Historians have focussed on mainstream medicine's promotion of a maternalist ideology¹ that confined women to the private sphere, while enhancing medical authority over an ever growing medical domain, much of it affecting women as patients.² As well, historians have shown that the physicians' view of women's role in society and the family profoundly affected the treatment and diagnosis of disease among women patients.³ The pioneering role of early women doctors,⁴ who managed to break through the barriers to become professionals, has also engaged the interest of historians.

More recently historical focus has shifted to women's agency in attempting to redefine the boundaries of medical practice by negotiating with physicians and public health authorities for medical improvements designed to ensure the health and safety of women and children.⁵ This collection contributes to and expands on this new approach by examining women as nurses, as patients, and as members of laywomen's organizations. Medical professionalization with its attendant risks and benefits, and its frightening but liberating medical technology, knowledge, and methods, is seen here as neither a total defeat for women, nor an unqualified triumph. Although the ideology of medicine in the late nineteenth and early twentieth centuries stressed a gendered division of labour in which highly paid prestigious and autonomous male physicians "cured," while poorly paid and subordinate female nurses "cared" for patients,⁶ women successfully built a professional niche for themselves in health care. This role was built upon an

older tradition that did not separate, or hierarchically order, curing and caring. Occasionally as pioneer women physicians, but more commonly as a professionalized model of the traditional nurse, women offered health services to other women and children.

Less well known, but equally important, is the long tradition of laywomen's active involvement, even leadership, in the medicalization of childbirth and other areas of concern to women. As the predecessors of modern public health professionals, middle-class women, through their charitable activities, brought the message of health care to poor and isolated women, and in the process helped improve the quality of care. As well, women's organizations promoted and supported professional women health workers in their struggle to define their health care role.

Women health care workers and their lay allies had a perspective on health care that differed from the mainstream. As a result, many worked quietly toward ameliorating the harsher effects of mainstream medicine's one-dimensional approach to medicine. Although class, ethnic and even regional distance often separated women health care practitioners from the female patients they served, these women implicitly challenged mainstream medicine by giving nursing care, midwifery and prevention a more prominent place. The more vocal and organized among these women healers demanded greater recognition, autonomy and even a redefinition of health care, from their male colleagues. Thus the volume offers confirmation that women's experience of professionalization was and has been fundamentally different from that of men. Women's demands, however, were muted and remained largely unheeded by mainstream medicine.

Nurses as Health Care Professionals

Our emphasis on the history of nursing redresses an imbalance in the literature that has allowed a scholarly interest in the professionalization of medicine to obscure a similar trend occurring in nursing. This process clearly affected a much larger group of women health care workers. The three contributors who explore nursing history in this volume, Beverly Boutilier, Meryn Stuart, and Kathryn McPherson offer new perspectives on modernized, professionalized nursing and its contribution to health care in Canada. In Canada, as elsewhere, nursing moved out of the domestic to the public sphere in the nineteenth century. As yet another aspect of women's domestic work performed in the home in times of

illness and/or childbirth, nursing bestowed no particular stature, and certainly no remuneration. Its domestic roots indeed haunted nursing as it slowly evolved into a twentieth century profession attempting to cloak itself in the authority of science. These three papers address, in different ways, the complex and sometimes contradictory definitions of the role of the nurse that emerged as nurses realigned and renegotiated their relationship to a changing medical establishment.

As we see from Boutilier's paper on the National Council of Women's changing view of nursing, even laywomen reformers were not immediately friendly to the idea of trained nurses. Worried that the hospital environment, where nurses trained, would "unsex" middle-class women, they were also ambivalent about separating nursing from the more general maternal-domestic role with which they identified. Merging its concern for providing women with adequate nursing services in the home, with an impulse to create roles for middle-class single women in the burgeoning industrial economy, the National Council of Women endorsed trained nurses in the 1890s and eventually founded the Victorian Order of Nurses. Ensuing conflict with the medical profession over the role and definition of "nurses" helped push the Council to adopt a professional model.

Hindered by a traditional image, and its association with domestic work, nurses met with considerable obstacles in their efforts to professionalize. Despite the heavy workload and unusual level of responsibility imposed on nurses, hospital administrators and physicians have seldom given them autonomy and recognition as professionals.⁷ Nowhere is physician hostility to the autonomous nurse more apparent than in the case of public health nursing, a practice that originated in the mid-nineteenth century as a service to the sick poor and as an occupation for single, middle-class women. As Stuart points out in her contribution on Ontario's rural child welfare project in the 1920s, the Ontario Provincial Board of Health marginalized women in both the clinical and administrative aspects of its program. They also confined nurses' public health role to the promotion of infant welfare alone. This despite the fact that public health nurses, as cheap, well-trained, and committed workers were the vanguard of the new public health movement that emphasized the special power of one woman—the nurse—to teach mothers about child care.⁸

It is clear from Stuart's paper as well as several others in the collection that in isolated areas public health nurses often did the work of physicians, particularly in obstetrics. Admonished against suggesting treatment or diagnosis, even against advancing opinions, these nurses

were consistently denied the recognition or autonomy they needed to effectively meet the demands of their work.

Nursing leaders, however, did not openly challenge prevailing gender norms, which linked nursing with domestic work, and made it appear as a natural extension of the wife–mother role. Instead they emphasized womanly self-sacrifice. While this made nursing a less threatening role for women to assume than that of physician, it also prevented nurses from assuming the degree of autonomy thought necessary to professionalism. Indeed many rank and file nurses saw themselves not as professionals but as workers who had a special womanly gift for nurture. Many of the tensions that emerged between trained and untrained nurses, between private-duty nurses and hospital superintendents, are linked to this ever present conflict between professional and gender identity.⁹ As Kathryn McPherson describes the day-to-day reality of most nurses' working lives in her contribution on the history of nurses' work, education and self-identity, it is clear that the conflicting demands of patients, their families, hospital administrators, and physicians—many of whom still viewed nurses as servants—did little to foster a professional ethic.

But McPherson's central point in her contribution to this volume is that nurses resisted the many forces intent on defining nursing as non-professional, domestic labour. McPherson challenges much previous scholarship on the relationship between nursing and science and posits that nurses were engaged in a process of redefining nursing as a profession based, as medicine was, on science. Science was not compatible with nursing's traditional values, and further, was often used as a tool by hospital administrators and physicians to increase "efficiency" in the workplace. Still, McPherson asserts that nurses' work, even in the pretechnology era of the 1920s and 1930s was indeed based on science, and that nurses themselves perceived their work as scientific. In their struggle to redefine their role, nurses repudiated domestic expertise as a basis for authority, and adopted the male model of science. Because nurses' perception of science offered the prospect of reintegrating caring and curing, they perhaps redefined science in the process, McPherson suggests.

The work of Boutilier, Stuart and McPherson reveals that professionalization in nursing offered middle-class Canadian women a role in the public sphere with remuneration and some degree of publicly authorized skill and authority. However, while nurses' self-identity may have challenged mainstream medicine, nurses remained subordinate to physicians, in the hospital, as private duty nurses, and as public health

nurses. As well, their leaders' efforts to professionalize were thwarted by a gender ideology that stressed women's subordinate role in society.¹⁰

Yet our contributors also demonstrate that nurses were not as subservient in reality as in rhetoric. Nurses' efforts to improve their status involved the adoption of a rhetoric of professionalism that, although modified by the ideology of femininity—and therefore fundamentally different from male professionalism—placed nursing under the aegis of science, so essential to modernized medicine.

Mothers, Midwifery and Medicine

The papers in chapters 5 through 7 link together several disparate themes relating to the evolution of midwifery in Canada. They also offer differing interpretations. J. T. H. Connor examines the views of male physicians on midwifery in the nineteenth century; Dianne Dodd's paper is concerned with the views of the pioneer Canadian woman physician Dr. Helen MacMurchy on maternity care; and finally, Denyse Baillargeon examines the way in which a group of working-class Montreal housewives of the 1930s responded to the medicalization of maternity care.

Connor re-examines the conflict between professionalizing physicians and traditional midwives. Although the "regulars" among the male physicians organized themselves to oppose competition from folk healers or "irregulars,"¹¹ including midwives, Connor asserts that the modernizing medical profession was not monolithic in its opposition to midwives. He also points out that the Canadian medical profession, like its American counterpart, was ambivalent toward the very technological breakthroughs—anaesthesia and forceps¹²—that have been cited as factors in the demise of the traditional midwife. Finally, he elaborates on the theme suggested by the telling phrase in his title, "Larger Fish to Catch Here than Midwives," and points out the physicians had more formidable opponents than midwives and that attacks on the status and legitimacy of the traditional midwife cannot be blamed exclusively on physicians.

J. T. H. Connor's research into the views of a number of individual nineteenth century physicians offers substantial support for his statements, and his paper offers an important perspective on the midwife-physician controversy. However, there are some issues touched on in the paper that are open to opposing interpretations. While

Connor makes a good case for the ambivalence of individual physicians concerning the traditional midwife, his work does not vitiate the central premise of much recent feminist scholarship concerning the rivalry between physicians and midwives: namely, that physicians, collectively and individually, were happy to let the traditional practice of midwifery die of neglect.¹³ In Canada—in contrast to Europe—a modernized midwifery, with formal methods of accreditation, was not allowed to develop.¹⁴ Connor's distinction between educated and uneducated midwives must be seen in light of the medical profession's failure to endorse any type of formal education for midwives that might rival their own. Once the profession had established the need for an exclusive and scientifically based education as a prerequisite for practising medicine, and had established dominance over obstetrical technologies, it could assert authority over fields formerly dominated by women without openly attacking individual women practitioners.¹⁵ Clearly, middle-class male physicians built on, and exploited class, ethnic and gender advantages, which allowed them superior access to education, and earned them the sympathetic ear of the state in their licensing struggles.

While male physicians may have taken the lead in discouraging the practice of traditional midwifery, the newly professionalizing nurses and women physicians did not themselves champion these premodern female healers. Instead for the most part they adopted male conceptions of professionalism and saw the midwife as a practitioner of low status and dubious legitimacy.¹⁶ Clearly the loss of women's traditional medical expertise¹⁷—and the midwife was undoubtedly the most important exemplar of that expertise—must be viewed not only in terms of loss, but also in terms of women's gains as health care professionals.

Such gains certainly accrued to the handful of women who became physicians. Although medical professionalization initially ensured the exclusion of women, who by custom and by law were denied entry into the universities that granted the degree necessary to practise medicine, it also inadvertently opened the doors by codifying the requirements for training. Women physicians such as MacMurchy drew upon an already established constituency and legitimacy as health workers, and gained a measure of professional recognition their domestic predecessors could not have achieved.¹⁸ The fact that contemporary male practitioners, forced to share their expertise and professional status,¹⁹ perceived women's entry into the profession not as a harmless continuation of an older traditional role, but as an intolerable incursion into male territory, is evidence in itself of the gains made by women physicians.

The career of Dr. Helen MacMurchy, the prominent Canadian public health authority, eugenicist, and educator illustrates that women physicians, like other women health care workers, often served as a bridge between the older tradition associated with the now degraded midwife, and modern professionalized health care roles. Dodd in her paper focusses on one specific venture in MacMurchy's career as a public health physician: her plan to introduce a popular midwifery guide for women into isolated areas of Canada. Dodd's textual analysis of the guide reveals MacMurchy's deep ambivalence toward women's traditional expertise when it came to birthing. On the one hand, MacMurchy was convinced that medical science would do more to save mothers and children from preventable deaths than traditional patterns. On the other hand, she recognized and even respected the skills that ordinary women could bring to this women's event. MacMurchy's efforts to reduce maternal mortality in rural Canada encompassed a broader view of healing than most of her male colleagues would tolerate. Despite her middle-class reform and eugenicist sympathies, and her commitment to medical professionalization, MacMurchy showed considerably more sympathy with midwifery than did the male physicians Connor describes.

How did the medicalization of childbirth and other aspects of women's health affect the health services women patients received? Some historians contend that the increasing dominance of medicine by elite male practitioners led to a deterioration in patient care for women. One thing is apparent from all of these papers, however. The twentieth century professionalization of medicine,²⁰ particularly the medicalization of childbirth, was not immediately and universally accepted. Both Meryn Stuart's examination of a public health nursing project sponsored by the Ontario government in the 1920s, and Denyse Baillargeon's analysis of a group of working class Montreal housewives in the 1930s, demonstrate that urban working class women and rural women did not passively adopt all of the new ways that modern "experts," male or female, attempted to impose upon them. Some they rejected and others they accepted. And, because of their poverty and/or isolation, some were simply not available to them.

The role of laywomen health reformers as the vital link between medical professionals and their patients, is an important but neglected aspect of the history of women and health care in Canada. This volume's exploration of women's advocacy of health reforms, and their promotion of the medicalization of child and maternal health highlights the origins of public health. Modern bureaucratic structures

aside, public health is merely a continuation of older folk traditions in which women played a prominent role. The emphasis on living a healthy lifestyle, religious commitment in the pre-1920s period, prevention of illness, and the focus on education within the family, make public health a modern version of women's visiting.

Several papers in this volume make a significant contribution toward enlarging our understanding of the role of these voluntary women. Denyse Baillargeon, for example, shows that laywomen reformers in Montreal responded to high rates of infant and maternal mortality by setting up services such as visiting nurses, *Les Gouttes de lait* and other charities. It is worthy of note that women pushed the male-dominated medical profession to adopt such procedures as prenatal care only after public health nurses, in conjunction with women reformers, proved their efficacy and popularity. Milk depots developed into baby clinics,²¹ and were eventually taken over by provincial and/or municipal authorities.²² As Baillargeon demonstrates, visiting nurse organizations were so effective that in both Canada and the United States, a private insurance company adopted the measure in order to reduce maternal and infant mortality among its policy-holders.²³

Administrative and clinical control over public health was eventually wrested from voluntary women's organizations, its unrecognized pioneers, by male authorities and physicians. As Meryn Stuart points out in her paper on public health nursing in Ontario, the expansion in these programs was also accompanied by strict control by male physicians and administrators over women's role as "health teachers." Women complied with this medicalization of women's health, in the belief that public health would improve national health and give women a recognized role in health care and society.²⁴

Receiving substantial backing—emotionally, financially and politically—from the women's movement, women professionals, particularly in public health, tried to represent the interests of middle-class women and indirectly the poor, geographically isolated women they served. They were not entirely successful. Physicians such as MacMurchy who became missionaries in underdeveloped countries, or public health workers, took the message of medicalization to the poor and isolated. They used their position as white upper middle-class professionals to overcome the disadvantages they suffered as women. Indeed their focus on professionalization denigrated traditional domestic and maternal skills, and displaced the "untrained" midwife and working-class hospital nurse. Indeed, the whole nursing movement was based on the replace-

ment of working-class “domestic drudges” with “gentlewomen” of middle-class origins. Public health nurses who were thought to require tact and diplomacy, were often of upper-class origins. Stuart’s public health nurses clearly held class and ethnic loyalties that put them at a distance both from their women patients and from the rural doctors with whom they worked and whose education was not, they thought, of the highest quality.

The middle-class urban notion of health that these women sought to disseminate among the poor and isolated is examined through these papers. For example, the information Denyse Baillargeon gathered through her use of oral history offers the opportunity to compare the vision of women health reformers and professionals with those of working class recipients of their services. Recent historical work has examined women’s ambivalent attitude toward the services that modernized medicine could offer them during childbirth. Women may have perceived losses as birthing was transformed from a woman-controlled social event into a male-dominated medical emergency with a vast array of obstetrical interventions, and a change of location from home to hospital. Physicians, no doubt, did wish to appropriate control over maternity in order to justify their expanding ambitions in obstetrics and gynaecology and even pediatrics, but it is nonetheless true that women actively sought greater safety and comfort in childbirth. As Judith Leavitt has pointed out, high maternal mortality rates made traditional childbirth an event that women universally feared.²⁵

These fears are poignantly expressed in MacMurchy’s *Supplement*, and in Baillargeon’s evocation of the reactions of individual Montreal housewives in the 1930s. Although their mothers had used them, a fear of maternal mortality caused many of Baillargeon’s respondents to shun midwives in favour of male physicians as birth attendants. On the other hand, these working-class mothers were often hostile toward male practitioners whose competence they questioned, and expressed a greater appreciation for the services of visiting nurses. Baillargeon’s paper thus suggests that women found the strictly medical approach insufficient, viewing maternity services in ways more closely resembling that of nurses and public health physicians than private medical practitioners. Nonetheless it is also clear that the working-class mothers did not share all the views of public health nurses, in particular they questioned their faith in breastfeeding as a panacea for infant mortality and morbidity.

In the Canadian context, any discussion of social medicine must take into account the factor of geographic isolation, a subtext that runs through several of the papers. It is especially important in light of the

midwifery and maternal mortality campaigns. As both Dodd's and Boutilier's papers show, middle-class women tried to provide Canadian outpost mothers with either nursing services, or alternative medical services such as midwives. Through their campaigns, which won them the active hostility of the medical profession, women reformers pointed out the stark contradictions in the public health message. The emerging medical system advocated increased medical consultations while narrowing the definition of an acceptable medical practitioner. However, in a country where the availability of recognized medical expertise was severely restricted by cost, distance and professional rivalry, inequities resulted.

Women Physicians

At the time that they first gained admission to the profession the small number of women who became physicians in Canada in the late nineteenth and early twentieth century often adopted a strategy of adapting the ideology of femininity to their professional aspirations. Like nurses, many women physicians claimed to provide a more caring, natural and non-interventionist approach to medicine²⁶ and to serve the special needs of women and children.²⁷ This strategy gave women a foot in the door. However, it also served to divert attention away from the reality of discrimination that women faced as physicians and continued to face throughout the twentieth century.

In the concluding paper in this volume, Deborah Gorham analyses aspects of women's experience as physicians in training and in practice during the second half of the twentieth century. She is especially concerned with raising questions about the recent decisive increase in the numbers of women physicians in Canada. Now that women physicians are "no longer an invisible minority," what will the increase mean, she asks, for the women themselves, and for the practice of medicine?

At the turn of the century women such as MacMurchy were relegated to the margins of medicine and confined to areas pertaining to women and children. Gorham suggests that even today sex segregation is a factor in the medical profession. Women gravitate toward family practice, pediatrics, and obstetrics and gynecology, while men continue to dominate such prestigious specialties as surgery and biomedical engineering. Women physicians still encounter role conflict in juggling

domestic and career demands. As well, Gorham points out, women physicians must struggle to balance conflicting norms for feminine behaviour on the one hand, and masculine professionalism on the other. In this regard, Gorham presents a perspective on the meaning of professionalism and its relationship to gender that differs in significant respects from that of other contributors to this volume, most notably McPherson and Stuart. In their work on nursing, they stress the efforts of nurses to feminize professionalization, whereas Gorham maintains that modern professionalization has been and continues to be so closely linked to modern conceptions of masculinity that it will take more than muted reforms to break those links and develop genuinely gender-free, egalitarian concepts of skill and achievement.

On the issue of women physicians' possibly greater capacity for caring,²⁸ Gorham maintains that any stress on feminine virtue, especially given an identification of science and technology with masculinity, will only reinforce women's marginal status within the profession. And, as long as medical ethics continue to accord greater value to an increasingly technologized view of curing than to caring, the hope that women will change medicine is surely futile.

Gorham's paper also points to the fact that the recent increase in the numbers of women entering the field of medicine, like the earlier increase of the late nineteenth century, has been fuelled by (or at least coincident with) a rise in the strength of the women's movement. The recent success that midwives have achieved in their struggle to gain recognition from legislators and government health care planners, to which Gorham briefly alludes, also owes much to the women's movement. Clearly, the history of women and health care reveals meaningful links between health reform and feminism. But will continued pressure for health reform from women's groups result in an increase in the status of caring, as opposed to curing? Will the newly transformed professionalizing midwives in Ontario, for example, be able to transform obstetrical care? These are questions that remain as yet unresolved.

Conclusion

As health care consumers, as lay reformers and as health care workers, women have been ambivalent about the modernization of medicine throughout the period with which this volume is concerned. On the one

hand, they actively sought the improvements to health and safety that new medical science could bring to women and children. As well, middle-class women struggled to build a professional role for themselves as nurses, doctors and lay health reformers. Initially basing their claim to such work on an older tradition in which healing was part of women's domestic role, they were forced to repudiate that tradition in favour of a professionalized model. Only by doing so could they achieve recognition within the modern health care system.

Nevertheless, women health care workers continued to define their role in significantly different ways from the men who controlled the system, and to voice their own demands for recognition and for a degree of autonomy as health care professionals in their own right. Although they accepted and perhaps even reinforced prevailing gender norms, as well as class and racial prejudices, they also attempted to soften the harsher effects of male medical dominance. By voicing the demands of women patients for greater emphasis on caring and prevention rather than curing alone, professional women articulated a health reform agenda within the health care system, albeit in a constrained fashion.

The essays in this collection demonstrate that the history of women and healing in Canada must be seen neither as a simple story in which science and technology brought progress to women, nor as a story of the oppression of women by an inhuman, unfeeling medical profession. Not only has health care remained wider than medicine, even as it has modernized, women themselves have had agency during the process of modernization. And as women they have often succeeded in redefining aspects of health care affecting women, in spite of their own limitations and the limitations imposed upon them by barriers of race, class and sex.

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13. Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality," in *A Not Unreasonable Claim*, ed. Kealey, 131–150; C. Leslie Biggs, "'The Case of the Missing Midwives': A History of Midwifery in Ontario from 1795–1900," in *Delivering Motherhood*, ed. Arnup et al., 20–35; "A History of Midwifery in Canada," *Report of the Task Force on the Implementation of Midwifery in Ontario*, Appendix I (Toronto: Government of Ontario, Ministry of Health, 1987): 197–232.

14. Such a modernized midwifery is now developing. See Gorham's paper in this collection.
15. Howell, "Reform and the Monopolistic Impulse"; Rothstein, *American Physicians*; Starr, *Transformation of American Medicine*.
16. Judy Barrett Litoff, *American Midwives, 1860 to the Present* (Westport: Greenwood Press, 1978): 135–152; Frances E. Kobrin, "The American Midwife Controversy: A Crisis of Professionalization," in *Women and Health in America*, ed. Leavitt, 318–326. Studies have suggested that midwifery, as practised in Newfoundland and Labrador in the twentieth century, was closely associated with domestic work and bestowed on women practitioners little of the dignity and autonomy of a "profession." Cecilia Benoit, "Traditional Midwifery Practice: The Limits of Occupational Autonomy," *Canadian Review of Sociology and Anthropology* 26, 4 (1989): 633–649.
17. Barbara Ehrenreich and Deirdre English, *Witches, Midwives and Nurses, A History of Women Healers* (London: Writers and Readers Publishing Cooperative, 1973).
18. Mary Roth Walsh, *Doctors Wanted, No Women Need Apply: Sexual Barriers in the Medical Profession* (New Haven: Yale University Press, 1977). Similar arguments have been made concerning the professionalization of science and its impact on Canadian women, which can be said to have been uneven at best. See Marianne Ainley, "Last in the Field?: Canadian Women Natural Scientists 1815–1965," in *Despite The Odds, Essays on Canadian Women and Science*, ed. Marianne Ainley (Montreal: Vehicule Press, 1990): 25–62.
19. Mary Beacock Fryer, *Emily Stowe, Doctor and Suffragist* (Toronto: Dundurn Press, 1990): 77; Strong-Boag, ed., "A Woman with a Purpose"; Strong-Boag, "Canada's Women Doctors, Feminism Constrained," in *A Not Unreasonable Claim*, ed. Kealey; Hacker, *The Indomitable Lady Doctors*.
20. Starr, *Transformation of American Medicine*.
21. Diana Pedersen, "The Scientific Training of Mothers: The Campaign for Domestic Science in Ontario Schools, 1890–1913," in R. Jarrell and A. Roos, eds., *Critical Issues in the History of Canadian Science, Technology and Medicine* (Ottawa: HSTC Publications, 1983): 178–194.
22. Cynthia Abeele, "'The Infant Soldier': The Great War and the Medical Campaign for Child Welfare," in *Canadian Bulletin of Medical History* 5 (1988): 99–119; Abeele, "The Mothers of the Land Must Suffer: Child and Maternal Welfare in Rural and Outpost Ontario, 1918–1940," *Ontario History* LXXX, 3 (September 1988): 183–205.
23. See Denyse Baillargeon's article in this collection.
24. Morantz points out the role health reformers had in making public the idea that health is a women's responsibility. Walsh, on the other hand, links the emotional and financial support provided by the nineteenth century women's movement to the successful career of women physicians such as Marie Zakrzewska. See Regina Markell Morantz, "Making Woman Modern: Middle-Class Women and Health Reform in Nineteenth Century America," in *Women and Health in America*, ed. Leavitt, and Mary Roth Walsh, "Feminist Showplace," in *Women and Health in America*, ed. Leavitt.
25. Judith Walzer Leavitt, *Brought to Bed, Childbearing in America* (New York: Oxford University Press, 1986); Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* (New York: Free Press, 1977).
26. Regina Markell Morantz-Sanchez, *Sympathy and Science* (New York: Oxford University Press, 1985).

27. This strategy some historians have called “maternal feminism.” Wayne Roberts, “‘Rocking the Cradle for the World’: The New Woman and Maternal Feminism, Toronto, 1877–1914,” in *A Not Unreasonable Claim*, ed. Kealey, 15–46.

28. Virginia G. Drachman, *Hospital with a Heart: Women Doctors and the Paradox of Separatism at the New England Hospital, 1862–1969* (Ithaca and London: Cornell University Press, 1984).

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Helpers or Heroines? The National Council of Women, Nursing, and “Woman’s Work” in Late Victorian Canada

BEVERLY BOUTILIER

In 1905, the Canadian-born nursing reformer Isabelle Hampton Robb lamented that the “good nurses do in hospitals is now unquestioned, but outside the hospital the trained nurse is still regarded as a not altogether unmixed blessing.” At the root of the problem, she suggested, was the public’s failure to distinguish between the professional, modern nurse and her old-fashioned competitor, “the well-meaning, enthusiastic, but untaught amateur.”¹ One group of Canadians who did grasp the difference between these two classes of nurses was the National Council of Women of Canada. In the early 1900s, the National Council of Women adopted the registration of trained nurses as one of its many reform concerns. In the trained nurse, the women of the National Council saw reflected a measure of themselves. Like many of them, the trained nurse was middle-class, educated, and perhaps most importantly, a full-time care giver.² Moreover, the popular association of trained nursing with the middle-class social ideals of efficiency, order, and cleanliness made these new professional women the natural allies of the many National Council affiliates engaged in organized charity and moral uplift among the “deserving” urban poor.

The National Council of Women’s decision to ally itself with professional nursing in the 1900s marked the culmination of its decade-long struggle to reconcile two competing constructions of “woman’s work,” one trained, remunerative, and professional, and the other domestic, voluntary, and evangelical. From its inception in 1893, the National Council defined “woman’s work” as the moral and spiritual guardianship of society, and asserted that women’s traditional responsibility for homemaking and motherhood accounted for the growing social influence of Victorian women. As a result, during the 1890s, the National Council responded to the self-conscious professionalism of

North American nursing leaders with a predictable degree of ambivalence. While its members looked upon the development of trained hospital nursing as confirmation of the importance of "woman's sphere," they were initially reluctant to accord middle-class nurses the kind of professional status claimed by male-dominated occupations such as medicine and law. Instead, sacred images of trained nursing as an "avocation" and "refuge" for women who chose to serve a higher master than man dominated their initial deliberations on the subject.

This kind of sentimental imagery complemented Council women's own sense of responsibility for the physical and spiritual welfare of their less affluent urban neighbours. Evangelical sentiment permeated the benevolent nursing enterprises sponsored by societies federated with the National Council in the last decade of the nineteenth century. In general, Council women carefully distinguished between the work of trained nurses and the act of nursing itself. While they acknowledged that only women specially trained in hospitals should be engaged professionally as nurses in well-to-do households, many evangelical women within the National Council believed that any woman called to God's service could nurse among the poor. For members of affiliated societies like the Order of King's Daughters and the Toronto Nursing-at-Home Mission, nursing the sick poor in their own homes was a peculiarly feminine form of social service. Whether calling their workers "friendly visitors" as in the case of the King's Daughters or "missionary nurses," these evangelical women hoped that their organized nursing work would not only bring middle-class standards of physical care and hygiene into the households of the urban poor, but spread the transformative influence of the gospel as well. In this way, both bodies and souls would be "saved" in the poor neighbourhoods of urban Canada.

The National Council's decision to found a national district nursing order in the latter half of the decade ultimately forced its members to confront the limitations of defining the work of middle-class women solely in domestic and voluntary terms. Although Council women discussed nursing extensively, they paid very little attention to the needs of trained nurses themselves until Lady Ishbel Aberdeen, the British social reformer and Canadian social leader who presided over the Council between 1893 and 1898, founded the Victorian Order of Nurses for Canada in 1897. For an organization wary of public notoriety, the experience of founding and defending a controversial institution such as the Victorian Order proved a crucible of sorts for the National Council. The fierce campaign mounted by the organized medical profession and by segments of the popular press against the Council's

initial proposal to establish a “Victorian Order of Home Helpers”—whose members would be skilled birthing attendants but not necessarily trained nurses by Canadian standards—took Council women by surprise and forced them to concede that the question of who nursed was as important as the act of nursing itself. The persistence of medical opposition to the reformulated “Victorian Order of Nurses,” a district nursing institution to which only trained hospital nurses would be admitted, fully awakened Council women to the need for a definition of female professionalism that would neither undermine their own status as voluntary workers nor impede the expertise of trained nurses as a group.

This study considers the National Council’s discussion of nursing and the advent of the “modern” trained nurse at its annual meetings in the 1890s. The first part explores Council women’s use of conventional middle-class domestic ideology to define and delimit the meaning of trained hospital nursing in the early 1890s. The second part explores the class and gender assumptions inherent in the distinction made by some Council women between the work of trained nurses and the act of nursing as an expression of evangelical sentiment. The third part outlines the terms of the maternal welfare scheme sponsored by the National Council in 1897, and considers its reasons for employing “home helpers” rather than trained nurses to safeguard the lives of childbearing women in the Canadian Northwest. And finally, the fourth part considers the Victorian Order controversy and its impact on the National Council’s domestic construction of nursing at decade’s end.

The “Modern Nurse”

The education, social bearing, and financial independence of the “modern” nurse marked her as a new kind of woman worker. She was middle-class, and though she might work from necessity, she might also work from choice.³ For most of the nineteenth century, however, nursing had been a form of domestic service undertaken in well-to-do homes and in urban charity hospitals by working-class women of varying degrees of social “respectability.” The handful of nursing schools established in Canada during the 1870s and 1880s attracted a small number of middle-class students and public attention, but it was not until the 1890s—when over thirty established and newly constructed hospitals opened training schools—that nursing was widely accepted as an occupation suitable for Canadian women of the middle classes.⁴ Despite the growing popularity of trained nursing in this and subsequent decades,

the perception that nursing was a natural feminine calling and that nurses, trained or otherwise, were domestic workers persisted. The medical profession's representation of trained nurses as subordinate helpmeets, and hospital reformers' exploitation of them as symbols of middle-class domesticity, merely reinforced the popular image of nursing as a specialized department of female domestic labour.

During the 1890s nursing reformers began a concerted effort to distance the work of nursing from its association with domestic labour by identifying themselves and other graduates of "recognized" hospital training schools as "professional" workers. In North America, this impulse led to the formation of the American Society for Superintendents of Training Schools for Nurses in 1893, to which sixteen superintendents of Canadian hospital schools belonged by 1899.⁵ Using the medical profession as their model, these nursing elites attempted, first, to raise the educational calibre of nurses and prevent overcrowding by lobbying hospitals to implement a standard three-year nursing curriculum; second, to rationalize nursing practice by forging a set of recognizable nursing skills; and third, to evolve a code of ethics that would clearly identify public well-being with an exclusionary and hierarchical model of nursing professionalization. These reforms were designed to legitimate trained nursing as a form of paid work for middle-class women, on the one hand, and to imbue its practitioners with an occupational status commensurate with both their social rank and their medical role as "handmaids to science," on the other.⁶

Trained nurses were not the only middle-class "women workers" to organize in the 1890s. Like organized nurses, most of the women who joined the National Council of Women of Canada after 1893 also represented themselves as workers. But unlike nurses, who shared an acknowledged occupational identity that was forged by a common institutional training and publicly valorized by wages, the work of National Council women was intuitive and voluntary, and its value asserted rather than formally recognized. The work identity of National Council members derived from their assimilation of conventional ideas about women's responsibility for the home and family life. The evangelical sense of mission that underlay the social work of so many National Council affiliates and individuals during the 1890s further defined womanhood itself as a special and morally suasive force within the public sphere. At the first annual meeting of the National Council in 1894, Lady Aberdeen asked her audience,

how can we best describe this woman's mission in a word? Can we not describe it as "mothering" in one sense or another? We are not all called

upon to be mothers of little children, but every woman is called upon to "mother" in some way or another; and it is impossible to be in this country, even for a little while, and not be impressed with a sense of what a great work of "mothering" is in a special sense committed to the women of Canada.

This special, "grand women's mission" to mother permeated the National Council's reform program and was regarded by Council members as the source of organized women's public, as well as private, authority. As a common definition of purpose, it embodied Council women's equation of homemaking with nation building, and cast their organization as a "new opportunity which he affords us of being fellow-workers with Him for all that makes for righteousness."⁷

Coming of age in an industrializing and urbanizing society increasingly driven by waged labour and specialized knowledge, during its first few years the National Council eagerly appropriated the language of the paid labour market to redefine the household as a place of business and women's traditional domestic duties and benevolent activities as work. In this way, organized middle-class women entered the social sphere as skilled workers, armed with expert knowledge about the needs of the home circle and ready to shield it from the threats and temptations of the outside world. As a self-styled "representative" body of women workers, the National Council's special mission was to those women and children too weakened by poverty, disease, or moral transgression to help themselves. The missionary watchword, "woman's work for woman," guided the National Council's reform initiatives and defined a feminine work ethic built upon the cultural designation of women as the moral and spiritual guardians of society. From the viewpoint of the National Council, then, "woman's work," both in the home and in the community, was obligatory, and hence non-remunerative. It was also vocational, infusing the duties of womanhood, and particularly of motherhood, with moral and evangelical purpose. And, most importantly, its skills were those of domesticity, and as such, they were the exclusive purview of women.

Viewed through this ideological lens, the care of the sick was construed by Council women as both the private and the public responsibility of women. At their annual meeting in 1894, National Council delegates gathered to consider the question of "Women's Work in Connection with the Sick." The first speaker, Miss Agnes V. Harris of the Hamilton Local Council of Women,⁸ sketched the development of hospital nursing as an "avocation" for middle-class women and explored its relationship to a domestic and non-remunerative construction of

woman's work. No longer a degraded occupation reserved for working-class women, nursing was now "a field of labor at once honorable and remunerative." The burgeoning crop of hospitals offering instruction in nursing accounted for the elevated status of hospital nurses, according to Harris, and explained the recent and "remarkable" transformation of the public's attitude toward nursing as an occupation for middle-class women. Trained to bring the skills of domesticity to the work of science, Harris argued that the "modern trained nurse" was

peculiarly an end of the century production, certified, armed cap-a-pie with technical knowledge, the handmaid and valued assistant of the great corps of workers who labor tirelessly in the interests of humanity and science when the healthy public is sleeping.

"The necessities of the modern physician," then, had "created the modern nurse." Harris most fully expressed her approval of this new breed of woman worker by contrasting her with that archetypal mid-Victorian nurse, Sairy Gamp. "No greater contrast can be conceived," she asserted, "than the type presented by Charles Dickens in his delineation of Sairy Gamp, the typical nurse of his time."⁹

But training alone did not make a good nurse. The personal qualities of nurses themselves were equally important. Just as the drunkenness and disobedience implicit in the image of Sairy Gamp were meant to convey the socially degraded status of the untrained workhouse nurse, the wide range of feminine virtues attributed to the trained modern nurse were meant both to signify the social elevation of nursing work and to suggest the improved moral calibre of the women undertaking it. Only those women fully conversant with the intuitive skills of womanhood would be good nurses. It must be understood, Harris reminded her audience, that while the training school could teach the student how to learn and profit from "the ever varying experiences that unfold themselves as she advances in her profession," only a fully developed feminine character would ensure success. "[A]s physicians too well know, there is the trained incompetent as well as the trained competent nurse, for tact and sympathy, and an intuitive sense of how to do the right thing at the right time, are natural gifts that cannot be learned in a training school." In essence, the requirements of the "ideal nurse" were those of the ideal woman, whose personal qualities, Harris suggested, were summed up in a few lines by Wordsworth: "The reason firm, the temperate will, / Endurance, strength and skill; / A perfect woman, nobly planned, / To warn, to comfort and command." This was not "an impossible combination of virtues," Harris assured

delegates, for there were already "such women, both in hospital wards and outside them, and truly they make glad the waste places of the earth."¹⁰

This representation of the ideal nurse as a "perfect woman, nobly planned" underscored the ambivalence of National Council women toward hospital nursing as a source of income for women of their own social class during the early 1890s. The apparent disparity between a traditional construction of nursing as a feminine domestic duty and its reconstruction as an "honorable and remunerative" occupation was a potentially troublesome one, for it threatened to erode the very foundation upon which Council women's identity was built. Echoing contemporary attitudes about the cyclical nature of women's paid work, Harris suggested that, for some, nursing might prove to be a temporary occupation before marriage. A woman's early retirement from paid work would in no way diminish the value of her professional training, however: "Even if the nurse only followed the calling for a brief period, it would have a tendency to broaden her sympathies and increase her capacities for usefulness in her own home and among her own circle of friends." Because the path travelled by nurses was an arduous one that severely tested the strength of their characters, Harris cautioned her audience that only exceptional women should undertake the "avocation of the modern professional nurse," and only after giving the implications of their choice "serious consideration." A willingness to take charge of the care of strangers would in particular test the depth of her calling, for "tasks that are considered a labour of love in the home circle, become repugnant when undertaken for strangers, and only the strong persevere to the end, the strong in mind as well as body."¹¹

Although Harris described hospital nursing as a profession and referred to trained nurses as professionals, she used these terms not to suggest the similarity of men's and women's work, but to assert its difference. As a masculine construct, professionalism privileged education, public service, and self-fulfilment as the pillars of an elite occupational identity founded on the cultural and remunerative value of men's work. On a functional level, Harris used the term profession both to denote paid work appropriate for the "certified" daughters of professional families and to signal nurses' subscription to a corporate ethic of service. Yet here any similarity between male and female professional work ended. Culturally, women's work was predicated upon the value of personal rather than public service, and upon the unpaid, reproductive work of mothering rather than the waged work of male breadwinners. Accordingly, the religious and domestic construction of nursing as a "calling"

advanced by Harris rejected remuneration as the cornerstone of a female professional identity. While hospital training had "had the tendency to elevate the calling [of nursing] almost to the dignity of a profession," Harris argued that the work of nurses belonged not to the "commercial world" of monetary exchange but to the "world of higher human effort." Nursing was thus not principally a livelihood for those motivated by the "spur of necessity." It was a "refuge from sad memories" and a sanctuary for "bruised hearts" who sought solace "in caring for those more unfortunate than themselves."¹²

In contrast to masculine professional ideology, which rationalized paid work as a form of public service, the vocational construction of nursing articulated by Harris expressed an ideal of womanly service undergirded by self-forgetfulness and personal self-sacrifice.¹³ According to Harris, this feminine notion of service was most fully actuated by the nursing sisterhoods of the Catholic Church. "To-day, as in the past, their deeds are 'speaking deeds,' wrought without desire for the approbation of the world, yet, crowned with the imperishable beauty of conscious self-sacrifice." Their seclusion from the distractions of domestic life, and their training in "habits of self-repression and unquestioning obedience," eminently fit Catholic sisters for the "duty" of nursing, for these circumstances enabled them "to labor for the love of their profession and not for the emolument connected with it." Yet Harris's conflation of the traditional nursing sister with the ideal modern nurse was more figurative than literal. The nursing sister's disavowal of worldly goods and rewards, her spiritual vocation to serve, and her self-forgetfulness reveal less about nursing sisters themselves than about organized women's idealization of modern nursing as a secular calling for women of their own social class.

As the only institutional model of female social service traditionally known to women of the "respectable" classes,¹⁴ such a comparison simultaneously enhanced the status of hospital nursing and emphasized the strength of its ties to a domestic and religious construction of women's work. Thus while training of some sort was now required to master the work of nursing, only those exceptional women who eschewed domestic happiness, whether by design or by default, would choose to spend their lives "in deeds of direct beneficence" as nurses. Harris acknowledged that most middle-class women were not willing to travel "the rugged path of duty" followed by the modern nurse. But this did not mean that there was a lack of sympathy between trained nurses and the women workers of the National Council, and she urged delegates "to give earnest thought and practical aid to this noble calling."

"[A]s women," she concluded, "the work belongs especially to us. Let us show ourselves worthy of the trust."¹⁵

Nurses and Nursing

Trained nurses had no clear voice within the National Council of Women during the early 1890s. Two groups of trained nurses, the Trained Nurses' Association of the Kingston General Hospital and the Hamilton Society of Trained Nurses, affiliated with the National Council in 1895 and 1896 respectively but their representatives did not take an active part in any of the Council's early deliberations on the subject of nursing.¹⁶ In general, trained nurses pursued an alternative reform agenda within their own organizations during the 1890s. Aside from the American Society of Superintendents of Training Schools for Nurses, which limited its membership to nursing educators from large general hospitals, during the 1890s trained nurses in Canada and the United States began to forge the local links that eventually resulted in the formation of national organizations such as the Nurses Associated Alumnae Associations of the United States and Canada in 1896 and the Canadian National Association of Trained Nurses in 1908. Local nursing societies and hospital alumnae associations addressed, in varying degrees, the problems and issues specific to the work of trained nurses, and offered isolated graduate nurses engaged in private practice the kind of occupational identity and sororal associations they had enjoyed as students in their hospital schools.¹⁷

The relationship of trained nurses to National Council workers was also explored in some detail by Council women in 1894. Mrs. Hodgins of Toronto attempted to marry a traditional construction of nursing as "woman's work" to the emergence of trained nursing as a skilled branch of modern medicine. Hodgins applauded the trained nurse as a positive development in elite health care, and enthused that "the new era has brought all that is most desirable in a nurse to our bedside." Tracing the broad strokes of Harris's portrait of the hospital nurse, she observed that "hundreds of noble and unselfish women of education and refinement have devoted their lives to the profession of nursing." This unique combination of personal and professional qualifications gave "thoroughly trained and efficient nurses" a role as crucial as that played by physicians in the care of the sick: "the doctors will tell us, that honestly speaking in nine cases out of ten the patient owes

everything, sometimes even life itself to their gentle and intelligent care."¹⁸

The development of this skilled band of workers did not relieve laywomen of their obligation to superintend the health care of their own families, however. The "professional skill" of a trained nurse made her an indispensable addition to the middle-class sickroom, but in times of emergency a trained nurse was not always on hand. While previously experience alone had prepared a woman to nurse her own family, Hodgins asserted that the specialized knowledge of the modern health care professions now precluded such a casual approach to nursing, and advised her audience that "a certain amount of training" was now required. A course of St. John Ambulance first aid lectures would equip laywomen to meet most emergencies and teach them to appreciate "the thousand and one little things" done by trained nurses to mitigate the suffering and soothe the pain of their patients.

Just as Harris had used the image of the Catholic sisterhood to illuminate a religious construction of trained nursing, Hodgins used the image of trained nurses to empower middle-class laywomen as skilled workers. Like other National Council commentators in the 1890s, Hodgins equated systematic training with skill; in turn, skill imbued an occupation with respectability and the worker who performed it with a recognizable vocation. As one Council member observed, "A vocation that requires no systematical or recognized training is not likely to be regarded as very high or respectable, or have an honored place in the field of labor."¹⁹ Emergency training, despite its cursory nature, would give middle-class laywomen the authority to redefine themselves as skilled nurses within the confines of their own homes. Although she was careful to articulate a clear division of responsibility between "amateur" and "professional" nurses, Hodgins implied that the difference between the two groups of workers was more a matter of degree than of kind.

A quick, light hand, a firm though tender touch, and a cheerful and decided manner, are worth everything to a nurse, whether amateur or professional, and these are possible to all, but like the perfect rose or stately lily require and repay careful cultivation.²⁰

Thus while only the professional nurse would make the kind of personal sacrifice required of her vocation, both amateur and professional nurses, when tested, possessed the presence of mind and self-forgetfulness that trained workers needed to apply their knowledge effectively and skilfully.²¹

While Hodgins's paper suggests the extent to which trained nurses had become a fixture in the homes of the middle and upper middle classes, their services remained largely inaccessible to working-class families, except in urban charity hospitals. Many late Victorian social reformers nevertheless regarded trained nursing as the ideal antidote for the growing physical and spiritual degradation they perceived among the industrial urban poor. Beginning in the 1850s, English nursing reformers like William Rathbone and Florence Nightingale pioneered a system of urban home care known as district nursing, which they promoted as a specialized department within the new middle-class discipline of hospital nursing.²²

Evangelical sentiment informed the efforts of trained district nursing advocates like Nightingale and Rathbone, as well as the practice of many of the earliest district nurses. Nightingale argued that *trained* district nurses would introduce order, cleanliness, and fresh air into the homes of the poor. As "health missionaries," they would help eradicate the environmental causes of poverty by teaching the poor the basic principles of sanitation and hygiene.²³ Throughout the latter half of the nineteenth century, however, the phrase "nursing the poor in their own homes" assumed many different meanings. Charitable societies, city missions, and churches in Great Britain and in many American cities employed a variety of women to nurse among the poor. Nightingale deplored the tendency of many charities and missions to offer the sick poor material relief rather than good nursing, and she was especially critical of organizations like the Raynard Biblewomen, whose "missionary nurses," she charged, were better equipped with theological knowledge than with nursing skill. But, while the methods of district and missionary nursing advocates differed, the ultimate purpose of their work was the same: the creation of the Kingdom of God on earth.²⁴

At the National Council of Women's Conference in 1894, Elizabeth M. Tilley of the London Local Council of Women,²⁵ outlined two schemes by which local councils might take up the work of nursing. Tilley argued that an organized service to nurse the poor in their own homes was urgently needed. As the Dominion Secretary of the Order of King's Daughters, an "interdominational religious organization" whose members laboured in witness to Christ, Tilley assumed that the needs of the sick poor were spiritual as well as physical in nature.²⁶

It is a problem that constantly comes before the minds of the women who go in and out of the homes of the brothers and sisters who have not much of this world's goods. In times of sickness, while not being cases

for hospital treatment, they are in need of proper care, medicine and nourishment.²⁷

Like many of her contemporaries, Tilley regarded nursing the sick poor as a branch of organized charity. In this sense, nursing the sick poor in their own homes was an extension of the kind of "friendly visiting" work undertaken by middle-class women's groups like the Order of King's Daughters, whose members offered themselves "for service, in personal and friendly visitation among the poor, regarding those they visit as friends and neighbors."²⁸ By extending the hand of personal friendship across class lines, friendly visitors hoped to inculcate the ethic of self-help among the needy poor and, in the case of overtly evangelical groups like the King's Daughters, to sow the seeds of religion in previously untilled soil.²⁹

But what constituted "proper care" and who was qualified to give it? The most "efficient" method of meeting the health needs of the sick poor, Tilley suggested, was to enlist the services of "a corps of trained nurses" whose members, in tandem with a diet and medical dispensary, would care for the poor. Her "vision" included the erection of a nurses' home, "a centre where they could be found, and from which they would go forth to the homes of the sick poor to nurse and carry nourishment." The latter would be prepared by "those in charge of the home," a Board of Women. While the skill of trained nurses was clearly acknowledged in this scheme, their authority as "woman workers" was not. The hierarchical relationship foreseen by Tilley between the home's female board of management and its nursing staff privileged the "efficiency" of organized middle-class women, not that of their paid agent, the trained middle-class nurse.

A second, less efficient, but also less expensive scheme would establish a diet and medical dispensary, along with a central information bureau for "women who are willing and able to nurse" among the sick poor. Although Tilley suggested that the only difference between this plan and her initial suggestion was the absence of a nurses' home and its consequent expense, more was at stake than she implied. Without the formalization of their authority within an institutional framework like a Home, organized laywomen would likely lose control of the venture. The establishment of a medical dispensary depended upon the "generosity" of medical men, not the will of organized women. Similarly, as free agents within a medicalized authority structure, trained nurses themselves would no longer be required to labour under the supervision of a hierarchy of laywomen.³⁰

Tilley suggested that the absence of a corps of trained women to nurse among the poor constituted an “emergency.” The same circumstance that made the amateur nurse described by Hodgins necessary in the family circle thus also compelled some laywomen to care for strangers in the social circle. Although Tilley sought to provide the poor with the same kind of trained nursing care to which members of her own class were becoming accustomed, she also regarded a member’s willingness to nurse among the sick poor as a measure of her assimilation of the Order’s motto, “Not to be ministered unto, but to minister.” In this sense, nursing the poor in their own homes was the duty of all women called to God’s service.³¹ A laywoman’s willingness to give physical care to strangers was widely interpreted as a concrete expression of spiritual grace and of individual responsibility “to The King, Our Lord and Saviour Jesus Christ”—the avowed object of the Order.³² Unlike Hodgins, however, Tilley did not refer to her workers as nurses; this designation was clearly reserved for the graduates of hospital schools to whom the King’s Daughters turned for advice and training.³³ But for evangelical women like Tilley, the skill or proficiency of the women who volunteered to nurse the poor was not the principal concern. It was hoped that nursing the poor in their own homes would offer them spiritual solace as well as physical relief. Caring for both “the souls and bodies of our fellow creatures” was, Tilley informed the Council, the singular purpose of the Order. Tilley described for her audience the steps taken by London-area “circles” of the King’s Daughters to meet the medical needs of their less fortunate neighbours. Helping poor women and children was the principal focus of their efforts. Some circles, which varied in size from six to onwards of twenty women, lent parturient women maternity bags, which provided “all articles needed by mother and infant, including sheets, pillow cases and towels,” and visited them daily until they were able to care for themselves. Another very large circle “composed mostly of working girls,” engaged in night nursing among the poor. Tilley praised the willingness of these “sisters” to sacrifice their own interests in the care of others. This, in her estimation, marked them as true students of Christ:

In their desire to help their fellow creatures in the name of Christ, they were willing to take two days of hard, steady work in the factory or shop without a night between for sleep, the night being given to nurse the sick. All honor to these dear sisters who were willing to make personal sacrifice to carry out their Master’s teachings. “Bear ye one another’s burdens and so fulfil the law of Christ.”

Tilley's narration of another episode implied that the nursing labour of the King's Daughters revealed more than the spiritual grace of its workers; it was also a means of evangelizing among the sick poor and their families. Tilley recounted the efforts of yet another circle to "save" a woman suffering from consumption and neglect, whose brood of small children was too young to care for her or tend to the upkeep of her house. Although the pair of King's Daughters sent to the house found "a scene of dirt and confusion," their daily visits soon restored order and cleanliness, and gave the woman physical as well as spiritual relief:

For three weeks they gave several hours each morning to teaching and directing the children how to do the work, often doing a good deal of it themselves. They cared for the sick woman and made nourishment for her, and after attending to her bodily wants one or the other would sit down and read God's Word to her, thus providing food for her soul.

The impact of this care was spiritually transformative, Tilley declared. "The woman's husband, who was a sceptic, told the doctor with tears in his eyes of all the loving care shown to his dying wife, and added, 'I'll say no more against Christians.'"³⁴

Another missionary nursing service, the Nursing-at-Home Mission of Toronto, was briefly affiliated with the National Council of Women at mid-decade.³⁵ According to Mrs. Helliwell, a mission worker who attended the annual meeting of the National Council in 1894, the Nursing-at-Home Mission employed "trained nurses capable of giving most efficient care to women."³⁶ Her use of the adjective "trained" brings into relief the variable meanings attributed to the term "trained nurse" during the 1890s, and indeed in subsequent decades.³⁷ Although Mission nurses were reputedly trained "in the latest ideas of nursing," they did not receive the kind of training advocated by nursing leaders who joined the American Society of Superintendents after 1893. Instead, after passing a two-month probationary period and completing a further one-year and ten-month apprenticeship—which included a course of medical lectures in the "rudiments of obstetrical, medical and surgical nursing"—they were examined and awarded the diploma of the Nursing Mission Training School. In contrast to "recognized" hospital training schools, which were increasingly concerned with the educational and social backgrounds of pupil nurses, the principal qualifications for prospective Mission nurses were spiritual:

No one will be accepted as a nurse unless she is an earnest, evangelical Christian, and is seeking to enter the service in order to glorify the Lord Jesus Christ, and with a view to leading souls to Him through ministering to the bodies of the sick whom she visits.

It was hoped that their peculiar combination of training and spiritual resolve would counter the unsanitary conditions that bred the ignorance, crime, and vice that managers of the Mission associated with the poorer homes of Toronto.³⁸

In common with the King's Daughters, Helliwell noted that the Nursing-at-Home Mission ministered "to the souls as well as to the bodies of these poor people."³⁹ To the homes of the "sinful, sick and sorrowing" Mission nurses brought with them "the message of a loving Saviour whose heart was ever filled with compassion and love." Mission supporters likewise believed that nursing the sick poor in their own homes would exert a potentially transformative influence over their lives: "However much of the dark side of life is seen in the work, there are yet many bright spots, where the kindly influence of a kindly nurse has led to right thinking and right doing. Who can estimate the far-reaching influence of kind words and deeds done in the name of the Master?"⁴⁰ As Helliwell told her co-workers in the National Council, many of the homes in which the light of Christ had been ignited by nurses "could have [been] reached in no other way."⁴¹ This comment underscores the ancillary status of nurses themselves in the world view of the women who founded the nursing service. Theirs was primarily a mission of spiritual relief; the nurses whom they hired and trained were but one means to this wider end.

Helping Heroines

Poor urban dwellers were not the only beneficiaries of the National Council of Women's considerable charitable and spiritual resources in the 1890s. Just as local council affiliates in London and Toronto hoped that friendly visiting and missionary nursing would save urban Canada for Christ, the Council's national leadership looked to nursing—although not necessarily to trained nurses—as a way to empower prairie women as nation-builders. Members of the National Council strongly identified with the new generation of largely Anglo-Saxon women who were building farms and communities in the Canadian Northwest before 1900. Like their own pioneer "foremothers" who had helped "tame" the wilderness of central and eastern Canada in the eighteenth

and early nineteenth centuries, Council women described prairie women as "civilizers" and as nation builders.

That women played a crucial role in the nation-building process was repeatedly asserted by National Council members throughout the decade. They conceived of nation building as a gendered enterprise. While men made a new region productive by tilling the soil and generating economic wealth, only women's reproductivity could truly establish a new community and provide it with the moral and spiritual sustenance it needed to survive.⁴² This common bond of mothering that Council women projected upon prairie women not only anchored their understanding of nation building as "woman's work," it also made the maternal welfare of isolated homesteading women one of the most pressing national responsibilities of their new women's "parliament."

In February 1897, Lady Ishbel Aberdeen, the president of the National Council of Women, announced that "the women of Canada" would commemorate Queen Victoria's diamond jubilee by sending skilled maternity attendants to pioneer women residing in the Canadian Northwest and other "outlying districts." The name of the new organization was to be the Victorian Order of Home Helpers. According to Lady Aberdeen, women trained in midwifery, housewifery and simple nursing would "go from house to house doing all sorts of mercy and kindnesses."⁴³ Such a band of helpers was urgently needed by women in the Northwest in particular, where, as one National Council member observed in 1896, adequate health care was needed to attract "desirable" women as wives for "our settlers." "It would be impossible to speak too strongly about the need of a wife and mother for the settler's home," she asserted. "As a sympathetic companion, an economical manager, an actual helpmeet in the farm work, as a mother of future citizens, and as a standard bearer of civilization, she will always be invaluable."⁴⁴ Through the Victorian Order of Home Helpers, the middle-class women of the National Council would help prairie women fulfil their patriotic duty as heroic nation builders by helping them survive childbirth.

The immediate catalyst for the Home Helper scheme was a resolution moved by the Vancouver Local Council of Women at the third annual gathering of the National Council of Women in 1896. Spurred on by the growing number of local councils in the western reaches of the country,⁴⁵ delegates to this meeting turned their attention to the medical needs of women and children on the Canadian prairies. While public health issues like the containment of typhoid were discussed, delegates agreed that the most pressing health problem within the

region was the all too frequent incidence of maternal mortality among women on isolated prairie homesteads. Accordingly, the original resolution asked the governments of Canada to alleviate women's suffering in childbirth, "either by offering inducements to medical men and women and efficiently trained nurses to settle in those districts, or in any other way which they may see fit."⁴⁶ A majority of delegates, however, believed that the National Council of Women itself should act on behalf of prairie women. Thus, while the original resolution had effectively divested Council women of any further responsibility for the welfare of their pioneer sisters, the amended resolution passed by delegates was worded very differently. It required the National Council of Women, acting in concert with its local councils, to devise and implement what members called a "practical" solution to a problem that imperilled not just individual lives, but the very health of the nation itself.⁴⁷

Significantly, the final resolution omitted all references to doctors, as well as to "efficiently trained nurses." The women sent to help parturient pioneer women in the Canadian Northwest would have to be more than nurses. Adelaide Hoodless of the Hamilton Local Council of Women urged the creation of a "Dominion" scheme that would recruit "sober and reliable" young women to "take care of and cook for sick persons." The training they would receive would not qualify them as nurses; instead, they would be practical workers, well versed in housewifery as well as nursing care. Their domestic status was reinforced by her proposal that candidates for "this North-West work" be trained in a special department of Ontario's new Normal School of Domestic Science.⁴⁸ Although such a system of training might undermine contemporary standards of nursing education, it would help to elevate the new field of household science, a cause to which Hoodless herself had devoted much time and energy.⁴⁹

Although the specific terms of the scheme outlined by Hoodless did not find expression in the Victorian Order of Home Helpers, the sentiments that underlaid them did. The ostensible model for the Victorian Order of Home Helpers was the Queen Victoria Jubilee Institute for Nurses, a district nursing organization founded in 1887 to provide the urban poor of Great Britain with the services of hospital-trained nurses. Like the Jubilee Institute, the Victorian Order would commemorate the reign of Queen Victoria. But, here, the similarity between the two groups ended. In practice, the Victorian Order of Home Helpers had more in common with the system of village or cottage nursing pioneered in rural England during the 1880s to provide isolated communities with "semi-skilled" or "less ambitious" nursing and

maternity aid.⁵⁰ Like village nurses in Britain, home helpers in Canada would not qualify as trained nurses. Instead of the two- or three-year hospital apprenticeship required of graduate nurses in Canada, home helpers would train in hospital for only one year, during which time they would learn the basic skills needed to gain admission to the order, including the rudiments of first aid to the injured, simple nursing, and basic cookery. A three-month course of training in "midwifery" would further distinguish home helpers from regularly trained nurses. The great need for health care workers in the Canadian Northwest justified the expediency, Lady Aberdeen asserted.

The training of home helpers in midwifery likewise precluded their designation as "nurses." In Canada, no system of formal midwifery training existed as it did in England, where many trained district nurses, including the first superintendent of the Jubilee Institute, were qualified both as nurses and as midwives. Training in obstetrical nursing taught pupil nurses how to assist a doctor; it did not prepare, or authorize, them to act as autonomous birthing attendants.⁵¹ But members of the Victorian Order of Home Helpers would no more be "midwives" than they would be "trained nurses." By the late nineteenth century, "midwifery," or "obstetrics" as it was increasingly known, had been appropriated as a branch of masculine medical science, and its traditional female practitioners largely discredited. As Mrs. O. E. Edwards of the Montreal Local Council of Women observed in 1900, "Midwifery as a profession for women is almost a thing of the past. Her work is now largely divided between the trained nurse and the doctor."⁵²

Although middle-class women like Edwards and her colleagues in the National Council of Women had long ceased to employ midwives and, as a social class, welcomed the medicalization of childbirth,⁵³ the practice of female midwifery continued to flourish in many rural areas and in some urban working-class neighbourhoods of Canada at the end of the nineteenth century. But, largely as a result of the organized medical profession's persistent campaign against the unregulated competition of midwives, the traditional female midwife was now popularly associated with images of dirt, ignorance, and danger.⁵⁴ Like the archetypal workhouse nurse, she too had become an "old-fashioned" foil for the cleanliness, training, and medical subordination of the "modern" nurse. Thus, just as an apparent lack of skill would deprive Home Helpers of the designation "trained nurse," their proposed training in a masculinized branch of knowledge known as midwifery would also set them apart from the degraded image of the midwife. Midwifery, then, was simply one skill that Home Helpers would need to

supplement and even replace the work of doctors in remote pioneer districts; Home Helpers would not themselves be “midwives.”

But, as their name implied, Home Helpers would be domestic workers. As such, they would be subject to the authority of elite laywomen, rather than part of a gendered medical hierarchy. The name chosen by the National Council for these workers also implied a lack of social hierarchy. As James Hammerton has argued, in the rhetoric of late nineteenth-century imperialism a home help was a domestic servant of equal social rank to the family in which she served. Use of the term therefore implied that neither party suffered a loss of caste in the exchange of labour.⁵⁵ By calling their workers “home helpers,” National Council women hoped to neutralize any association of the order with urban poor relief. Moreover, in contrast to urban district nurses whose duties took them into several poor households in one day, the home helper at work on the Canadian prairie would necessarily reside for an extended period of time in the household of the woman she was assisting. The National Council’s adoption of this well-known title suggests that it was meant to reassure pioneer homemakers that the woman entering her household would endeavour to lighten her burdens, not add to them.⁵⁶

Local women would make the best Home Helpers, Lady Aberdeen argued. Women “who have already lived in these country districts, and who are respected, and have the confidence of their neighbours, would be preferable to all others.” As a domestic worker and as a “neighbour,” the home helper would integrate herself into the fabric of family life, performing the domestic chores of the household while superintending the two- to four-week lying-in period that sometimes followed childbirth at the turn of the century. Lady Aberdeen declared that hospital-trained nurses who could pass the prescribed examinations would be welcome in the order, but implied that neither home helpers nor trained nurses were the real heroines of this great Northwest work. That status was reserved for the nation-building prairie mothers whose lives they would safeguard. Thus, like evangelical missionary nurses, home helpers’ special combination of practical skills, would be the means by which organized benevolent women would empower their “less favored sisters”—as well as themselves—as maternal builders of the Kingdom of Canada.

Trained District Nurses

The medical response to the "Home Helper" scheme was immediate, decisive, and largely negative. Supporters and opponents alike condemned the implication that "half-trained" helpers could be employed in place of fully trained "professional nurses." Little appreciating the line drawn by Council women between the work of trained nurses and nursing as one of women's numerous domestic responsibilities, medical commentators represented Home Helpers as substandard nurses. The editors of the *Montreal Medical Journal*, who were among the Victorian Order's supporters, argued, however obliquely, that the training provisions of an unidentified health care scheme would undermine the professional standing of fully trained nurses. While they applauded that "so much thought and energy should be expended to relieve the necessities of suffering humanity," the scheme would, they suggested, create two "classes" of nurses. Members of the best class of nurses would be graduates of a three-year course of training at a recognized hospital school, and would find employment in the homes of well-to-do families where their justifiably higher wages could be paid. Members of the other class of nurses, whose year-long training was considerably briefer and therefore less thorough, would work only in poor households where the service of a well-qualified nurse was a "luxury." This kind of arrangement was a "dangerous experiment":

Much time and labour have been expended in bringing trained nursing to its present high state of efficiency and this proposed scheme seems like a retrograde step and we very greatly fear will prove to be such. To a large portion of the laity a nurse is a nurse no matter how long or short a time she has spent acquiring her training, and the public mind would utterly fail in many instances to grasp the difference between the two classes of nurses.

The existence of the lesser class of nurse that the editors clearly associated with the Victorian Order of Home Helpers would eventually undermine the authority and livelihood of the best class of nurse, for "if a nurse with one year's training is good enough to nurse some people she may be considered good enough for all people."⁵⁷

The support expressed by the *Montreal Medical Journal* for the Victorian Order scheme was exceptional.⁵⁸ Most organized medical men in Canada took extreme exception to the Home Helper scheme's implicit censure of their ability to meet the health care needs of the nation. The Winnipeg Medical Society, for example, resolved that their

“more necessarily perfect knowledge of the requirements of the country in attending the sick” led them to believe that the scheme would “prove an entire failure.”⁵⁹ The Ontario Medical Association concurred, and passed a particularly damning resolution at its annual meeting in June 1897:

The Ontario Medical Association feels that it would be neglecting a serious public duty if it failed to express its most unqualified disapproval of the scheme, on account of the dangers which must necessarily follow to the public should such an order be established.⁶⁰

Medical commentators took particular exception to the Council’s suggestion that even specially trained female birthing attendants were an adequate substitute for male medical expertise, but, in general, they attacked the Victorian Order as yet another form of unregulated female competition that was apparently—and quite inappropriately—beyond medical control. Medical commentators expressed their fears most fully by representing the concerns of urban doctors about uniform educational standards, overcrowding, and adequate financial compensation for expertise as identical to the interests of trained or graduate nurses already at work in Canada’s cities.

The editors of *The Canadian Practitioner* argued that “competent professional nurses should be encouraged and protected from the warfare of unqualified nurses just as regular physicians and lawyers are protected from the rivalry of the irregular in both professions.”⁶¹ There were already too many trained nurses in the cities, where there were “numbers of nurses, graduates of our best hospitals, who have spent their best time in careful preparation for their work, and who are unable to obtain enough to do to support themselves; *the supply is already much greater than the demand.*” The introduction of “half-trained ‘helpers’ entirely free of charge” would adversely affect the livelihood of professionally trained nurses by undercutting their fees, which, because of their superior training, were necessarily higher than the “bargain day prices” that would be charged by Victorian Order “charity nurses.” Although the editors of *The Canadian Practitioner* and several other Canadian medical journals assured readers that they wished to ensure that the fees charged by trained nurses remained “moderate,” they defended these higher fees as adequate compensation for the extended course of disciplined training to which nursing professionals had subjected themselves.⁶²

The vehemence of the attack mounted by doctors against the Victorian Order surprised Lady Aberdeen, who, rightly or wrongly,

attributed much of their irritation to a personal dislike of herself and Lord Aberdeen.⁶³ The effect of this opposition on the National Council's understanding of the relationship of trained nurses to middle-class women's work for woman was profound, however. Nursing leaders' reservations about the Home Helper scheme also helped reshape their attitudes. In February 1897, Lady Aberdeen received a letter from Nora Livingston, the superintendent of nurses at the Montreal General Hospital. Livingston urged Lady Aberdeen to consider the value of thoroughly trained nurses for the work she contemplated. The work of district nursing, she contended, required more than mere skill. Echoing the views of Florence Nightingale and other prominent champions of district nursing, Livingston wrote: "It should not only be the *trained* applicant but the exceptional woman who should be chosen to serve in the highest of all service, that of God's poor. She must have breeding, tact, courage, self-control." Moreover, Livingston continued, "May I be pardoned if I suggest another title than that of 'Home Helpers.' The word is misleading, for if the organization is to be a success, it must stand for something definite, must express at least an approximate standard of attainment, or it will be chaotic and of limited influence."⁶⁴

Propelled by the objections of medical practitioners, and by the competing reform agendas of the elite businessmen, civil servants, politicians, and clergymen whom she had recruited to shepherd the foundation of the Victorian Order of Home Helpers, Lady Aberdeen accepted that the Home Helper organization must be reconstituted as the Victorian Order of Nurses and only fully trained hospital nurses be employed. The first circular advertising the scheme was published in March 1897, and asserted that the principal object of the new Victorian Order of Nurses was to place "the aid of trained skilful nurses within the reaches of all classes of the population." Rather than a practical helper to pioneer women, the Victorian Order nurse was to be an envoy of middle-class values among the urban poor, teaching them the rules of "scientific cleanliness" in order to combat ill health in the home and in the city at large.⁶⁵ Lady Aberdeen continued to champion the scheme's original purpose as a maternal welfare measure for rural women facing the "unspoken fear of approaching the gate that swings both ways—into new life or into death—without competent skilled help."⁶⁶ But mounting pressure from some eastern local council leaders and from her hand-selected lay and medical advisors ultimately forced her to concede that the Victorian Order would, at least initially, function primarily as an urban nursing order.⁶⁷

Ironically, the tenaciousness of the medical opposition to the Victorian Order of Nurses helped the National Council of Women forge a viable line of defence for its new worker, the trained district nurse. By the time the National Council of Women met again, in June of 1897, the focus of its Victorian Order work had changed decisively. Members of the Victorian Order were now no longer the agents of middle-class women's organized benevolence, but rather heroines and co-workers in their own right. In their jubilee address to Queen Victoria, National Council women remarked,

Your Majesty's reign has been marked by a material and social progress unparalleled in any age of the world. . . . Coincident with this movement and inherent in it is that single and momentous advance in thought and opinion which has so heightened the ideas and enlarged the possibilities for women. And in that wider sphere of usefulness and activity now happily opened to women no service is more honourable or more blessed in its results than that of the trained nurses—a calling which Your Majesty has done so much to elevate and promote. . . .⁶⁸

Although at this meeting Lady Aberdeen continued to equivocate about the level of training that the Victorian Order would demand of its nurses,⁶⁹ by the following year, after the training provisions and constitution of the Order had been finalized, her assimilation of the nomenclature and standards of trained district nursing was complete.

All references to home helpers and partially trained nurses were banished from the National Council's 1898 annual meeting. Council and platform speakers repeatedly characterized the Victorian Order as "a system of district nursing" and described its personnel only as "district nurses." As in 1897, the National Council devoted its entire public meeting to the Victorian Order and the subject of nursing. Lady Aberdeen began by introducing the first Chief Superintendent of the Victorian Order of Nurses, Charlotte Macleod, a Canadian who had had charge of the Waltham Training School for Nurses near Boston, Massachusetts, before her appointment to the Victorian Order. Macleod, she said, was both "a very exceptional woman and a very exceptional nurse." The other nurses recruited into the Victorian Order were to be hardly less remarkable: "We take only nurses who have previously attained the highest possible degree of efficiency in hospital work, and who have full diplomas; they then have six month's training in district homes and are ready to be sent out to work in the country or wherever the work may be." Victorian Order nurses, in other words, were more than simply

good nurses; they were extraordinary women whose work was distinguished by “enthusiasm, devotion, and self-sacrifice.”⁷⁰

While the educational standards advocated by North American nursing leaders were met and even exceeded by the reformed Victorian Order, its nurses did not necessarily adopt the “masculine” professional credo promulgated by elite nursing organizations such as the American Society of Superintendents of Training Schools for Nurses (ASSTSN). The model for the Victorian Order’s training regimen was the Waltham Training School for Nurses, a special school for district or visiting nurses that was not recognized by the ASSTSN. Its founder, Dr. Alfred Worcester, defined district nursing as “nursing in its very highest form” and suggested that district nursing work—undertaken by an elite corps of specially trained nurses under medical supervision—would “surely help forward that time when the kingdom of this world shall become the kingdom of God and of His Christ.”⁷¹ Macleod seems to have been motivated by the same evangelical desire to serve that underlay the social work of so many National Council women, embracing what Barbara Melosh calls the “traditional” nursing ethic that regarded womanliness or feminine character as the essential quality of a good nurse.⁷² “The greatness of our work is overwhelming,” Macleod confided to Florence Nightingale about the Victorian Order, “but I can only try it trusting for the blessing.”⁷³

At the 1898 annual meeting, the expertise of trained nurses was formally acknowledged by the National Council for the first time when it invited a socially prominent St. John nurse to speak. Lady Aberdeen told the public meeting that Elizabeth Robinson Scovil, an honorary member of the St. John Local Council of Women, was “a Canadian nurse who has highly distinguished herself and who is coming to tell us what district nursing means.” Scovil described the district nurse as “a reformer” who married the traditional skills of domesticity with the modern principles of sanitary science. In contrast to the evangelical charity nursing undertaken by some Council affiliates, district nursing was not intuitive. The systematic acquisition and application of knowledge distinguished the district nurse from the untrained middle-class “amateur.” “Of course,” she observed, “the carelessness of the friends is sometimes exasperating but it is no more trying than the efforts of the amateur nurse in some of the highest walks of life.” But district nurses shared organized women’s concern for woman’s welfare. In particular, the trained district nurse had “a special mission to the mothers” as a teacher of enlightened maternity and infant care. And, like the

organized middle-class woman, the chief duty of the district nurse was to exert her "influence for good."

No person is so degraded, so destitute, so sunk in the filth and wretchedness, as to be beyond the ministrations of the district nurse. It is part of her business to restore them to the decencies of life, and her training shows her how to do it in the easiest and best way.

It was not the job of the district nurse to dispense relief, however. Although Scovil identified the district nurse as a member of the almsgiving class, in cases where she judged relief warrantable, her only role was to notify those persons "whose duty it is to attend to it." Thus, the district nurse did not usurp organized women's moral obligation to care for the poor; instead, armed with specialized knowledge, she became the natural ally of the many philanthropic and evangelical women at work within the National Council of Women in the late 1890s.⁷⁴

Conclusion

One member of the National Council worried in 1900 that so "remunerative, honorable and even fashionable has nursing become that there is some danger of the restless and dissatisfied seeking in it a refuge from themselves rather than opportunities for service."⁷⁵ As this statement suggests, at the turn of the century, the National Council of Women continued to reject a male professional standard to validate the work of middle-class women. Instead of paid work and self-fulfilment, its members articulated a gendered ethic of service grounded in a vocational construction of women's traditional domestic, familial, and community responsibilities to care for the needs of others. To embrace the kind of "masculine" professional identity advocated by North American nursing elites during the 1890s would have denied the domestic and evangelical foundations upon which Council members had constructed their public authority as women.

The trained district nurses whose expertise and opinions were so anxiously sought in the wake of the Victorian Order controversy, reaffirmed these basic tenets of the National Council's construction of "woman's work" with one important exception: only women committed enough to obtain a systematic training as nurses were qualified to nurse. But, while being a woman was no longer an adequate preparation to nurse, even among the sick poor, an ideal of "feminine" self-sacrifice and self-forgetfulness still undergirded the Council's construction of

nursing as one of the “female” professions. Thus, despite the changed status of trained nurses within the National Council at decade’s end, its members were not forced to abandon the domestic bases of their collective identity as women workers entirely. Instead, they opened their ranks to include a new kind of middle-class woman worker, the efficiently trained district nurse, whose social class, training, and womanly desire to serve made her a heroic confederate of that “splendid army of organized womanhood,” the National Council of Women of Canada.

Endnotes

1. Isabelle Hampton Robb, “The Nurse and the Public,” *The Canadian Nurse and Hospital Review* (March 1905): 9–11.

2. The middle-class character of the National Council of Women, and of the late nineteenth-century women’s movement in general, is well established. See Veronica Strong-Boag, *The Parliament of Women: The National Council of Women of Canada, 1893–1929* (Ottawa: National Museum of Man, 1976); Carol Lee Bacchi, *Liberation Deferred? The Ideas of the English-Canadian Suffragists, 1877–1918* (Toronto: University of Toronto Press, 1983); Diana Pedersen, “The Young Women’s Christian Association in Canada, 1870–1920: ‘A Movement to Meet a Spiritual, Civic and National Need’” (Ph.D. dissertation, Carleton University, 1987); Sharon Anne Cook, “‘Continued and Persevering Combat’: The Ontario Woman’s Christian Temperance Union, Evangelicalism and Social Reform, 1874–1916” (Ph.D. dissertation, Carleton University, 1990).

3. Pauline Jardin has constructed a profile of nursing students at the Toronto General Hospital School of Nursing between 1881 and 1914, see “An Urban Middle-Class Calling: Women and the Emergence of Modern Nursing Education at the Toronto General Hospital 1881–1914,” *Urban History Review/Revue d’histoire urbaine* 17, 3 (February 1989): 177–190.

4. No reliable statistics for the number of hospitals opening nurse training schools in the last third of the nineteenth century are available. This figure is based on a compilation of data from two sources: John Murray Gibbon and Mary Mathewson, *Three Centuries of Canadian Nursing* (Toronto: Macmillan of Canada, 1947), and the National Council of Women, *Women of Canada: Their Life and Work* (Ottawa: Department of Agriculture, 1900): 80–83. Between 1891 and 1911 the number of nurses and nursing students in Canada nearly quadrupled; see Marjorie Griffin Cohen, *Women’s Work, Markets, and Economic Development in Nineteenth-Century Ontario* (Toronto: University of Toronto Press, 1988), 215, n. 120.

5. List of Members, 1899, in *Annual Conventions 1893–1899: The American Society of Superintendents of Training Schools for Nurses* (New York: Garland, Publishing Inc., 1985), 91–94.

6. In her presidential address of 1898, Agnes Snively, the Superintendent of the Toronto General Hospital School for Nurses, raised these and other “professional” issues; see *Annual Conventions 1893–1899*, 6–10. See also Barbara Melosh, “The Physician’s Hand”: *Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982), chap. 1; and Celia Davies, “Professionalizing Strategies as Time- and Culture-Bound: American and British Nursing, Circa 1893,” in Ellen Condliffe Lagemann, ed.,

Nursing History: New Perspectives, New Possibilities (New York: Teachers College Press, 1983), 47–64.

7. Lady Ishbel Aberdeen, "President's Address," in *Women Workers of Canada: Being a Report of the Proceedings of the First Annual Meeting and Conference of the National Council of Women of Canada* (Ottawa: Thorburn and Co., 1894): 10–13. See also Anna Davin, "Imperialism and Motherhood," *History Workshop* 5 (Spring 1978): 9–65.

8. Women Workers of Canada (Ottawa, 1894): 140–152. Although not a member of the executive of the Hamilton Local Council of Women in 1894, Miss Harris is identified as the President of the Arts and Craft Association of Hamilton in 1896. See *Women Workers of Canada* (Montreal, 1896): 5.

9. Agnes V. Harris, "Hospital Nursing," in *Women Workers of Canada* (Ottawa, 1894), 141; Mrs. Hodgins, "Emergency Lectures," in *Women Workers of Canada* (Ottawa, 1894), 147. See also Joyce M. MacQueen, "Who the Dickens Brought Sairi Gamp to Canada?" *The Canadian Journal of Nursing Research* 21, 2 (Summer 1989): 27–37.

10. Harris, 141–142.

11. Harris, 141, 143.

12. Harris, 142.

13. Melosh, "The Physician's Hand."

14. Martha Vicinus argues that the religious sisterhood was the model for many of the female institutions and professions founded by middle-class women in late nineteenth-century England. *Independent Women: Work and Community for Single Women 1850–1920* (Chicago: University of Chicago Press, 1985), chap. 2. See also Marta Danylewycz, *Taking the Veil: An Alternative to Marriage, Motherhood and Spinsterhood in Quebec, 1840–1920* (Toronto: McClelland and Stewart, 1987).

15. Harris, "Hospital Nursing," 143.

16. The Trained Nurses' Association of the Kingston General Hospital affiliated with the Kingston Local Council of Women in 1895 and remained a member throughout the 1890s. The Hamilton Society of Trained Nurses affiliated with the Hamilton Local Council of Women for only one year.

17. Between 1894—when nurses at the Toronto General Hospital established the first alumnae association in Canada—and 1900, nurses at most hospital training schools in Canada formed alumnae societies; by 1910, many of these had combined to form amalgamated graduate nursing societies in Toronto, Ottawa, Vancouver, and Montreal. Gibbon and Mathewson, *Three Centuries of Canadian Nursing*, 354–356. For a discussion of nursing culture in one nineteenth-century hospital school, see Nancy Tomes, "Little World of Our Own": The Pennsylvania Hospital Training School for Nurses, 1895–1907," in Judith Walzer Leavitt, ed., *Women and Health in America: Historical Readings* (Madison: The University of Wisconsin Press, 1984), 467–481.

18. Hodgins, "Emergency Lectures," 146.

19. Emily Stowe, "Domestic Problem: Cause and Cure," in *Women Workers of Canada* (Ottawa, 1894), 166. See also Harriet Boomer, "The Problem of Domestic Service from the Mistresses [*sic*] Point of View," 156.

20. Hodgins, "Emergency Lectures," 149.

21. In addition to Florence Nightingale's ever popular *Notes on Nursing* (London, 1860), which was intended as a manual to instruct women at home, other sources of "expert" nursing advice were available to Canadian laywomen in the 1890s. See, for example,

- Nursing the Sick: Practical Information by a Trained Nurse: Directions for Amateur Nursing at Home* (Montreal: Davis & Lawrence Co., Ltd., 1897). For a discussion of the relationship of nursing to women's domestic labour during the first third of the nineteenth century, see Patricia O'Brien, "All a Woman's Life Can Bring': The Domestic Roots of Nursing in Philadelphia, 1830-1885," *Nursing Research* 36, 1 (January/February 1987): 12-17.
22. Mitchell Dean and Gail Bolton, "The Administration of Poverty and the Development of Nursing Practice in Nineteenth-Century England," in Celia Davies, ed., *Rewriting Nursing History* (London: Croom Helm, 1980), 76-101.
23. Quoted in Annie M. Brainard, *The Evolution of Public Health Nursing* (Philadelphia: Saunders, 1922), 123-124.
24. Brainard, 102-143, 194-202; Françoise Ducrocq, "The London Biblewomen and Nurses Mission, 1857-1880: Class Relations/Women's Relations," in Barbara J. Harris and JoAnn McNamara, eds., *Women and the Structure of Society* (Durham, N.C.: Duke University Press, 1984), 98-107; Karen Buhler-Wilkinson, "Left Carrying the Bag: Experiments in Visiting Nursing, 1877-1909," *Nursing Research* 36, 1 (January/February 1987): 42-47.
25. In 1894, Elizabeth Tilley was the vice-president of the London Local Council of Women and the General Secretary of the Dominion Branch of the International Order of King's Daughters and Sons.
26. The International Order of King's Daughters and Sons was founded in New York City by two laywomen in 1886. The first Canadian "circle" was formed later that same year and, in 1891, a Dominion branch was established. By 1900, the group had approximately 6,000 members in Canada, virtually all of them women and most of them resident in Ontario.
27. Elizabeth M. Tilley, "Nursing the Poor in Their Own Homes," in *Women Workers of Canada* (Ottawa, 1894), 143.
28. Tilley, "The Need of Organized Charities and How to Adapt Them to Small Communities," in *Women Workers of Canada: Being a Report of the Proceedings of the Third Annual Meeting and Conference of the National Council of Women of Canada* (Montreal: John Lovell and Son, 1896), 216.
29. "Sectional Conference Report: The Order of King's Daughters," in *Women Workers of Canada* (Ottawa, 1894), 203-204.
30. Tilley, "Nursing the Sick Poor in Their Own Homes," 144. For a discussion of the relationship between women's authority and their representation on the boards of charitable institutions, see "Representation of Women on Boards of Philanthropic Institutions," in *Women Workers of Canada: Being a Report of the Proceedings of the Second Annual Meeting and Conference of the National Council of Women of Canada* (Toronto: Oxford Press, 1895), 171-173.
31. Brainard, *The Evolution of Public Health Nursing*, 141.
32. In Canada, the Order of King's Daughters established Homes for Friendless Women, for Aged Men and Women, a Young Women's Guild, and a House for Young Women Wage-Earners. In addition, they built and furnished hospitals, organized an annual summer crèche, and supported district nursing work. See Helen R.Y. Reid, comp., "Organized Societies," in National Council of Women of Canada, *Women of Canada: Their Life and Work* (Ottawa: Department of Agriculture, 1900), 263-264.
33. "Sectional Conference Report: The Order of King's Daughters," in *Women Workers of Canada* (Ottawa, 1894), 203.
34. Tilley, "Nursing the Sick Poor in Their Own Homes," 145.

35. The Nursing-at-Home Mission affiliated with the Toronto Local Council of Women in 1895. Along with many other affiliated societies in Toronto, it withdrew its support after losing the Silent Prayer vote at the annual meeting of the National Council of Women.
36. Mrs. Helliwell, "Women's Work in Connection with the Sick: Discussion," in *Women Workers of Canada* (Ottawa, 1894), 150.
37. Susan Reverby discusses the variable meanings of the terms *nurse* and *trained nurse* in late nineteenth-century America in *Ordered to Care: The Dilemma of American Nursing, 1850-1945* (Cambridge: Cambridge University Press, 1987), chap. 1.
38. Toronto Mission Union, Nursing-at-Home Branch. Miscellaneous Papers, *Fifteenth Annual Report of the Nursing-at-Home Mission (Branch of the Toronto Mission Union), for Year Ending December 31st 1901*, 4, 9. Thomas Fisher Rare Book Library, University of Toronto.
39. Helliwell, "Women's Work in Connection with the Sick," 150.
40. Toronto Mission Union, Nursing-at-Home Branch. Miscellaneous Papers, *Report of the Nursing-at-Home Mission 1901*, 3, 4, 9. Thomas Fisher Rare Book Library, University of Toronto.
41. Helliwell, "Women's Work in Connection with the Sick," 150.
42. See, for example, Mrs. Archibald, "The Importance of the National Council in Fostering and Developing the Patriotism of Canadian Women," in *Women Workers of Canada* (Montreal, 1896), 73-81, and Mrs. John Cox, "The Immigration of Women," in *Women Workers of Canada* (Montreal, 1896), 196-208. See also, The Countess of Aberdeen, *Through Canada with a Kodak* (Edinburgh, 1893), 102-103; James Hammerton, *Emigrant Gentlewomen: Genteel Poverty and Female Emigration 1830-1914* (London: Croom Helm, 1979), 163; Elizabeth Jameson, "Women as Workers, Women as Civilizers: True Womanhood in the American West," in Susan Armitage and Elizabeth Jameson, eds., *The Women's West* (Norman, Oklahoma: University of Oklahoma Press, 1987), 145-164.
43. The original terms of the Victorian Order of Home Helpers are outlined by John Murray Gibbon, in *The Victorian Order of Nurses for Canada: 50th Anniversary 1897-1947* (Montreal: Southam Press, 1947), 6-7. See also Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality," in Linda Kealey, ed., *A Not Unreasonable Claim: Women and Reform in Canada 1880s-1920s* (Toronto: The Women's Press, 1979), 131-150.
44. Cox, "The Immigration of Women," 196-201. See also Barbara Roberts, "'A Work of Empire': Canadian Reformers and British Female Immigration," in Kealey, *A Not Unreasonable Claim*, 185-201.
45. By 1896, local councils of women had been founded in the following nine western centres: Winnipeg (1894), Victoria (1894), Vancouver (1894), East Kootenay [n.d.], Regina (1895), Vernon (1895), Calgary (1895), Brandon (1895), and Rat Portage (1895). In 1896, a total of twenty local councils of women were affiliated with the National Council of Women.
46. "Need of Medical Aid in the North-West Territories," *Women Workers of Canada* (Montreal, 1896), 439.
47. *Ibid.*, 439-440, 445.
48. *Ibid.*, 444-445.
49. Adelaide Hoodless was the Treasurer of the National Council of Women of Canada. As a result of her efforts, the National Council adopted "industrial" or "manual" training

- for girls as one of its earliest reform concerns. See Adelaide Hoodless, "Industrial Training for Girls in Public Schools," *Women Workers of Canada* (Ottawa, 1894), 114–123.
50. For a contemporary description of a British cottage nursing scheme that bears a striking similarity to the VON, see the discussion of Miss Broadwood's Ockley system in The Hon. Mrs. Stuart Wortley, "On Nursing," in The Baroness Burdett-Coutts, ed., *Woman's Mission: A Series of Congress Papers on the Philanthropic Work of Women by Eminent Writers* (London, 1893), 222–223.
51. Georgina Pope, "Obstetric Nursing," in Isabel Hampton et al., *Nursing of the Sick, 1893* (New York: McGraw-Hill Book Company, 1949), 164–171.
52. Mrs. O. E. Edwards, comp., "Professions and Careers," in National Council of Women of Canada, *Women of Canada: Their Life and Work* (Ottawa: Department of Agriculture, 1900), 84.
53. Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto, 1991), chap. 6; Pat Jalland, *Women, Marriage and Politics, 1860–1914* (Oxford, 1986), chaps. 5 and 6; Leavitt, *Brought to Bed: Child-Bearing in America, 1750–1950* (New York: Oxford, 1986), 198–200.
54. C. Lesley Biggs, "The Case of the Missing Midwives': A History of Midwifery in Ontario from 1795–1900," *Ontario History* 75, 1 (March 1983): 21–35. See also Jean Donnison, *Midwives and Medical Men: A History of Inter-professional Rivalries and Women's Rights* (London: Heinemann 1977), 100–105. For a different perspective, see James Connor's paper in this volume.
55. Hammerton, *Emigrant Gentlewomen*, 155. The term was still in use in Canada and Great Britain as late as 1912; see Ella Sykes, *A Home Help in Canada* (London, 1912). For a discussion of the American usage of the term "help," see Faye Duddin, *Serving Women: Household Service in Nineteenth-Century America* (Middletown, Conn.: Wesleyan University Press, 1983), 4–6.
56. Wortley argued that, in England, "less ambitious" nurses were needed in rural areas because rural homemakers expected nurses to care for the domestic needs of the family as well as the medical needs of their patient; see "On Nursing," in Baroness Burdett-Coutts, ed., *Woman's Mission*, 221.
57. *Montreal Medical Journal* 25, 10 (April 1897): 836–838.
58. Drs. James Stewart and Thomas Roddick, the editors of the *Montreal Medical Journal*, were among the ten specialist and academic medical practitioners recruited by Lady Aberdeen to serve on the Victorian Order's Medical Advisory Council. Their public criticism of the scheme was therefore circumspect and limited to this one instance. Their concerns about both the name and level of training of the Order's personnel, as well as their refusal to allow Victorian Order nurses to practise midwifery, shaped the final version of the scheme in a way that was denied other medical men. For a fuller discussion of the medical response to the Victorian Order, see "An intelligent handmaid and not an interfering interloper': Gender, Medical Authority, and the Founding of the Victorian Order of Nurses for Canada," paper presented to the annual meeting of the Canadian Historical Association, Queen's University, Kingston, Ontario, June 1991.
59. Report of a meeting of the Winnipeg Medical Society, quoted in *Canadian Journal of Medicine and Surgery* 1, 6 (Toronto, June 1897): 271.
60. Reported in *Canadian Journal of Medicine and Surgery* 1, 6 (Toronto, June 1897): 269–271. See also *The Canada Lancet* 29, 11 (Toronto, July 1897): 576; *Canadian Practitioner* 22, 6 (Toronto, June 1897): 433–434, 447–448.

61. "The Victorian Order of Nurses in Canada," *The Canadian Practitioner* 22, 4 (April 1897): 280–81.
62. "The Victorian Order of Home Helpers," *Canadian Journal of Medicine and Surgery* 1, 5 (May 1897): 22–24. See also *The Canadian Practitioner* 22, 4 (April 1897): 280–281; *ibid.*, 22, 6 (June 1897): 433–434.
63. National Archives of Canada (hereafter NAC), Aberdeen Papers, MG 27, I B5, vol. 12, Journals of Lady Aberdeen, 28 February 1898.
64. Nora G. E. Livingston to Lady Aberdeen, 20 February 1897, quoted in Gibbon, *The Victorian Order of Nurses*, 7.
65. NAC, Records of the Victorian Order of Nurses for Canada, MG 28, I 171, vol. 1, file 2, "The Canadian Fund for the Commemoration of the Queen's Diamond Jubilee," March 1897.
66. *Ibid.* Immigration advocates within the National Council also continued to represent the Victorian Order as a rural health care scheme. See, for example, "Resolution IV.—Immigration," *Women Workers of Canada: Being a Report of the Fourth Annual Meeting and Conference of the National Council of Women of Canada* (Halifax, 1897), 156.
67. For a fuller discussion of these changes, see my forthcoming Ph.D. dissertation, "Gender, Organized Women, and the Politics of Institution Building in the 1890s: Founding the Victorian Order of Nurses for Canada" (in progress).
68. "Public Meeting," *Women Workers of Canada* (Halifax, 1897), 102–103.
69. *Ibid.*, 109–114.
70. "Public Meeting: Report on the Victorian Order of Nurses," *Women Workers of Canada: Being a Report of the Fifth Annual Meeting and Conference of the National Council of Women of Canada* (Ottawa, 1898), 114–118.
71. NAC, Aberdeen Papers, MG 27, I B5, vol. 12, Journals of Lady Aberdeen, Toronto newspaper clipping, ca. November/December 1897, "The Victorian Order: The Origin, Aims and Methods of the Order Explained by Dr. Albert [*sic*] Worcester." For Dr. Worcester's influence, see also Meryn Stuart's paper in this volume.
72. Melosh, "*The Physician's Hand*," 10–11, 27. Martha Vicinus has also identified a clear division between nursing reformers' use of "maternal" rhetoric in the nineteenth century and "professional" rhetoric after the turn of the century; see, Vicinus, *Independent Women*, 85–120.
73. Boston University, Special Collections, Mugar Memorial Library, Records of the Waltham Training School for Nurses, N56, typescript copy of British Library, Nightingale Collection, Add. Mss. 45, 815, ff.48–50, Charlotte Macleod to Florence Nightingale, 10 December 1897. See also Charlotte Macleod, "Report of the Victorian Order of Nurses," *Verbatim Report of the Sixth Annual Meeting of the National Council of Women of Canada* (Ottawa, 1899), 152.
74. Miss Elizabeth Robinson Scovil, "District Nursing and the Work Before the Victorian Order of Nurses in Canada," *Women Workers of Canada* (Ottawa, 1898), 118–125. See also, Scovil, "Nursing as a Profession for Women," *Verbatim Report of the Seventh Annual Meeting of the National Council of Women of Canada* (Ottawa, 1900), 166–170.
75. Carrie M. Derick, "Professions Open to Women," in *Women of Canada: Their Life and Work*, 58–59.

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3

Shifting Professional Boundaries: Gender Conflict in Public Health, 1920–1925

MERYN STUART

In recent years, much has been written about the failure of modern public health nursing to reach its historically much glorified potential.¹ The profession of nursing itself is suffering from what Susan Reverby has called a “disorder” spawned by the uneasy hospital–nursing relationship initiated over a century ago.² Fleeing this hospital bond, nurses who began a career in public health nursing were hoping for autonomy, independence and a chance to use their skills in a new way—to prevent illness, rather than heal it.

As Beverly Boutilier’s paper in this volume points out, the historical beginnings of public health nursing reveal its class-conscious roots, both in terms of who should constitute the client, and who the nurse. Boutilier’s discussion of the evangelical women (not trained nurses) who were members of such societies as the Order of King’s Daughters and the Toronto Nursing-at-Home Mission, reveals that they believed that any respectable woman called to God’s service could nurse among the poor. In like fashion, district or visiting nursing, which originated in England in the mid-nineteenth century, was a form of charity for the sick poor at home.

Although dissimilar in structure, visiting or public health nursing organizations in the Anglo-North American world shared many values and assumptions about the work and moulded their service to suit their own contexts. However, each stressed the importance of cleanliness, morality and compliance to the middle- and upper-class values of its lady patrons, who were often either titled (in the case of England and Canada), wealthy or both. Each endeavoured, with varying success, to recruit nurses who had the requisite “gentlewoman” qualities to reform and teach those they visited. Florence Nightingale’s model, incorporating environmentalism, sanitary reform, and a rigid class structure, largely dictated the way district nursing was practised in the English-

speaking world from the 1860s until the turn of the century. Her values reflected widely accepted Victorian views of health, disease and class relationships.³

This paper reports on one aspect of a larger historical analysis of public health nursing in rural Ontario, which examined the daily work of a group of public health nurses and their relationships with families, women's organizations, politicians, and physicians in small rural communities.⁴ The Ontario Provincial Board of Health's child welfare demonstration project of the 1920s provides the context for the analysis. In 1919, the Board received funds from the legislature to send sixteen nurses across the province, hoping to decrease childhood mortality and morbidity in small towns, and in rural and northern Ontario where new immigrants and the poor predominated. Typically, our knowledge about such projects has been from the "top down"—from the perspective of the policy makers—rather than from the central actors themselves. In this instance, a great deal of rich, day-to-day documentary evidence, as well as oral testimony, and annual reports,⁵ exist to provide a more realistic description of actual, everyday work. My central concern was the way in which the particular conformations of gender and class informed decisions about rural public health work and what this revealed about the deployment of power in contemporary society.

I want to explore the sometimes conflicted and often ambiguous relationships between the nurses—all female—and two kinds of male physicians: their "superiors" at the Board of Health and the local, small-town general practitioners. I want to begin to answer the following complex questions: How was gender a primary field within which power over decision making was articulated? How did the nurses both transform the external constraints on their work and yet reinforce the dominance of medical authority?

I will argue that the extent of responsibility that public health nurses shouldered for the success or failure of the child welfare project precluded a passive and subordinate stance. On the one hand, they were often hundreds of miles away from a physician and were required to substitute for physicians as the need arose. On the other hand, their tacit acceptance of the professional protocol that warned against "diagnosis, prescription or treatment" meant that they deferred to physicians, or covertly used strategies to get around the rules. This was the difficult, sometimes impossible, situation in which the nurses found themselves. One anonymous Victorian Order Nurse in Canada's frontier West justified her work in this way: "The nurse is not supposed to take a medical man's place," but "half a loaf is better than no bread."⁶

The Victorian Order of Nurses

Since the organization of trained nursing and well into the twentieth century, nurses have acquiesced to being subordinate to physicians' authority over patient care and over themselves in relation to the medical care of patients. But, as historian Joan Lynaugh has concluded, "nurses tried to draw a distinction between authority over patient care and authority over themselves *as persons*" (emphasis mine). Unfortunately, their "acceptance of the military metaphor complicated and compromised that distinction."⁷ They were expected to obey the physician and be loyal to him, almost without question, since he was the "captain of the ship." Isabel Hampton's characterization of the nurse as "the physician's lieutenant" preceded the following passage from her influential speech to the 1893 World's Fair assembly, and was typical of the way in which the practice of nursing was viewed:

The hands of a nurse are the physician's hands lengthened out to minister to the sick. Her watchful presence at the bedside is a trained vigilance supplementing and perfecting his watchful care; her knowledge of his patient's condition an essential element in the diagnosis of disease; her management of the patient, the practical side of medical science.⁸

Much of nursing's dependence on the professional authority of physicians lay in the fact that most nurses trained in hospitals where, by 1900, physicians were the acknowledged heads. When the nurse graduated to the uncertain world of private duty, she depended upon the good will of physicians to refer cases to her. When Canadian visiting (or district) nursing began at the end of the nineteenth century with the Victorian Order of Nurses (VON), a distance was created between the nurse and the physician, which theoretically allowed the nurse more autonomy and control because she almost never saw him. And, since she often visited the poor, she avoided much of the physician's concern over competition for fees. However, working with the middle classes was a different matter: they had a small amount of money that might be used for the physician's care, rather than the nurse's.

As Boutilier's paper demonstrates, Lady Ishbel Aberdeen, the dynamic wife of the Queen's representative in Canada, encountered trouble when she first attempted to raise funds to support the VON in the late 1890s. Doctors in every major city and town were almost uniformly against the venture, and wealthy, influential people had

refused to support it when physician hostility was so high. Lady Aberdeen recalled that in early 1897:

Rumours had gone abroad that the Victorian Nurses were only to be partially trained, and secondly, that they were to act independently of doctors in country districts, and were thus likely to be employed in the place of medical men because of their lower fees. . . .⁹

Fund-raising was so difficult that the Governor-General, Lord Aberdeen, paid the first superintendent's annual salary himself for two years; this was the only way to start the venture.

The opposition by physicians was finally quelled by an American medical man, Dr. Alfred Worchester, the controversial founder of the Waltham School for District Nurses in Massachusetts. Lady Aberdeen had visited Waltham several times seeking advice from the school, and had followed its program with interest, in part because no one in Canada seemed suitable to be the lady superintendent of this promising, new organization. (Indeed, the first three superintendents, who were Canadian by birth, came from Waltham.) In 1897, Aberdeen persuaded Worchester to come to Toronto and Ottawa to "convert" Canadian physicians to the idea of district nursing. The meetings were successful: he provided information, as well as "what physicians like to eat, smoke and drink at ten o'clock of the evening." By December 1897, the doctors in Toronto and Ottawa had agreed that visiting nursing should go ahead. After all, Worchester urged, the nurses were "trained to know their own proper sphere . . . they know too much to interfere with the physicians." And if they did interfere, they would be "very quickly discharged by the rules of the Order."¹⁰

Lady Aberdeen's problems with Canadian physicians, and the subsequent silencing of opposition, revealed the subtle ways in which gender and class were important variables in the articulation of power. Aberdeen found it necessary to utilize an elite American medical man who knew the "language" and habits of his fellow physicians, and how to win them over. It is unlikely that they would have acquiesced to anyone but a male physician, given the prevailing attitudes toward female authority and the necessary subordination of nurses. This pattern would continue into the twentieth century as many physicians continued to find it difficult to accept a female nurse's authority in matters of child welfare and public health organization.

The "New" Public Health

Allopathic (or regular) physicians in both Upper and Lower Canada established medical licensing boards as early as 1790. By 1868, the Canadian Medical Association had adopted its inaugural Code of Ethics, which "combined points of moral concern with monopolistic and paternalistic injunctions designed to assist the regular profession both in its specific struggle to discredit irregular practitioners and in its general attempts to improve upon . . . the privileged socioeconomic position of regular practitioners." Professional associations in Canada developed in concert with licensure and with tightly controlled numbers of medical schools, which were always associated with universities.¹¹

By 1900, physicians had ensured their control over hospitals, and were sending their patients there. They also moved to dominate the field of public health. Indeed, the central theme in the history of late nineteenth and early twentieth century public health is the hegemony of medicine and science over the voluntary pietistic reform movements that dominated earlier efforts. However, there was no sudden takeover. Rather, gradual change softened by shared social values and the appropriation, or "medicalization," of many reform ideas characterized the period. The perspectives of the physicians and scientists on the Ontario Board were typical of many in North America who embraced the so-called "new public health movement."¹²

The new public health movement was essentially characterized by the rise of modern professional workers: public health physicians and nurses, sanitary engineers, bacteriologists, vital statisticians and epidemiologists. Physicians tended to dominate since many bacteriologists and epidemiologists were medical doctors who had received special training in the United States and Europe.¹³ Indeed, specialization in medicine was expanding into many areas. For example, pediatricians and obstetricians were added as consultants to boards of health everywhere. When the causes of many of the diseases that scourged the population were discovered in the 1880s, reformers began to see illnesses as specific clinical entities with unique courses and pathologies. Thus, by 1890, scientists and physicians were beginning to see disease as preventable. However, cleanliness was still important, although for different reasons than people previously believed. According to one prominent reformer, Dr. Hibbert Winslow Hill:

The modern public health man cares nothing, so far as restriction of disease and death is concerned, for the dirty back yard or the damp

cellar in themselves, but only as they may enter into the transmission of infected discharges. Then, at once they become of vital importance.¹⁴

In this new preventive work, the special ability of one woman to reach another was a powerful incentive to using nurses, almost always female, rather than the medical officers of health, who were always male. It was believed that the compassionate, caring "nature" of the nurse was much more suited to the teaching functions involved in child hygiene, and that the physician's realm was the technical, decision-making, administrative aspect of public health work. And the nurse was practical: in the home she could work with the mother's own facilities and show "how necessary things can be done." Later, she could return to supervise, safe in the knowledge that she had the mother's trust.¹⁵

Another equally important reason for using nurses rather than physicians or sanitary inspectors in a "child-saving" project was the relatively low cost of a nurse's salary compared to that of the district or city medical officer. In 1919, the year before the demonstration began, the Toronto board was clear about the advantages of using a nurse for some aspects of the work:

Because a doctor costs about twice as much as a nurse, it is the policy of the department to have the public health nurse do as much work as she can thus making it possible for the public health physician to spend all of his valuable time doing only those things that demand this special skill and training.¹⁶

Indeed, in Fort William, "the visiting nurse," Miss Fisher reported in 1916 that she had been able to accomplish much in the "coal-dock section" at a cost of eighteen cents per visit. One reformer stated that it was clear that it had been the "personal supervision, personal interest, personal teaching by an expert (a doctor or a nurse)" that had lowered the death rate of infants in Fort William by thirty-three percent from 1910 to 1911: none of the babies who had died there had been breast-fed. It is not surprising that in North Bay the medical officer argued that "big dividends would be returned on a small outlay" if nurses were used to save babies and children.¹⁷

Control of Nurses' Work

On 5 March 1917, Hill was a key figure in a meeting of the Board called to consider the question of hiring public health nurses to educate

mothers about child care. It was an important meeting. All of the physician Board members were present, as well as Dr. John G. Fitzgerald, director of the Connaught Laboratories; the directors of the Branch Laboratories (all male physicians); the Provincial Chemist; three District Officers of Health; the Provincial Statistician; the Chief Sanitary Engineer and the Provincial Secretary, Mr. McPherson. Dr. John McCullough, the Chief Medical Officer of Health, was in the Chair. Miss Mary Power, the non-physician Director of the Child Welfare Bureau from 1916 until 1925, was the sole woman present and was referred to as "our friend." Miss Knox, the nurse-in-charge, who had been travelling around the province with the Child Welfare display, was absent.¹⁸

The physicians clearly dominated the meeting and the decision making.¹⁹ Hill, Fitzgerald and McCullough controlled much of the discussion due to their status within the group and Hill's previous experience with rural demonstrations in Minnesota. The non-physicians such as Mr. Lancaster, the Provincial Chemist, apologized for "not being a medical man" and seeing things "only from a chemist's viewpoint." Power and Hill clashed over the function of the nurses: she understood that they were to be general public health nurses, while he believed that they should only be involved with infant mortality work, not getting mixed up with "all the old squabbles and quarrels about sanitation." McCullough immediately agreed with Hill and a motion was passed, delineating the nurses' role as involving childhood mortality.²⁰

Although the members spent considerable time debating such questions as how to increase birth registrations, very little time was spent in discussing to whom the nurses would report, and who would have direct authority over them. Even the question of their legal status within the communities went unanswered. Power and Knox had some administrative control, but who would really direct their work in the towns and villages? Would they be left to their own initiative?

Dr. Maloney, the Health Officer in District Five, was concerned about this. He wanted control over the nurses' activities and predicted problems if this was not to be the case. As he put it:

It looks to me as if you are going to have a little friction with the district officer. If you are going to have a nurse going here and there in our districts over whom we have no control, we are going to have friction. I think the matter should be so arranged that the nurse should work in cooperation with the district officer, that is, as to where she shall go and what she shall do, and in the meantime she should specialize in this

office as to the particular work she shall take up under the direction of the district officer.²¹

McCullough agreed that the nurse "ought to be somewhat under the district officer of health" and that the two groups should be "in harmony." One of the Board members, Dr. Kaiser, put it more forcefully, saying "she ought to report to him and he should report to you." Regarding the local, private physicians and any potential conflict with them, McCullough was clear in stating, "I do not want the nurse to be a doctor; I do not want to have her come into conflict with the doctor." Power was quick to reply that the nurse "would never do diagnostic work." However, the matter of who would have day-to-day authority over the nurses was never to be finally decided in the meeting and would cause problems for them in the future.²²

Rules of Professional Etiquette

After the nurses had begun their work, the "regulations" included admonition concerning the relationship of the nurse to the physician. The nurse was cautioned to suggest "absolutely no treatment or diagnosis," nor to advance "opinions." Family physicians were to be notified "in writing" after the nurse made her first visit to a patient and future visits were to be deferred for two weeks "pending his reply." If a physician objected to the visits, "they [were to] cease immediately." The nurse was required to send a report of each visit to the physician as soon as possible. Furthermore, nurses were advised never to recommend a physician and to always "explain the importance of regular visits to the doctor, and careful attention to his instructions." Any instructions from family physicians to the nurse were to be carried out without fail.²³

Instructions about the conduct of a "well-baby clinic" also included statements about the advice "the public health nurse attending at a clinic may properly give" to mothers, and about the way she was to assist the physician "any way she as a nurse can." In addition, all the nurses' records were to be available to "the medical attendant."²⁴ Such vague directives were all the nurses had to guide them and only pertained to the clinic situation when the physician was present. What was the nurse to do when she came upon a sick patient or a community whose survival depended upon her medical diagnosis? Teaching preventative measures to mothers was all well and good, but when people were sick and could not (or would not) consult a physician, what was the nurse to do?

Contemporary public health nursing textbooks carefully admonished readers against trespassing onto the physician's territory. For example, Mary Gardner's eight principles of public health nursing, assigned to the nurses by the Toronto public health nursing supervisor Eunice Dyke for the purposes of class discussion during their three-month educational preparation, prescribed "rules" of appropriate behaviour for the public health nurse.²⁵ These principles were adopted as fundamental because they were felt to be of vital importance to the nurse who would be out in her district, away from her supervisors. According to Gardner, one of the early leaders of American public health nursing, appropriate behaviour according to the principles included avoidance of giving "material relief" to patients; shunning interference with the patient's religious views; the necessity to co-operate with other social agencies—that is, not to "play her own game"; the importance of keeping "suitable and accurate records"; the insistence that "patients unable to pay for nursing care should receive free service, and that those able to pay for it should do so according to their means"; regulation of hours of work for the nurse; and, finally, rigid observance of "professional etiquette" in relations between physicians and nurses.²⁶

Acknowledging that "public health nursing has had in the medical profession its greatest friend, and not infrequently its greatest stumbling block," Gardner insisted that it was necessary to win over "former opponents" in order to ensure the co-operation of all physicians and, thus, the continued development of public health nursing. If nurses followed the "rules" of professional etiquette, the support of physicians would be assured.

Acknowledging that disregarding her own judgment about a patient's care could be difficult for the nurse—not to mention dangerous for the patient—Gardner nevertheless believed that this dissonance could not be resolved by breaking the rules, but rather "by the gradual education of public opinion to the point where the importance of baby work is understood." In other words, it was the responsibility of the patient and family to understand "good" versus "bad" care. Unfortunately, leaders such as Gardner wished to avoid conflict with physicians more than they wished to help public health nurses deal with the problems that would inevitably come when nurses were more independent of physicians than they had been in the hospital milieu.²⁷

For public health nurse Marguerite Carr-Harris, the rules about physician–nurse conduct provided a structure for teaching future mothers the sexual division of labour in the health care system. In her Little Mother's League classes, she demonstrated to nine- and ten-year-

old girls how thoroughly she was indoctrinated with the expected role behaviours of the mother, doctor and nurse. Wishing to teach them “why babies die” and the “signs of a sick baby,” she first read them a lesson on signs of sickness and then divided the group into mothers with sick babies, mothers with well babies and public health nurses. Carr-Harris herself, role-playing the “doctor,” called on each mother inquiring how the baby was and then “the doctor left a public health nurse behind to instruct her as to why babies die and what she must do if baby becomes ill.” Not surprisingly, Carr-Harris reported that the “little mothers entered wholeheartedly and seriously” into the game. This anecdote was reported in the nurses’ Bulletin as an example to other nurses of a good teaching strategy for girls who would one day be mothers.²⁸

Experiences of Shifting Boundaries in the Field

Although it was clear that nurses were to do something *different* from the physician, always supporting and reinforcing his directives to the mothers, the boundaries were often blurred and shifting, particularly when no physician was available or when the nurse encountered serious illness that needed immediate attention. In some instances, the nurse was sure that she knew more about a case and how to treat it than the physician. In the small towns and villages, many physicians were out-of-date and unfamiliar with the new prevention and treatment modalities that the nurses had learned from elite, urban medical specialists. Some physicians wished to learn from the nurses and co-operate with them. Others were hostile and unco-operative, or simply indifferent.²⁹

One incident revealed the kind of medical ignorance and indifference that the nurses encountered in managing communicable disease and its prevention. In 1923, Carr-Harris found that whooping cough was epidemic in the isolated Tait and Mather townships of Rainy River District. As she put it, “nearly every family in this back country seemed to be in some stage of it.” This is what Carr-Harris did:

We advised those with babies who had not yet become infected or were in the early stages, to take them to their doctor for preventive treatments as we knew one Emo doctor had been giving serum for whooping cough on the occasion of the unveiling of the Barwick Monument. The Post Master at Blackhawk accordingly drove in 25 miles to Emo, and his own doctor, happening to be the other man, said he did not think that

anything could be done. The whole family later had the disease and the baby very severely.³⁰

This incident occurred almost ten years after the Board made serum available, free of charge, to any physician requesting it.

Public health nurse Marjorie Heeley recalled a number of incidents of conflict with physicians and confusion of roles. In Parry Sound in 1923, she had a “set-to with a *young* doctor” after she gave him some information that she had gathered. He “resented . . . *resented*” her giving him any information and gave her a calling-down. She could not understand how her action was infringing on his territory, although she was certain he perceived that it had. He later put her on an overloaded boat back to the mainland, an action that put her in some danger and made her feel that he was angry and wished her ill. In Englehart, there were two doctors, one was drunk all the time (although he was a good doctor), and the other, who was young, didn’t know anything about child care. He would ask her, “What would you do?” and left a lot of responsibility to her. For example, he didn’t know what to do if a baby had dysentery.³¹

Responsibility for the lives of her patients, often babies, weighed heavily on her when she feared the physicians weren’t “up to date” or when there was no physician, either because of distance or poverty. Sometimes she questioned whether she had done the right thing to send a patient to the doctor in these situations, either because she knew they wouldn’t go or because she did not trust the physician’s knowledge. She remembered going up to a mother on the street and seeing that the baby in the pram was very ill, and that the mother did not realize it. She told the mother to go to the doctor right away, but the baby died, either because the mother did not go or went too late.

In Whitney, where there were no doctors, she found a sick child and got orders from a doctor over the telephone to give the child some medication. The child died, and this is the way that Heeley expressed her feelings of guilt and confusion over what she should have done:

Whatever he told me to give that child . . . killed it, and he wasn’t there, you see . . . it died. I don’t know whether it was an injection or what, I forget. It was *old medicine* and it was too strong . . . that’s what I felt afterwards. It was practically poisoned . . . instead of being helped. If I’d done it my way . . . I wouldn’t have, you know . . . if I’d done it alone, on my own, I think I could have saved that child. But because I got the doctor. . . .³²

Although she did not remember exactly what she would have done, the strong impression remained that she could have done better on her own, without the doctor. However, her professional training and the rules of the Board told her that she must call the doctor, even though he practised old medicine. On the other hand, there were times when she was called to homes and did the best she could, knowing that she was the only medical person available and yet feeling totally inadequate for the job. This was especially true of maternity cases: she remembered a baby being born very prematurely to a mother with five other children; by the time she could look at the baby, it had hemorrhaged and died. She knew that she did not have the knowledge nor the equipment to save the child, and resolved her grief by doing the best she could and going on to the next case. However, the feeling that one had to be ready for anything stayed with her.³³

What many physicians (and some nurses) apparently did not understand was the difference between nursing care and medical care. Board consultants had prepared the nurses with the newest ideas in the primary and secondary prevention of childhood and communicable diseases. They should not have presented a threat to physicians, who were skilled in the diagnosis and treatment of disease. Heeley recalled very clearly that what the mothers needed was “*nursing* care, not doctor care.” There were many things that mothers did not know about feeding and caring for their children that the doctor was not prepared to teach, nor did he have the time. “It was education they needed” and the physicians “hadn’t been trained about childcare” in the way the nurses had been. Besides, in the home, the nurse could see things that the mother was doing that were “inadequate”; the doctor would never see these problems since people wouldn’t call him unless the baby was already sick, and no home remedy had worked.³⁴

In teaching preventive measures, the nurses often came into conflict with physicians’ orders, especially with regard to infant feeding. Breast-feeding was acknowledged by most pediatricians and public health experts as the best prevention for infant diarrhea in the first year of life.³⁵ But, as Public health nurse Edna Squires wrote from the impoverished town of Arnprior in 1923, the doctors there gave lip service to the importance of breast-feeding, “but half the babies in town are on Allenbury’s and Malted Milk ordered by the doctor.” Although it was widely believed that every bottle-fed baby should be under a doctor’s care, many physicians in the rural areas were not well informed about artificial infant feeding practices. Therefore, the nurses attempted to

promote and support breast-feeding whenever they could, especially for the most high-risk (usually poor) babies.³⁶

In Kenora, Carr-Harris and her colleague Miss Whitworth tried to counsel a Galician mother with five other children to keep nursing her twins, although the physician, Dr. Paton, had suggested to "try one bottle a day." Because babies were continuing to die in the town, Carr-Harris was afraid that the bottle-feeding would lead to weaning, and subsequent disaster. To complicate matters, the nurses were asked to visit sick babies who were under the care of a physician, but who were not getting better. How should the nurse act in this situation? It was obvious that some of the physicians were less informed than the nurses, so Carr-Harris received help from a pediatrician in Winnipeg, consulted Maternal and Child literature and continued to encourage breast-feeding.³⁷

When Carr-Harris and Whitworth attempted to organize their program in Kenora, they found that the physicians were a "stumbling block" and did not give immediate support as the other groups did. They stalled on holding a meeting to decide what assistance they would provide and Carr-Harris concluded that neither the Medical Officer of Health nor the doctors were "at all keen" on the idea of holding a baby clinic. They needed the support of one physician in particular, Dr. Gunne, who was extremely influential and worked on contract for the Canadian Pacific Railway. Carr-Harris expressed her feelings this way:

The Doctors at present are so lukewarm that we will have to go very gingerly—am hoping great things from Dr. Middleton and his power to change their attitude, for the whole future of this district hangs on making a successful beginning here—It will be most difficult to recover from any friction or upset with these doctors—we would be unable to work here and the example would be very harmful & would in fact prevent our going to any of the places over which Dr. G. presides.³⁸

Gunne and the other physicians were indeed "won over," largely because of the visit from Dr. Middleton, the Director of the Division of Public Health Education. In order to gain credibility for their program of action, it was necessary for many of the nurses to call in their superiors, the physicians who were employees of the Board—Dr. McCullough, Dr. Bell (the Board's pediatrician), Dr. Middleton, and later, Dr. Phair—to convince local physicians that they should support the nurses. And the nurses had to be careful, lest their superiors thought that they were too aggressive in making suggestions, or that they did not wait for permission and direction from them.³⁹

Olive Gipson reported from Smith's Falls on 17 March 1921 that she was not getting any co-operation from the physicians—the response was distinctly frigid, even from the local Medical Officer of Health, who was distinctly “not with us.” After Bell came to a baby clinic and explained the medical Attendant's work in great detail to the physicians, “he cleared the whole atmosphere for us.” Gipson concluded that “now we hope to be able to carry on successfully.”⁴⁰ Edna Squires wrote from Alexandria on 3 July 1924 that although she saw the need for a throat specialist—and was afraid “the local men will be taking up the work” (incompetently)—she had to wait for Bell to arrange it or for the local doctors to request an outsider. On 23 January 1924, Squires had written to Power that the children desperately needed dental work and she proposed to approach the dentists about holding a clinic (at no charge). Power replied that “the dentists must organize their own clinic,” and added, “you offering all assistance within your power, but undertaking no responsibility in the direction of the work, etc.” Such matters needed to be carefully handled so that the nurse never appeared to be interfering as an outsider, nor inappropriately requesting specialists' help.⁴¹

As might be expected, there were sometimes problems when the nurses attempted to circumvent their constraints by creative means. Squires reported from Almonte in October 1922 that the doctor's wife—a member of the Women's Institutes—had so much trouble and received so much criticism for organizing tonsil clinics that her husband was ready to divorce her. The woman blamed Squires for getting her into it. The specialist from Ottawa had charged fifty dollars per operation, the poor couldn't pay and the local doctors were annoyed that an outsider was brought in. Squires lamented: “Is it any wonder that so many people think there is something lacking in our work when it just points out the defects and then makes no provision for helping poor people get them corrected.”⁴²

However, in order to be effective and feel satisfied with their work, the nurses needed to take initiative. Often, they were successful in getting across their message or in averting disaster. As Heeley put it, “you *had* to diagnose, you wouldn't be any good as a nurse if you didn't.” For example, Squires decided to change an Alexandria baby's formula, ordered by Bell at a clinic, because it had developed diarrhea. Mothers in Kenora frequently called Carr-Harris or Whitworth to help with infant feeding problems. The nurses felt their responsibility (and inexperience) in giving advice, especially since the cow's milk supply in the town was not adequate, but how could they refuse to help?⁴³

Frequently their successes were more subtle, due to their ability to defuse hostility or convince doubters before larger problems arose. In Alexandria, Squires encountered the inspector of the public school who sent a letter to the principal stating that "as they have two doctors in their family," he did not see the need to have his child inspected by the nurse. She accepted this, recognizing that he was unfamiliar with the public health nurses' role, and allowed him to watch her examining children, spending time talking to him. His opposition vanished. In Belleville, Heeley spoke to an open meeting at City Hall about public health work. She received a letter from the Chamber of Commerce, praising her for her address. They called it "a model of lucid and forcible exposition," and complimented her on her "tactfulness . . . displayed all the way through without at the same sacrificing truth and effectiveness."⁴⁴

Often, however, the nurses were forced to work within the narrow limits that were invoked by the social processes and power relationships of gender. They had to deny their ambition and their achievements in order to be evaluated successfully by their superiors. For example, Squires wrote to Knox in 1924 that she had a suggestion about what kind of advertising should be put in the newspaper for the Alexandria Health Week, but "would rather Dr. Bell should not know that I suggested it."⁴⁵ Carr-Harris was frequently asked to address many different community groups about the Public Health Movement. Organizations such as the Women's Institutes considered her 1926 speech to their District Annual Convention sufficiently important to publish it in their Annual Report. However, before preparing this speech, she wrote to Dr. Phair, then the Director of the Division, hoping that someone "in command" would be able to come and speak. When this proved impossible, she asked to be instructed as to her message in regard to the work, writing that she wished to "strike the note which you wish struck."⁴⁶

Even their private lives were regulated in a military fashion: the nurses required permission to leave their communities for the weekend or a holiday such as Christmas; one nurse was required to stay in the district at all times, even at Christmas. They often pleaded overwork, as if they needed an excuse to get away.⁴⁷ If their presence was requested by a District Officer of Health or a Medical Officer of Health, there was no question about obeying, even if such a request interfered with their own plans. Some of the nurses, like Squires, complained privately to Knox about unreasonable demands, not wanting the physician to know.⁴⁸ Others, like Ethelda Corbman, complained openly in a letter to Power about having no part in decisions regarding her own work. Dr.

Sparks (the District Officer of Health) and McCullough had decided that she would travel to Toronto with Northern tuberculosis patients at Christmastime; it was never discussed with her, and she was opposed to the trip because she had previously made plans to stay in the North for Christmas. Complaints such as the following also revealed the lack of control and the frustration some of the nurses must have felt:

I am very short of funds and have been for some time. It is five months today since I have had expense account cheque. I have bills to pay myself that I have not been able to meet as I have had to use my salary for travelling expenses. I have had to slight my work on account of shortage of funds and have not accomplished all that I would have on account of having to return before I should have. . . . It makes one feel rather disgusted and the work suffers.⁴⁹

Not all of the nurses were sufficiently prepared to deal with the kinds of situations in which they found themselves; these nurses left the Board's employ. By the summer of 1922, at least two of the nurses had resigned because of the Board's dissatisfaction with their performance. One of the nurses, Olive Gipson, did not understand why her work was unsatisfactory and believed that she was being discredited unfairly by the Board physician. In a letter written to Knox on 1 March 1922, requesting a conference with her superiors she stated:

All I want is for Dr. Bell to produce his proof of what he has reported and give me a chance to defend myself, . . . to me honour is the greatest asset a person possesses and I do feel that mine is involved. . . . I have written you very frankly but you have always urged us to do so and even at that, I have not expressed even a little of what I feel.⁵⁰

Fanny May Bagshaw became very discouraged when Northern physicians "failed" her: she admitted to wanting to give up. In late 1921, Power and Knox began to openly express in letters that they were "very much disappointed" in her reports. In the next six months, Bagshaw was berated for not obeying "orders" from head office and for not consulting the local Medical Officer of Health before she approached the council. When she asked for help in convincing local authorities of the need for a nurse, the responsibility was put entirely on her shoulders. Knox told her: "Our demonstration should clear up any doubts he [the Medical Officer of Health] has as to the usefulness and need of a community health nurse." She had failed to get a nurse appointed in Thessalon, where she blamed the failure on her Protestantism: eighty percent of the community was Roman Catholic. She was contemptuous

of the Medical Officer of Health there who was a “little Russian Jew and very hard to deal with.” In June 1922, Bagshaw was recalled from the North and she resigned in July.⁵¹

Conclusion

Conflict and contradictions were inevitable as public health nurses and physicians attempted to work together. As a result of their medical training, physicians had come to believe that they were the “captains of the ship,” shouldering total responsibility for the outcomes of patient care. The Board’s Toronto physicians, particularly McCullough and Bell, both elite and well-connected socially, had legitimate authority over the nurses, who were almost all from families never considered elite. Local community physicians were geographically close, yet had little real authority and were generally reluctant to accept the nurse as an equal, socially or professionally. The nurses’ “outsider,” urban status undoubtedly influenced their acceptance by locals. Both groups of physicians may have seen the nurses’ work as surrendered authority rather than as delegated functions, or appropriately independent actions.⁵²

As a result of their training, nurses were likely to defer to medical authority, seeing physicians as superior in skills and knowledge. However, because they were experimenting with new self-images as health teachers and medical diagnosticians, ethical dilemmas and internal discomfort could be expected. Away from the hospital, the work of health care did not have the same well-known, rigid rules. In the community, a “no man’s land” existed between medical care and nursing care. Who was the principal care provider? Who should make what decisions?

One way to handle the problem of professional boundaries has been called “the doctor–nurse game.” First described in 1967 by an American psychiatrist, the cardinal rule of the game was that open disagreement must be avoided at all costs. Conflicting messages underpinned the game:

The first set of messages implies that the physician is omniscient and that any recommendation [the nurse] might make would be insulting to him and leave her open to ridicule. The second set of messages implies that she is an important asset to him, has much to contribute, and is duty-bound to make those contributions. Thus, when her good sense tells her a recommendation would be helpful to him she is not allowed

to communicate it. The way out of the bind is to use the doctor–nurse game and communicate the recommendation without appearing to do so.⁵³

The following anecdote exposes the conflicts and contradictions inherent in the relations between nurses and physicians, suggesting that the nurses discussed problems, privately, among themselves, but never publicly. In an April 1922 personal letter to her supervisor, Miss Knox, Edna Squires inquired if Knox had heard the following “joke”: A public health nurse was asked by one of her patients “if she didn’t think it was nice weather.” The nurse replied, “I don’t know, you had better ask your physician.”⁵⁴ Ultimately, the joke revealed that the nurses were forbidden to have an opinion about anything; an opinion was the physician’s prerogative.

The nurses were able to deal with the dilemmas imposed by their unfamiliar roles through using such passive strategies, enabling the physician to believe that the ideas were his own and thereby maintain his authority. Nurses also involved community women and men in organizing public health activities, rather than risk displaying their own ambitions publicly. As Barbara Melosh points out, on the one hand, they accepted and even reinforced medical domination of health care, because public health opened up unprecedented opportunity for nurses in the physician’s absence.⁵⁵ On the other, they saw that the lack of role clarity and direct communication could gravely affect people’s health. However, they could only privately express resentment over their lack of control because public outcry and rebellion were not perceived as options for women in 1920s nor 1930s Ontario.

Endnotes

1. For the United States, see the articles written in *Nursing Outlook* 31 (November/December 1983) especially Katherine Chavigny and Mary Kroske, “Public Health Nursing in Crisis,” 312–316. For historical scholarship interpreting why public health nursing “failed,” see Karen Buhler-Wilkerson, “False Dawn: The Rise and Decline of Public Health Nursing, 1900–1930” (Ph.D. dissertation, University of Pennsylvania, 1984). For an account of why public health nursing declined in a Canadian city after 1925, see Kathryn McPherson, “Nurses and Nursing in Early Twentieth Century Halifax” (M.A. thesis, Dalhousie University, 1982), 75–105. For Ontario, Canada, the best evidence of dissatisfaction and powerlessness in the ranks can be found in the Newsletters of the Community Health Nurses’ Interest Group of the Registered Nurses’ Association of Ontario. See, for example, the winter 1986 issue in which public health nurses’ “image” and “ineffective utilization” were identified in a survey of members as two of the most important issues facing the profession. The creation of a new category of public health worker, the “health

educator," is also of concern to Ontario public health nurses, who are being laid off in increasing numbers. See the spring 1993 issue of the above Newsletter, p. 19. Health educators are often male; the overwhelming majority of public health nurses are female. Male nurses work in hospital critical care and psychiatry units, for the most part.

2. Susan Reverby, "The Nursing Disorder: A Critical History of the Hospital-Nursing Relationship, 1860-1945" (Ph.D. dissertation, Boston University, 1982). Evidence of widespread disillusionment and low morale in Canadian hospital nursing is to be found in the bitter labour strikes of the late 1980s in B.C., Alberta, Quebec and Manitoba.

3. For a discussion of Nightingale in the context of Victorian social medicine, see John M. Eyler's *Victorian Social Medicine: The Ideas and Methods of William Farr* (Baltimore: The Johns Hopkins University Press, 1979), 159-175. For a discussion of her beliefs about disease, reform and nursing see Charles E. Rosenberg, "Florence Nightingale on Contagion: The Hospital as Moral Universe," in Rosenberg, ed., *Healing and History* (New York: Dawson, 1979), 116-136. Unlike many of her peers, she resisted the idea of contagion. For an analysis of her religious views see Elaine Showalter, "Florence Nightingale's Feminist Complaint: Women, Religion and 'Suggestions for Thought,'" *Signs* 6 (Spring 1981): 395-412.

4. For an account of the context and outcomes of the demonstrations, see Meryn Stuart, "Ideology and Experience: Public Health Nursing and the Ontario Rural Child Welfare Project, 1920-1925," *Canadian Bulletin of Medical History* 6, 2 (Winter 1989): 111-131.

5. These documents are in the Archives of Ontario (hereafter A0), RG 10, Series 30 and RG 62, Series F. The Provincial Board of Health Annual Reports (hereafter PBHAR) must be read with caution, since they were left partially as a record of accomplishment, seeking to place things in the best light possible. Correspondence of the nurses in the field is, of course, also suspect because they may have wanted to rationalize their own failures (and successes) to their superiors, and, undoubtedly, "filtered" much of what occurred. Typically, the population's response to the project is lacking; only one or two letters attest to some reactions. Some relevant suggestions on the latter were offered by Katherine Arnp, "Mothers and Nurses: Enemies or Allies?" (Paper presented to the First National Nursing History Conference, Charlottetown, 16 June 1988). For popular reaction to vaccination see Paul A. Bator, "The Health Reformers versus the Common Canadian: The Controversy over Compulsory Vaccination against Smallpox in Toronto and Ontario," *Ontario History* LXXV (December 1983): 348-373.

6. VON Column, *The Canadian Nurse* XV (June 1918): 1093. For Eastern Canada, see also Barbara Keddy, "Private Duty Nursing Days of the 1920's and 1930's in Canada," *Canadian Woman Studies* 7, 3 (Fall 1986): 99-102. These are oral history accounts of nurses' work in Nova Scotian homes.

7. Joan Lynaugh, "Narrow Passageways: Nurses and Physicians in Conflict and Concert since 1875" (Paper presented to the Twenty-Second Symposium on Philosophy and Medicine at U.N.C., 15 May 1986), 11.

8. Isabel Hampton, "Educational Standards for Nurses," in John S. Billings and Henry M. Hurd, eds., *Hospitals, Dispensaries and Nursing* (Chicago, 1983), 33.

9. For this quote from her book *What Is the Use?*, see John Gibbon, *The Victorian Order of Nurses for Canada* (Montreal: VON for Canada, 1947), 16.

10. Gibbon, 19-23, 25. For a more detailed analysis of this conflict, see Boutillier's paper in this volume.

11. C. D. Naylor, "The CMA's First Code of Ethics: Medical Morality or Borrowed Ideology?" *Journal of Canadian Studies* 17 (Winter 1982/83): 31; J. F. Kett, "American and Canadian Medical Institution," *Journal of the History of Medicine and Allied Sciences* 22, 4 (1967): 343-356.
12. For an overview of Canadian hospital development, see S. E. D. Shortt, "The Canadian Hospital in the Nineteenth Century: An Historiographic Lament," *Journal of Canadian Studies* 18 (Winter 1983-1984): 3-14. The most comprehensive analysis of the American public health movement is found in Barbara Rosenkrantz, *Public Health and the State* (Cambridge, Mass.: Harvard University Press, 1972). For one Canadian analysis, see Heather MacDougall, *Activists and Advocates. Toronto's Health Department, 1883-1983* (Toronto: Dundurn Press, 1990).
13. Rosenkrantz, "Cart Before Horse: Theory, Practice and Professional Image in American Public Health," *Journal of the History of Medicine and Allied Sciences* 29, 1 (January 1974): 60-1; for a Canadian analysis of a well-connected public health physician, see Geoffrey Bilson, "Dr. Frederick Montizambert (1843-1929): Canada's First Director General of Public Health," *Medical History* 29 (1985): 386-400.
14. Hibbert Winslow Hill, *The New Public Health* (New York: The MacMillan Co., 1916), 13.
15. These views were expressed in the Toronto Department of Health Annual Report, published in PBHAR, 1919, 233. Typically, there were several female physicians who worked with the nurses in the field. They deserve a separate analysis.
16. *Ibid.*
17. Miss Fisher's report is in PBHAR, 1916, 333; the cause of the lowered mortality statistics in Fort William is in Helen MacMurchy, *Infant Mortality: Third Special Report* (1912), 13; PBHAR, 1915, 161.
18. Typescript, "Proceedings of Meeting of the Provincial Board of Health, March 5, 1917," AO, RG 8, I-1-A-1, Box 64.
19. For example, Miss Power spoke only eight times; the transcript is thirty-seven 8" x 11" pages long.
20. *Ibid.*, 5, 36, 37.
21. *Ibid.*, 36.
22. *Ibid.*, 37.
23. "Outline Plan of Work for Provincial Board of Health Nurses," AO, RG 10, 30A1, Box 8, File 15: 3-4.
24. "Procedure for Well-Baby Clinic," AO, RG 10, 30A1, Box 6.
25. Miss Dyke herself said that the public health nurse was "called to assist the health officer" and that he "granted initiative to his public health nurse." She also cautioned that the nurse should never express "an opinion of the capacity of the physician chosen by the patient." "The Public Health Nurse," Paper read before the Annual Conference of Illinois Health Officers and Public Health Nurses, 14 October 1928. (Published by the State Department of Health. Found in the Archives of the Canadian Nurses' Association.) Miss Dyke was fired in 1932 after she publicly defended a nurse on staff against a physician.
26. Mary Sewall Gardner, *Public Health Nursing* (New York: MacMillan Co., 1916), 38-39. Gardner was one of the early leaders of American public health nursing; in 1905 she became the Superintendent (later Director) of the Providence District Nursing Association in Rhode Island, heading it until her retirement in 1931. Her greatest contribution

was probably her book *Public Health Nursing*, revised in 1924 and 1936, and hailed as a classic in North America. (Barbara Sicherman and Carol Hurd Green, eds., *Notable American Women: The Modern Period*, vol. IV (Cambridge, Mass.: Belknap Press, 1980), 262–263. Canadian leader Florence Emory listed the book as a reference in almost every chapter of her 1945 book, *Public Health Nursing in Canada*. Emory also footnotes Gardner's fictional work, *So Build We* (p. 265), published after Gardner's retirement and "designed to dramatize the correct methods and goals of public health nursing." Susan Armeny, "Resolute Enthusiasts: The Effort to Professionalize American Nursing, 1880–1915" (Ph.D. Dissertation, University of Missouri-Columbia, 1983), 55–57.

27. Gardner, 4. Emory advised her readers that "mutual trust and respect" must exist between the medical doctor and the public health nurse. When the physician feared "encroachment" of the nurse, Emory admonished that "possibly again the public health nurse may have over-reached herself in her zeal and forgotten the responsibility of the physician for his patient." The public health nurse was warned to "never diagnose" and "never prescribe" (even for the common cold or a headache), and "never give treatment apart from medical supervision." Health teaching was "conceived as *supplementary to medical care*" [emphasis mine] and one of the public health nurse's functions was "strengthening the bond between the physician and his patient." In *Public Health Nursing in Canada: Principles and Practices* (Toronto: MacMillan Co., 1945), 119–124.

28. Ontario Board of Health "Bulletin," February/March 1923, AO, RG 10, 30A1, Box 3, File 3.

29. Rural–urban medical tensions undoubtedly existed, accounting for at least part of the hostility. For an account of early resentment towards urban specialists on the part of rural physicians, see C. David Naylor, "Rural Protest and Medical Professionalism in Turn-of-the-Century Ontario," *Journal of Canadian Studies* 21 (Spring 1986): 5–20.

30. "Report on Townships and Railways, Summer, 1923," p. 3, AO, RG 10, 30A1, Box 1, File 14.

31. Interview with Marjorie Heeley Whitney (hereafter, MHW), 12 August 1986.

32. Ibid.

33. Ibid.

34. Ibid., 13 August 1986.

35. See, for example, all the published work of Dr. Alan Brown, Chief of Pediatrics at the Toronto Hospital for Sick Children for thirty years, as well as the writings of Dr. Helen MacMurchy.

36. Squires to Power, 14 August 1923, AO, RG 62, Flb, Box 475. Evidence that rural (and urban) physicians were unfamiliar with feeding infants and children is provided by Dr. Alan Brown, "Problems of the Rural Mother in the Feeding of Her Children," *CN* 14 (July 1918): 1160. Mothers may also have asked for formula feeding instructions, influenced by widespread commercial baby-food advertising.

37. Carr-Harris to Knox, 10 December 1920, AO, RG 62, Flb, Box 478. See Also Carr-Harris to Knox, 22 November 1920.

38. Carr-Harris to Knox, 22 November 1920.

39. The tone of all letters from Kenora in the fall and winter of 1920–1921 indicated that the nurses wanted to keep their superiors informed of the situation, lest they make a mistake and cause problems for their employer.

40. Gipson to Power, 17 March 1921, AO, RG 62, Flb, Box 474. (All Gipson's subsequent correspondence is to be found in this source.)
41. Squires to Knox, 3 July 1924; Squires to Power, 23 January 1924. (And reply.)
42. Squires to Power, 11 October 1922.
43. Squires to Power, 16 May 1924.
44. Squires to Power, 9 January 1924; J. O. Herity to M. R. Heeley, 3 March 1922, letter in the possession of MHW.
45. Squires to Knox, 2 August 1924.
46. Carr-Harris to Phair, 26 September 1926, AO, RG 62, Flb, Box 479.
47. See, for example, Gipson to Knox, 17 March 1921. All of the nurses were single. Full-time paid work and marriage were seen as incompatible in this period.
48. Squires to Knox, 22 July 1922. (Marked "personal.")
49. Corbman to Power, 22 December 1922; Corbman to Power, 31 August 1923. Both in AO, RG 62, Flb, Box 479.
50. Gipson to Knox, 1 March 1922.
51. Bagshaw to Knox, 4 November 1921 and Knox to Bagshaw, same date; Knox to Bagshaw, 20 December 1921; letters from Thessalon were written 9 November 1920 and 20 December 1920, AO, RG 62, Flb, Box 478. The blatant anti-semitism was unfortunately all too common in the early twentieth century.
52. Barbara Bates's analysis of physician–nurse relations has greatly influenced my discussion. See her articles, "Doctor and Nurse: Changing Roles and Relations," *New England Journal of Medicine* 283 (1970): 129–134 and "Physician and Nurse Practitioner: Conflict and Reward," *Annals of Internal Medicine* 82, 5 (May 1975): 702–709. Of course, there were physicians who welcomed the nurses' work. See for example Beryl Knox's correspondence with a doctor in 1917.
53. Leonard I. Stein, "The Doctor–Nurse Game," *Archives of General Psychiatry* 16 (1967): 703.
54. Squires to Knox, 7 April 1922, AO, RG 62, Flb, Box 475.
55. Barbara Melosh, *The Physician's Hand. Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982), 132–142. For the same general argument about constraints see also Kari Dehli, "Health Scouts for the State? School and Public Health Nurses in Early Twentieth Century Toronto," *Historical Studies in Education* 2 (Fall 1990): 247–264.

4

Science and Technique: Nurses' Work in a Canadian Hospital, 1920–1939*

KATHRYN McPHERSON

Creating a conceptual framework from which to understand nurses' relationship to science has intrigued, and sometimes confounded, several generations of nursing scholars and educators. More recently, however, this question of the nurse–science dynamic has been raised by historians of women, who themselves have puzzled over how to fit nurses and the work they performed into the model of scientific medicine that developed in the nineteenth and twentieth centuries. For the most part, feminist scholars have concluded that until at least the post-World War II years nursing work fell outside the modern paradigm of science. This chapter challenges that conclusion by examining the daily practice of nurses at one large urban hospital in Canada during the 1920s and 1930s. As such, it shifts the historical focus away from the celebrated careers of the elite to examine how contemporary scientific concepts affected the work performed by ordinary nurses on the job. This study of the Winnipeg General Hospital and its graduates during the interwar decades reveals the centrality of science to the workplace experiences of nurses and provides some insights into the relationship between women and science in the twentieth century.

Science and scientific thought have been frequent topics of discussion in the scholarly literature generated within the field of nursing itself, whereas feminist scholarship has only recently taken up this issue.¹ Women's historians have characterized the content of nursing work in two ways. Some authors have emphasized the division of labour between caring and curing: doctors cure, nurses care. This "rigid distinction," claims Margaret Versluysen, was enforced in the late nineteenth century when the medical profession monopolized the "heroic saving of the sick" and nurses were allocated "mundane housekeeping chores."² Others have stressed the devaluing of nursing work, which

coincided with the devaluation of women's work in general. As Canadian scholar Judi Coburn has argued,

a certain class of men . . . took the more prestigious function of "curing" away from women, leaving them with "caring" (often indistinguishable from domestic work).³

According to this approach, the caring part of work should really be seen as domestic drudgery. Nurses were not ladies with the lamp, but domestic servants, performing devalued and demeaning tasks involved with maternal care, albeit in a more elaborate uniform.

A second framework utilized by women's historians to understand nursing practice links nurses more closely to science by defining nursing as an extension of medical care. Nurses were doctors' handmaidens, the "physician's hand." Within this approach, the 1940s and 1950s are considered critical decades during which many technical skills, such as taking blood pressures and starting intravenous drips, were transferred from doctors—who no longer had the time to perform what were by then fairly routine tasks—to Registered Nurses (RNs); at the same time many domestic duties previously performed by RNs were passed on to other hospital workers such as ward aides, who themselves had only recently been introduced into the health care hierarchy. The 1940s and 1950s are seen as the decades in which the exploitative and oppressive era of apprenticeship training and staffing of hospitals was finally phased out, and when graduate nurses took their rightful place in the curing end of the caring–curing dichotomy.⁴

Nursing historians who share this perspective have been hesitant to claim scientific status for nurses' work during the years "before the age of miracles."⁵ For instance, researchers out of Dalhousie University School of Nursing have asked whether nursing work in the interwar decades was "scientific or 'womanly ministering.'" They concluded that "because of the limited amount of medical knowledge of the 1920s and 1930s" nursing's "hand's-on technique . . . would have been considered to have been appropriately scientific for the era."⁶ According to these authors, the absence of technical apparatus during the interwar decades handicapped the scientific practice of both doctors and nurses alike, thus the "physician's hands" brought as little science to the bedside as did the physicians. While this analysis correctly identifies the limited range of equipment employed by either doctors or nurses, it conflates scientific theories, upon which modern medical practice rests, with the technological interventions that have characterized post-World War II health care. By failing to seriously examine the theoretical basis of

nurses' work, this second approach, like the first, defines nurses out of the realm of science, at least in the pre-World War II era.

Given these analyses it is not surprising that nursing has been excluded by researchers investigating the larger issue of women's relationship to science. For example, the recent collection of essays edited by Marianne Ainley, *Despite the Odds: Essays on Canadian Women and Science*, considers a wide range of women's "scientific" activity ranging from botany to photography to sociology. Yet, despite this impressive effort at inclusiveness, the collection does not address the largest single group of women who, in the twentieth century, have been most closely involved in scientific pursuits—nurses.⁷

Not all feminist historians have been so willing to dismiss nurses' work as unscientific. Informed by the growing field in social history of medicine, scholars such as Susan Reverby have drawn on the intellectual history generated within nursing itself, and examined nursing efforts to build science into nursing practice. Reverby's 1989 article "A Legitimate Relationship: Nursing, Hospitals and Science in the Twentieth Century" as well as her 1987 monograph *Ordered to Care: The Dilemma of American Nursing* both examine efforts by nursing leaders to come to terms with the scientific component of nursing practice and in doing so the author provides important analytical links between nursing history and that of medicine and science.⁸ In dissecting the tensions among service, professionalism, and science, Reverby focusses on the educators and administrators who constituted American nursing's elite. This chapter builds on Reverby's analysis by exploring the workplace practice of ordinary nurses and the influence that scientific theory and scientific management had on their daily lives. As such, this article complements Meryn Stuart's contribution to this collection. Her paper examines the experiences of public health nurses in Northern Ontario who, as women and outsiders, faced complicated and contradictory demands on the job. Unlike Stuart's study, the focus here is on science rather than gender and region and pertains to nurses training and working in an urban centre, for whom medical practitioners and the medical profession were never far away.

An examination of the work performed on the wards of the Winnipeg General Hospital (WGH) between 1920 and 1939 reveals that science played a larger role in everyday life of nurses than the scholarly literature suggests.⁹ Like most North American hospitals of the day, the WGH relied primarily on the labour of student nurses. These students apprenticed on the ward for three years in return for training and certification as Graduate or Registered Nurses. In turn a small staff of RNs

was employed to supervise and instruct students through the various stages of apprenticeship. Although it is true that between 1900 and 1940 the number of RNs on institutional payroll did increase,¹⁰ it was not until after World War II that improved health care funding transformed hospitals into large employers of not only graduate nurses but also subsidiary workers. Until that time, most institutional care was provided by students being groomed in the many facets of modern nursing, while the majority of graduates took their acquired skills into the private health care market where they provided one-to-one care for individual paying patients.

While hospital employment played a less significant role in the lives of graduate nurses than did private duty work, focussing on the element of institutional practice is nonetheless necessary and important. It was in the hospital that nurses learned the basics of their technique, which they would then carry with them into private duty or public health work.¹¹ As well, during the interwar years a growing number of Canadians elected to receive treatment in private hospital wards or pavilions. These paying patients hired private nurses as “specials” to supplement the institution’s student labour and as a result private duty nurses increasingly found themselves back in the hospital setting, although they continued to resist full-time staff positions. And finally, because nurses first learned the various elements of nursing practice in the hospital setting, documentation for that phase of their careers is significantly more complete. Not only did institutional staff generate a greater diversity of sources, but institutions themselves have served as important archival repositories for historical records. Thus, this research is based on student notebooks—the red handbooks, small enough to fit in a uniform pocket, in which novices transcribed the mandated steps for each procedure they learned—as well as on school yearbooks, and hospital reports, all housed in the WGH School of Nursing Alumnae Association Archives. Oral interviews conducted with graduates of the WGH School from the interwar years complement the documentary research base. As the following discussion will reveal, the interviews contain vital documentation about the relationship between nursing practice in the private market and the skills learned on the wards of the WGH.¹²

During their three-year apprenticeship, students learned their repertoire of skills first in the classroom, then on the ward, with the level of responsibility and difficulty increasing as the students advanced.¹³ Supervision was limited, but frequent repetitions of the various routines ensured nurses’ mastery of the expedient execution of assigned tasks.

Nurses graduating from their apprenticeship program were expected to be competent in six categories of work.

One area of expertise included administrative tasks such as labeling and storing patients' personal possessions when admitted, charting and recording all patient treatment, medication, and tests, and taking stock of hospital supplies. Nurses were required to print neatly all charts and correspondence and thus the instructors evaluated students' red handbooks and lecture notes as much for neatness as for accurate content.¹⁴ Feedback on 1933 WGH graduate Violet Erickson's first ninety-nine pages indicated that her work was "much improved. Would be neater underlined in red ink. Very Good."¹⁵ Another WGH graduate, Beryl Seeman, did not expect the Nursing Superintendent Kathleen Ellis to have noticed her amongst the large student population. Years later, however, when Seeman had advanced into a supervisory position herself and was reintroduced to Ellis, the latter responded: "I remember you. You had very good printing."¹⁶ The appreciation administrators like Ellis expressed for simple printing skills was somewhat infantilizing, but also was appropriate within the hospital's non-mechanized record-keeping system.

The second set of responsibilities entrusted to hospital apprentices embraced the various diagnostic tests ordered by medical staff. Tests were performed on the ward and then either sent to the laboratory for analysis or results were transcribed directly onto the patients' charts.¹⁷ All tests required that nurses prepare the necessary equipment, complete the proper documentation identifying the type of sample and to whom it belonged, and record results on the correct chart.

The third area of nursing practice, assisting medical and surgical personnel, involved some of the most precise techniques demanded of nursing staff. Nurses were responsible for preparing patients and for assisting doctors in examinations or treatments performed on a ward, or in a specialty service, such as the Operating Room.¹⁸ To facilitate the efficient use of doctors' time, pre- and post-operative examinations, shavings, dressings, dietary regimens and patient services were all assigned to nursing staff. For example, "aspiration," a technique utilized to remove excess fluid from the pleural cavity, required that the assisting nurse paint the injection site with iodine and then drape the patient so that only the treatment area was visible to the doctor. She subsequently tested the equipment, first in the service room and then, once sterilized, again while the doctor was inserting the needle. If all went well neither patient dignity and confidence, nor doctor's time and reputation, were lost.

While these patient services were performed in concert with doctors, other tasks were performed by nurses alone. This fourth category, therapeutic nursing duties, was comprised of the counter-irritants, medications, and numerous enemas, douches and lavages designed to "wash out" various anatomical parts. In this era before the introduction of sulphur drugs, counter-irritants—a range of poultices, packs, stupes, and fomentations that were placed on the diseased or infected area—were particularly important aspects of nursing practice. For patients on the medical wards, mustard plasters and linseed poultices were commonly prescribed.¹⁹ On either medical or surgical services, real or threatened sites of infection were usually treated with fomentations.²⁰ This latter procedure was a particularly labour-intensive one, which entailed placing strips of cloth in a linen holder attached to wooden handles. Nurses lowered everything except the handles into a vat of boiling water and when the fabric was hot enough the nurse carried it to the patient's bedside, placed the fabric or fomentation on the infected site, and then covered it with more dry cloths. This might be performed up to three or four times an hour and each time the nurse had to be careful to avoid burning the patient.²¹

Not all nursing responsibilities had direct therapeutic value. The fifth area of practice, the maintenance of the ward and equipment, served the hospital infrastructure. The tasks defined in this category sometimes involved simply cleaning the supply room—a job students on night duty often claimed they were doing when a midnight nap was required—but also included the critical assignment of sterilizing the many medical appliances used in the era before disposable supplies. Rubber gloves for instance had to be soaked in a 2% Lysol solution for twenty minutes, washed, and rinsed with hot then cold water, and finally dropped in boiling water for three minutes.²² Glass and rubber items each called for a particular regimen for cleaning and storing. If broken or ripped, replacement costs came out of nurses' small monthly stipend. This equipment was expected to be ready for use when tests, or medical or nursing procedures were undertaken.

In addition to maintaining vital hospital supplies, nurses were also responsible for cleaning and organizing the ward itself. Every day each patient's bed, nightstand and chair had to be tidied or washed. Following a patient's discharge a specific routine was followed according to the type of ward and particular case. While nurses themselves were not responsible for laundering bedding, they did have to soak any bloodstained linens before sending them down to the laundry.²³ If the outgoing patient was an "infectious" rather than

“clean” case, a substantially more elaborate procedure was required to sterilize frame, mattress and linens in order to ready that bed for a new occupant.

And finally, nursing work involved the many personal service tasks of bedside care, feeding patients, assisting them with ablutions, and maintaining the cleanliness of bed and patient alike. The skills that constituted this sixth category of nursing practice combined personal and therapeutic functions. For instance, nurses not only assisted patients with morning and evening toilets and with baths but in addition took responsibility for specific cleaning care of external genitals following a urogenital operation to prevent post-procedural infections.²⁴ Of course, instructions for some procedures stressed gentility and decorum more than therapy. When a female patient was getting into the bathtub, the nurse was to give her physical support, so the patient could not slip or fall, but the nurse was not to emphasize the patient’s dependency; “If she is unable to help herself and does not do it, give some excuse and help her.”²⁵ Patient sensitivities were also considered during mealtime. When feeding patients nurses learned that “too full a spoon or one that drips is inexcusable.” Some instructions seemed difficult for even a veteran of international affairs to follow. For example, nurses should “never argue with a patient concerning her meals, be diplomatic rather than use force” but at the same time were to be “very strict and give only food that is ordered by doctor.” Similarly, nurses were told “do not discuss food with patient,” but were also instructed to “try and find out patient’s likes and dislikes” and to “encourage patient to masticate food well.”²⁶

The degree to which students could negotiate these somewhat contradictory directives depended, in part, on where in the hospital they were working. To be fair, retired nurses insisted that treatment did not differ between private and public wards and that all patients received the same care.²⁷ However it seems clear that standards of gentility were more easily met on private wards wherein an upper-class domestic decor, complete with silver flatware and china dishes, was replicated, and where the patient–nurse ratio was substantially reduced.²⁸ As one WGH administrator stressed, “the service on the private wards would be generally reflected in the patronage of the Hospital.”²⁹ Of course, catering to private patients created its own frustrations, as nurses’ popular culture revealed. The 1923 WGH yearbook included the poem “The Training,” which proclaimed:

On private flats she learned to dust,
To wait and smile, as there you must,

While patients tell long tales
 On public flats she learned to rush,
 On flying feet some cries to hush
 While answering distant wails.³⁰

Even if the content of nursing care did not differ between private and public wards the conditions under which care was dispensed certainly did.

Within each of the above six categories two features stand out. The first is that nursing practice in this era must be defined and described as scientific in that it was based on the theoretical understanding and practical application of the germ theory of disease.³¹ From at least 1910 student nurses at the WGH attended lectures on Bacteriology and were instructed in the "Historical Theories of the Disease" beginning with Hippocrates and Galen, up through to Pasteur and Lister.³² The historical and theoretical basis was accompanied by detailed instruction regarding the application of antiseptic and aseptic technique. Antiseptic surgical technique, a system to "fight bacteria already in the wound" developed by Joseph Lister, is the best known of the two.³³ Perhaps more important for nurses in the 1920s and 1930s, however, was aseptic technique, which ensured patients did not acquire any new bacteriologically based afflictions while admitted for whatever health problem they already had. It was particularly important for the public wards of up to forty patients, all of whom were suffering from different problems, and all of whom potentially might introduce new and dangerous diseases into the hospital environment. Medical and nursing attendants alike could be confident that if they followed aseptic technique they would not be a source of cross-infection.

For nurses, aseptic technique demanded repeated applications of soap, water, and to a lesser degree, alcohol. It was also labour-intensive. The procedure for assisting with a surgical incision illustrates that any procedure that created a wound, and therefore a potential site of infection, necessitated the "strictest aseptic technique" from nursing staff.³⁴ The anatomical region to receive the incision first had to be washed with "plenty of hot water and soap" and then a "sterile bundle" of necessary equipment was taken to the bedside on a sterile tray. The nurse then screened the patient, unfolded the bundle and, leaving one corner of the cloth over its contents, transferred with sterile forceps the equipment from the tray to the table. She then draped the patient's bedding appropriately, scrubbed her own hands for five minutes, returned to the patient and draped the anatomical area with a sterile drawsheet and towels, all the while taking care not to contaminate her

fingers. She scrubbed the anatomical area three times with sponges appended to forceps, first using green soap and water, then ether, then alcohol, and finally applied a sterile towel or dressing and bandaged it in place. By carefully following this procedure nurses created a sterile region in which surgeons made their incision.³⁵

To create and preserve aseptic conditions, nurses had to execute the carefully delineated set of steps established for each procedure. The elaborate procedure for administering a hypodermic needle exemplifies this process. Nurses prepared for hypodermic injections by setting up a small tray with the medication, a sterile jar with alcohol and sterile sponges, one jar containing the needles, another with the alcohol and hypodermic syringe, a small bottle of alcohol and one of sterile water, an alcohol lamp and spoon, and matches. The seventeen-step process that follows is worth reproducing in its entirety in order to illustrate the interconnections among the various categories of nursing tasks.

1. Have medication ready
2. Test your needle
3. Place needle with stilette in spoon and cover with water
4. Boil over lamp 2 min
5. Place cover over wick
6. Rinse out barrel of syringe
7. Draw amount of water required into syringe
8. Discard water remaining in spoon
9. Attach needle to syringe and remove stilette
10. Place tablets on spoon and dissolve with water in syringe
11. Draw prepared fluid into syringe, taking up last drop
12. Expel air from syringe
13. Pick up sponge on point of needle and replace tray in cupboard
14. Cleanse the area, make a cushion of flesh and insert quickly
15. Withdraw slightly and insert fluid slowly
16. Withdraw needle quickly, massage area gently with a circular motion
17. Chart time, medication and initials immediately after giving drug, and mark off in order book³⁶

This example demonstrates the relationship between the specific therapeutic technique (injecting a medication into a patient) and the regime for non-therapeutic duties (maintenance of wards and equipment). Not only did nurses depend on the aseptic technique of the injection itself, they also relied on the aseptic preparation of basic ward equipment such as jars and water. Thus the step-by-step procedures

involved in the domestic tasks of ward cleaning and maintenance, usually interpreted by historians as evidence of nurses' subordinate domestic status, take on new importance when seen as part of a larger system of asepsis for which nurses were responsible.

The above example also illustrates the second influence of science on nurses' work, that of scientific management brought to science. Pioneered in the late nineteenth century by Frederick Winslow Taylor, scientific management was designed to establish managerial control over industrial production. Taylor and the "efficiency experts" who followed him would study a particular task, break it down into its component parts and then, with the help of their trusty stopwatches, determine the fastest method of performing each part. Scientific management increased employer control over production in several ways. It allowed managers to increase productivity per worker-hour by assigning one small part of production to a worker who would repeat that task throughout his or her shift, and it ensured that employees could be easily trained and therefore easily replaced. Most important perhaps, by dividing conception from execution, scientific management increased employers' knowledge and authority over how goods were made. Appropriating the term "scientific" for a process that was in fact not rooted in any theory of science served to legitimate employers' control over production, which in turn enhanced their position in the struggle over workplace control.³⁷

The influence of scientific management on nursing procedures in the interwar period is clearly evident. Each feature of nursing practice was subdivided into its component steps and students were drilled in the precise execution of each step. Conceptual authority over how a particular procedure should be performed remained in the hands of doctors, administrators and educators, while nursing students and staff remained responsible for completing the prescribed tasks according to the standard curriculum. Thus the elaborate delineation of step-by-step execution was provided for duties that did not appear to depend upon a "scientific principle" such as asepsis. For example, bedmaking, a task with which all raw recruits to the WGH would be familiar, was rationalized. Whatever system they had applied to the chore in their own homes, at WGH nurses learned that when stripping a bed, the table and chair had to first be moved away from it. The nurse was then required to place the pillow on the chair with the closed end of the pillowcase towards the door, loosen the linen and fold it in quarters, beginning at the foot of the bed and working up to the head. Similarly detailed

instructions like this were provided for the remaining elements of the bedmaking process.³⁸

The establishment of standardized procedures for such simple tasks obviously served other agendas than those necessitated by scientific theories of disease. The structure and content of nursing work reflected the powerful influence of "scientific" or rationalized production that had proven so successful in the industrial sector.³⁹ Even the imagery of the 25- to 40-bed wards, with each bed equidistant, each patient's table and chair placed right next to their beds, each patient covered in identical bedding, with all blankets tucked tight at the end and sides,⁴⁰ evokes mental images of assembly lines. Not surprisingly hospital vocabulary matched the interior design in its allusions to industrial production. Institutional administrators invoked the language of "efficiency," "standardization," and "percent capacity."⁴¹ In 1921 WGH Superintendent Stephens included in his annual report "an analysis of the work of the year, that is, what might be called 'the production sheet' of the Hospital."⁴² Like their counterparts in capitalist enterprises of the day, hospital administrators routinized staff procedures in order to effectively and efficiently "produce" healthy patients but also to overcome the questionable reputation that hospitals still had in this era, all while operating on limited budgets.

The reasons that hospital administrators and medical practitioners created and endorsed the rigid, routinized, and rationalized set of nursing procedures are obvious. Rationalization of technique ensured that the small staffs of RNs could supervise the large classes and high turnover of student nurses. As well, the growing number of patients could move in and out of the hospital without getting their charts, their diagnosis, their results, their treatments, their personal possessions or even their babies mixed up or lost. Standardized printing techniques ensured that the modern hospital generated administrative records accounting for patient therapy. Precise procedures for diagnostic tests, for assisting medical staff, and for performing therapeutic nursing duties ensured that the institution promoted its reputation as an appropriate location for medical treatment. The maintenance of ward and equipment ensured that nurses "produced" supplies and equipment that were not purchasable. Bedside nursing enhanced a hospital's reputation for gentility and decorum, necessary to attract private paying patients. Not only did nurses provide doctors with an inexpensive, skilled and subordinate therapeutic labour force—the physician's hand as we know it—but more importantly nurses ensured that once patients were admitted to the institution they were safe from possible cross-

infection, and they would leave in better, rather than in worse health. That was, after all, the point.⁴³

Indeed, the nursing staffs of Canadian hospitals during the 1920s and 1930s served their masters well.⁴⁴ It is for this reason, perhaps, that feminist historians, committed to critiquing gender asymmetry, have been hesitant to seriously examine nurses' relationship to science in this era. Nurses may have assisted the medical profession in its quest for scientific therapy, but scientific management ensured that nurses had little or no control over the content of their work. Rationalization was facilitated, as Susan Reverby has shown, by nursing leaders and administrators who embraced scientific management techniques in efforts to consolidate nursing's position as critical to efficiently run hospitals.⁴⁵ But surely rank-and-file practitioners chafed under this oppressive regime and perhaps even engaged in some sort of resistance to what labour historians would see as the deskilling of nurses work? To some degree ordinary nurses did, by leaving institutional work as soon as they graduated.⁴⁶ Rejecting the constraints of hospital life did not mean, however, that nurses abandoned the scientifically defined practice they learned there. Evidence from nurses who trained and worked in the interwar decades suggests just the opposite. While some nurses did resent the lack of creativity their education entailed, by and large the women who trained and worked in the 1920s and 1930s accepted and endorsed what they termed their "technique." Rather than accept nurses' attitudes as evidence of complicity in their own subordination, or as a reflection of their uncritical acceptance of leaders' professionalizing strategies, this examination of nurses' work at the Winnipeg General Hospital argues that while science—both in terms of scientific medicine and scientific management—may have served medical authorities well, it was also used by nurses to define and defend their position in the workplace and the marketplace. Nurses accepted the rituals of their daily practice for several important and revealing reasons.

The specific rituals of their practice empowered nurses to define for themselves what constituted good nursing. Rather than place nurses on one side or the other of the care-cure dichotomy, this definition enabled nurses to integrate caring and curing in daily tasks. Domestic and therapeutic functions were embedded in even the simplest of tasks, such as making a bed. A carefully made bed promoted the uniformity of ward presentation (highly valued by nursing supervisors) and ensured that patients' looked respectable and properly attended when receiving their medical or familial visitors. But a carefully made bed also prevented patients from acquiring bedsores, a "form of ulcer due to

pressure" which were a cardinal sin in nursing practice.⁴⁷ Given the length of time some patients spent at the hospital and the length of time patients stayed in bed following hospital procedures, keeping a patient comfortable was not always easy.⁴⁸ Patients might develop bedsores from "indirect" causes, such as old age or illness, or from "direct" causes such as "wrinkled bed linen, crumbs, lack of proper care and cleanliness, [and] continued pressure" but in either case "prevention" was the surest treatment.⁴⁹ A carefully made bed, and an evening massage, went a long way towards preventing bedsores and promoting a good night's sleep.⁵⁰ Not only did such preventive care aid the patient's recovery, it also ensured that nurses did not have to participate in the long and laborious procedures necessary to heal bedsores once they erupted. Thus given the therapeutic regimens of the day, a well-made bed was central to pre-empting both unnecessary ailments and the accompanying curative labour.

Integrating caring and curing was particularly important to nurses since much of their work entailed performing a number of functions at once. Sometimes this meant temporarily assuming the duties of medical practitioners, particularly in services such as obstetrics. Under normal circumstances, nurses assisted interns or private practitioners to manage the birth, and then provided post-partum care for mother and child back on the ward, or in the home once the doctor had left.⁵¹ In both home and hospital, nurses were never certain that medical assistance would arrive on time. For example, at the WGH enemas were commonly given to parturient women as a natural method to induce labour, but this often had more rapid effects than predicted. Isabel Cameron recalled that doctors expected to be in attendance "but maternity work is very uncertain"⁵² and deliveries would sometimes occur on the ward, rather than in the case room, and before medical staff could be summoned. Even more worrisome were the occasions when attending physicians failed to arrive to preside over home deliveries.⁵³ This temporary assumption of medical duties led some nurses to wish that more substantive obstetrical training had been provided.⁵⁴

Good technique also included a certain degree of innovation in order to recreate the appropriate conditions of nursing when providing home care. Long-time VON staff nurse Florence Paulson carried her black bag with her at all times. Its contents, including alcohol, forceps, aprons, and rubber gloves, permitted her to create a small sterile field within a client's kitchen and thus execute a specific procedure without the threat of infection.⁵⁵ Improvisation included making needed equip-

ment, since items like Q-tips and gauze pads were not readily available in many rural areas.⁵⁶

As well, nursing technique included functions that extended beyond that of medical therapy, and indeed extended beyond the life of the patient. Paradoxically, it was the “care of the dead” that integrated all the administrative, therapeutic, and proprietary elements of nursing technique. Immediately after a patient ceased to breathe the nurse began an elaborate set of steps designed to ensure the smooth transition of the corpse from the hospital to the morgue or funeral home. The nurse first confirmed her unofficial diagnosis with an intern and then notified the attending physician. Once family members had left the bedside—having been “treated with kindness and courtesy”—the nurse contacted the admitting office to arrange for removal of the body. Assembling the necessary equipment at the bedside “as when giving bath,” the attendant straightened the body out on the bed and closed the deceased’s eyes. Jewelry was removed and the patient’s valuables were listed on the “value card.” The nurse washed the body, hands and face, using ether to remove any marks, and then redressed any wounds. The nurse, or the orderly if the deceased was male,⁵⁷ used gauze to pack the body’s orifices and to tie the legs together, the jaw shut and the arms crossed. If the patient had died from an infectious disease, Lysol was used to wash the body, and forceps used to pack the orifices. As part of the final toilet, the nurse then inserted any false teeth, lubricated lips and eyelids, and arranged the patient’s hair, combing and braiding it or “if in a home do the hair in the usual way.” A tag stating the full name, ward, date and cause of death was attached with bandages to the wrist and neck, and the body was wrapped in a clean sheet.

At that point an orderly removed the corpse, and, when the hall was cleared of any living patients, the deceased was removed from the ward with “dignity and respect.” The administrative duties of the nurse then continued. The patient’s chart was completed with details of the time and cause of death, valuables and value card were sent to the cashier, the list of clothes and any other belongings were sent to the admitting office together with a bundle of any possessions. Thus even in death nurses laboured to ensure the dignity of the patient, guarantee the bureaucratic efficacy of the hospital, maintain aseptic conditions on the ward, defer to the diagnosis of the doctor, and comfort the survivors.⁵⁸ As this example illustrates, the scientific underpinning of nurses’ work—the many rituals of good technique—did not place nursing on one side or the other of the caring–curing dichotomy, but rather

science permitted nurses in the early twentieth century to resolve that dichotomy. For nurses caring was curing.

For working nurses, good technique not only facilitated self-definition, it also ensured self-protection. Careful adherence to the many steps involved in each procedure defended nurses against exposure to dangerous diseases. In an era when diseases that we now cure easily were then deadly, nursing technique was particularly important to practitioners providing bedside care. Nurses recognized that the most dangerous patients were those being treated for one affliction but also carrying other undiagnosed diseases. Medical and nursing commentators throughout the interwar decades decried the high frequency of tuberculosis among nursing personnel, while many hospital training schools employed medical and nursing personnel just to treat institutional staff.⁵⁹ As part of this preventive strategy, students learned that the study of bacteriology was important for both theoretical and practical reasons. Nurses were expected to understand the "habits and characteristics of the organisms . . . [that is,] the living world of germs around us" not only so that attendants could "intelligently follow the progress of the disease" but also so that they could "protect" themselves.⁶⁰

Students such as Myrtle Crawford learned the value of good technique the hard way. Crawford contracted mumps while nursing a mumps victim at the King George, Winnipeg's infectious diseases hospital affiliated with the WGH. As she recalled "I'm short and in trying to lift [the woman] I was very close to her and she coughed right in my face." The young apprentice landed in the hospital for two weeks, during which time her supervisor asked if Crawford would consent to being used as part of a teaching clinic. Crawford agreed and shortly thereafter the supervisor brought a group of student nurses "to see this nurse who had gotten mumps." When asked "did you wash your face with soap and water immediately afterwards," Crawford responded that it had not occurred to her, whereupon the supervisor seized the didactic moment and pronounced "so you see it's your own fault you got these mumps."⁶¹ Retired nurses acknowledged the danger of infectious diseases such as tuberculosis or diphtheria, and often had classmates who fell prey to such ailments, but also credited their good health to good technique.⁶² For their own protection, nurses embraced scientific explanations for the cause of, and the solution for, communicable diseases.

Nursing technique empowered practitioners in a third way. By providing a clear definition of their job it allowed nurses some grounds

on which to defend themselves against unreasonable demands by doctors, patients, or administrators. Adherence to specific rituals offered nurses one such set of limits with which to resist unfair demands or criticisms. Unlike workers in factory production, personnel in the service sector such as health care workers had to contend not only with supervisors but also with an animate "product," the patient. As Susan Porter Benson has argued in her work on American saleswomen "the two-way interaction between workers and managers became a complex triangle of saleswomen, managers, and customers." If managers and customers "exerted unified pressure" the saleswoman held little workplace authority, "but when she could play one off against the other she could create new space for herself on the job."⁶³ For nurses, similarly complex workplace relations involving worker (nurse), doctor, patient *and* administrator demanded an even greater sense of the occupational boundaries and limits.

In the hospital, conflict could and did develop between nurses on the wards and their supervisors, either medical or nursing. The most forceful forms of overt conflict occurred between nurses and unco-operative or unhappy patients. For example, Ingibjorg Cross once received instructions to treat a patient with an infection by applying fomentos to an infected area every fifteen minutes during the night. Cross did so, each time being careful not to wake the patient. The next day the doctor mentioned the fomentos to the patient, who replied that he had received no such treatment. In front of all the other patients, the doctor promptly questioned Cross regarding her alleged negligence. Her defence that she had followed the prescribed treatment was corroborated by the other patients who reported that every time they had woken in the night they had witnessed Cross dutifully applying her fomentos. Somewhat annoyed, the doctor instructed Cross to continue her treatment, but to wake the patient for every procedure. The tactic worked, and Cross recalled that the exhausted recipient of her nocturnal care "begged me to quit . . . he had [learned] his lesson."⁶⁴ Negotiating the social relations at the bedside was further complicated by the legal ramifications that other women workers rarely had to consider. For hospital nurses, both patient health and nurse's status could be jeopardized through carelessness, even when executing a simple task such as a fomentation. Beryl Seeman recalled that in spite of the many dangers that steam and boiling water presented she never burned a patient, nor herself. Others were not so lucky and while nurses accepted the occasional minor burns as part of the job, they knew that burning a patient could result in discipline, including suspension.⁶⁵ Nurses soon came to realize that the precision expected of students created a margin of error

that protected nurses once they were expected to assume full responsibility for patient care. Myrtle Crawford concluded "if you learned how to do it perfectly you wouldn't go too far off if you got careless."⁶⁶

Once nurses left the hospital school and entered into private practice they were legally responsible for remaining within the parameters of accepted medical and nursing practice. The experience of one graduate nurse exemplifies the delicate position that private duty nurses faced. In June 1937, nurse Mitchell took a job in Gainsboro, Saskatchewan, providing private care for a male heart patient, for whom strichnine had been prescribed. Concerned about the treatment, the nurse wrote to a medical practitioner she knew from her hospital training. The doctor replied with detailed instructions pertaining to the administration of "simple Strych. grain" or a hypodermic injection of strychnine tablets if that served to regulate the pulse.⁶⁷ The doctor later refined his prescription and recommended a combination of nitroglycerin, strychnine and digilatis taken orally, and codeine for sleeplessness. Throughout the correspondence the doctor praised the nurse's "very informative and intelligent" letter, and assured her that "we must depend on the nurse—her judgement and observation, etc."⁶⁸ This correspondence reveals several critical features of doctor–nurse interaction. Certainly, patients and doctors alike relied on nurses to provide intelligent patient care in conditions where access to medical attendance was limited. For nurses working in relatively isolated conditions, medical communication assured the nurse that she was following an appropriate therapeutic regimen particularly when administering such powerful drugs. Most significant, perhaps, written documentation such as the doctor's letters also offered legal protection should the nurse require it at that time, or in the future.

As scientifically informed technique served to define nurses in the workplace so too did it help distinguish them in the marketplace. Traditional analyses of scientific management have emphasized its significance in "deskilling" artisans and therefore disempowering them vis-à-vis the labour market. In many spheres of secondary production, scientific management ensured that male artisans were replaced by easily replaceable unskilled or semi-skilled workers.⁶⁹ On the other hand, women workers came into the world of paid employment from a different direction than did male artisans. Early in the industrialization process, women were defined as low-skilled and were ghettoized in poorly paid and unorganized sectors of production. Thus for female workers, white collar jobs, however rationalized, represented an improvement in status and conditions, especially those jobs that

required mathematical or literary skills.⁷⁰ In fact, for nurses, rationalization of production aided in the delineation of their skills, and in differentiating themselves from their “unskilled” female competition in the household and the community. Science allowed nurses to distinguish themselves ideologically from maternal care giving, which was (is) considered the domain of all women. As Barbara Melosh argues in her critique of nursing professionalism, “as professional leaders strove to distinguish their work from women’s unpaid domestic nursing, they had to dissociate themselves from the sentimental conception of womanly service.”⁷¹ Beverly Boutilier makes a similar point in her paper “Helpers or Heroines?” Her analysis of the relationship between the National Council of Women and the first generation of graduate nurses demonstrates that in the late nineteenth century the line between the paid work of trained nurses and the unpaid labour of volunteer women was a very fine one. For nurses at the workplace, claims to specific rituals, all in the name of science, helped distinguish trained personnel from the informally or untrained competition in the marketplace.⁷² The careful delineation of what was and was not good nursing was particularly important in the crisis-ridden interwar decades during which nurses struggled daily to win legal and financial recognition of their value.⁷³

In the private market, as in the hospital, the specific rituals of nursing practice represented the expertise that was critical to nurses’ economic and physical survival. For these reasons graduates of the WGH school felt proud of the specific skills that their technique represented, and incorporated that technique into their occupational identity. Student nurses admired their superiors who could perform specific tasks with ease. One WGH graduate recalled that

as a probie I used to envy the junior nurses when they would wring these foments because I thought those forceps were kept there by a neat twist of the wrist.⁷⁴

Another WGH veteran insisted that she could recall only one post-operative infection, and even then she suspected the surgeon to have been the culprit who “broke” the sterile field of her dressing tray.⁷⁵

Popular culture created by nurses themselves in the 1920s and 1930s revealed the centrality of science to daily life in the hospital. For example, student yearbooks, produced annually by graduating classes, were filled with humorous references alluding to features of scientific practice. In one edition, a joke entitled “Medical Definitions” reinterpreted the term aseptic to mean “person not believing in anything” and defined toxic as “loquacious.”⁷⁶ More elaborate parodies of hospital life

usually took the form of substantially revised poems or song lyrics. The 1927 *Blue and White* contained a poem entitled "The Microbe's Serenade" wherein a "love lorn microbe met bychance at a swagger bacteroidal dance" a "bacillian belle." This "protoplasmic queen" was the "microscopical pride and pet of the biological smartest set" who so impressed her microbible suitor that he asked "What futile scientific term can well describe they many charms?" Pursuing the germ, he "'neath her window often played this Darwin-Huxley serenade" and, declaring his fidelity, assured the subject of his affection that "we'll sit beneath some fungus growth, till dissolution claims us both."⁷⁷

In the 1931 yearbook, the poem "The Bacteriological Ball" once again featured personified bacilli. This time a "gay bacillus" held a party in the laboratory, inviting "only the cultured." Referring to the cellular structure of the various organisms, the poem continued:

The Streptococci took great pains
To eat themselves in graceful chains;
While, somewhat late and two by two,
The Diplococci came in view.

Forgetting the potential dangers,

Each germ engaged himself that night
with never a fear of the phagocyte
It was getting late and some were loaded,
When a jar of formaldehyde exploded

Not surprisingly, the poem ended with

Not one survived, they perished all,
At the nurses' bacteriological ball.⁷⁸

While nurses' daily workplace interaction with science most often involved ether, green soap and boiling water, nonetheless laboratories, formaldehyde, and microscopic organisms all emerged as central characters on the pages of student yearbooks.

Like science, the importance of technique in nurses' daily work was illucidated within occupationally specific popular culture. A poem from the 1923 yearbook was entitled "The Training." One verse read:

At last she reached the white "O.R.",
Where patients coming from afar
Endure the surgeon's knife:

And there she learned to sterilize
 And keep her technique in such wise
 She might not lose her life.⁷⁹

Similar themes were echoed in other contributions such as those entitled "Routine" and "Aseptic Technique."⁸⁰ A more elaborate depiction of nurses' practice and the social relations at the bedside was presented in the 1926 yearbook contribution "The Hooting of Dan Mackay." This parody of the poem by Robert Service described the "dangerous D. S. MacKay" and his treatment of nurses in the Operating Room. Because "the staff were all stepping out" a student assumed the role of senior scrub nurse. As the operation proceeded, the "well-masked" attendant was "trembling with fear" but "never batted an eye."

So they hacked and slashed and sliced away, till the deed was almost done;
 The surgeon, as usual, roared and raged and abused each nurse but one.
 The staff nurse, she just carried on, with her technique no fault could be found.
 She doled out retractors and forceps and her knowledge of suture profound.

In spite of the scrub nurses' competent assistance, the cranky doctor flew into a rage when he discovered that the nurse was not a graduate. The student concluded with a defiant tone,

We aren't so wise as you Doctor guys, but strictly between us two,
 If you'd only give us a fighting chance, you'd see what we really could do.⁸¹

Evidence from nurses in other Winnipeg hospitals and in other regions of Canada suggest that the experiences of nurses at the WGH were not unique.⁸² At Winnipeg's Misericordia General Hospital, graduating nurses also took advantage of their annual publication to boast about their accomplishments but also to speculate about the utility of their education to their futures in private duty. In the process much was revealed about the features of aseptic technique, rationalization, and gentility that nurses were to bring to their work. The poem "Farmyard Sanitation" observed the career of a nurse who "hied to Hick-Town Junction / Soon after graduation." Her introduction to "farm-yard sanitation" included trimming the turkey "with antiseptic shears." Her decision to place the hens on a "rigid diet" resulted in their "laying eggs in mass production," and she went on to "[souse] the sheep in Kresio

Dip" and to sterilize the ducks. However the final verse revealed the private's ultimate success:

A permanent wave in bossy's horn—
 With bobby-pins it's twisted;
 She's getting quite a boyish form
 Now that her tummy's lifted.
 The little chicks are always fed
 On sanitary worms;
 The calves and colts fumigated
 To keep them free from germs.
 And thoroughly to carry out
 Her systematic plan,
 Next week with germicidal soap
 She'll Scrub the poor hired man.⁸³

These humorous expressions of students' three-year engagement with the germ theory and scientific management reveal the critical intersection of science and nursing practice in defining nurses' workplace experience during the interwar years. Scientific theory of asepsis along with managerial efforts at rationalization combined to define what medical and administrative staffs thought nursing practice should be. But within those parameters, the scientific underpinning of nursing practice also helped nurses create their own standard of quality care while at the same time defend themselves economically, legally, and physically. Feminist historical scholarship, which concludes that "rank and file" nurses in interwar Canada were outside of or marginal to the dominant scientific concepts of the day, fails to capture the essential role those concepts played in nurses' daily lives.

This analysis suggests significant points of revision are needed regarding nurses' place in the history of medicine. Canadian medical historians have been slow to integrate nursing work into studies of health care history, often providing only cursory mention of nursing service before going on to detail administrative structures or medical achievements. Yet close examination of the nursing practice at the Winnipeg General Hospital reveals that nurses were active participants in creating the culture of scientific medicine and, as the largest patient-care workforce in the institution, in establishing the hospital as the dominant location for delivery of health services in twentieth century Canada. If we are to account fully for the particular development of the Canadian health care system, an analysis of nurses' work must be integrated into medical history.⁸⁴

In challenging the interpretation of nurses as non-scientific care givers, this paper demonstrates that we cannot characterize nurses as merely victims of modern science and modern medicine. This does not mean, however, that Canadian nurses in the 1920s and 1930s can simply be reclaimed as unrecognized women scientists, as another chapter in anthologies such as Ainley's *Despite the Odds*. Nurses had a fundamentally different relationship to science than did women struggling for equality and recognition in male-dominated fields such as chemistry, botany, or even medicine.⁸⁵ Like their counterparts in other scientific pursuits, nurses certainly used science and within the workplace used it to gain an element of control in daily practice. But nurses did not generate new scientific knowledge. Thus in that way they cannot be described as scientific practitioners or scientists. Rather, nurses in Winnipeg, as elsewhere, employed concepts generated by non-nurse researchers and utilized that knowledge under the direction of doctors. In other words, as the "physician's hand" it could be argued that nurses merely carried out scientific orders, but did not engage critically with scientific knowledge.

Of course, it could also be argued that practitioners in many fields of "science" did not generate scientific knowledge either. Medical science is the most obvious example, wherein general practitioners utilized concepts learned in medical school, but did not critically engage with, or develop additions to, that knowledge. Similar observations could be made about occupations such as pharmacy, physiotherapy or even engineering. However, two critical factors differentiated those practitioners from nurses. First, nurses were not trained in scientific investigation and the pedagogical emphasis on execution and economic efficiency, rather than conceptualization, of various procedures left little time for students to develop scientific research techniques.⁸⁶

Second, once licensed to practice, nurses could not generate scientific knowledge because they were legally barred from doing so. After all, only doctors were entitled to diagnose and prescribe. Indeed, the cornerstone of medical professionalism lay in the medical monopoly over such conceptual rights. Even public health nurses, who have long boasted greater autonomy than their counterparts in other branches of nursing, were reminded in 1919 that when visiting a sick patient "treatments must never be suggested nor opinions advanced. . . . Never commit the error of diagnosing."⁸⁷ This stricture was also a central point of contradiction confronted by the public health nurses studied by Stuart. Realizing the significance of this issue, the 1932 *Weir Survey of Nursing Education in Canada* asked its respondents the contro-

versial question "Do nurses prescribe?"⁸⁸ Even if nurses did observe repeatable trends in patient response to their care, such knowledge was illicit since that kind of diagnostic skill was reserved by the medical profession. When nurses did perform medical procedures, like delivering babies when doctors were absent, legal imperatives denied nurses the right to claim not only financial remuneration for that work, but also any intellectual contribution. This then speaks to issues of power and legitimacy more than scientific status. The mind has no sex, but the law did.⁸⁹

Recognizing the gendered nature of women's legal and social authority over scientific knowledge, some feminist scholars have concluded that because of culturally or biologically determined gender roles women "do science" differently from men. These authors have argued for examining women's "different voice" and "feminine science."⁹⁰ Yet the specific experiences of nurses suggest that a concept like feminine science must be applied judiciously, for not all women shared the same relationship to scientific authority. Comparisons between nursing and other female occupations seeking social legitimation through science illustrate this point. Domestic science is one such occupation that, in the early twentieth century, embraced scientific discourse by wedding the germ theory with scientific management in order to transform, largely unsuccessfully, the status of domestic labour.⁹¹ Such a comparison highlights the broad social application of the scientific paradigm in the twentieth century and serves as an important reminder of the many uses to which the word "science" has been put.⁹²

However, too heavy an emphasis on the ideological power of scientific language detracts from the very different successes women had in achieving social and occupational legitimation through science. Nurses' experience in the hospital, either as students, staff or special duty attendants, convinced them not just of the discursive importance of science in distinguishing their work from "untrained" care givers in the household, but also of the efficacy of treatment that aseptic technique and adherence to the procedural routines ensured. After all, during the 1920s and 1930s the WGH wards were not ravaged by cross-infections, nor were surgical patients afflicted with post-operative infections. Indeed, hospital administrators and doctors agreed that nurses' technique "worked." Thus even if science is best understood as a social and intellectual paradigm, rather than a distinct and documentable body of knowledge, nurses contributed to the development of that paradigm, and to its legitimation, in a way that occupations such as domestic science, or even social science, did not. Nursing practice incorporated

scientific thought but also produced a concrete or material body of evidence, that is, the ascent of the hospital as a safe and legitimate venue for health services, which itself was part of the dominant paradigm of knowledge in this century.

Nurses, therefore, occupied a unique place with respect to modern science. Neither victims nor unsung heroines, nurses cannot be categorized as oppressed or liberated by science. This highlights the importance of creating a conceptual framework for women and science that can capture the diversity of scientific roles women have assumed in the past. The historically specific conditions under which different groups of women interacted with scientific thought need to be explicated before any general statements about women, gender, and science can be made.

For nurses in the 1920s and 1930s, this means taking into account the particular dynamics of the workplace. Nursing cannot be written directly into the existing literature on women and science because their work was not just about science. As an exclusively female occupation, nursing practice was premised on other “paradigms” including socially constructed definitions of feminine nurturing and female sexual and social respectability. Science was but one, although a critical one, of the forces that constructed nursing life. Thus in fulfilling their role as the health care system’s largest patient care workforce, nurses used science in a manner specific to their relationship to production—to their patients. Positioned between doctors and patients, and between institutional administrators and familial care givers, nurses were defined by scientific concepts but also invoked these concepts to define themselves. Required to simultaneously care and cure, nurses in interwar Canada used scientific knowledge—both in terms of the contemporary theoretical understanding of infection but also in terms of the “rational” rituals of technique—to resolve the contradictions inherent in their daily lives.

Endnotes

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1. For an example of the discussion generated within academic nursing, see Helen K. Mussallem, “2020: Nursing Fifty Years Hence,” in Mary Quayle Innes, ed., *Nursing Educa-*

tion in a *Changing Society* (Toronto: University of Toronto Press, 1970). Mussallem argues that "the body of scientific knowledge of nursing is derived from and based on the principles of the behavioural, biological, and physical sciences" (p. 217).

2. Margaret Connor Versluysen, "Old Wives' Tales? Women Healers in English History," in Celia Davies, ed., *Rewriting Nursing History* (London: Croom Helm, 1980), 188-189.

3. J. Coburn, "I See and Am Silent': A Short History of Nursing in Ontario," in J. Acton et al., eds., *Women at Work, Ontario, 1850-1930* (Toronto: Canadian Women's Educational Press, 1974), 128.

4. Donna Lynn Smith, "Nursing Practice in Acute Care Hospitals," in Alice Baumgart and Jenniece Larsen, eds., *Canadian Nursing Faces the Future: Development and Change* (St. Louis, Missouri: C. V. Mosby, Co., 1988), 99. Nora Kelly's *Quest for a Profession: The History of the Vancouver General Hospital School of Nursing* (Vancouver: Vancouver General Hospital School of Nursing Alumnae Association, 1973) states that "the slowly growing conviction that knowledge and understanding are required even to follow orders competently, and more that it was making but poor use of the nurses' potential abilities to keep her in ignorance, is perhaps the most important theme in the history of nursing education. The expanding knowledge and functions of the nurse and her evolving relationship with the physician and other health workers are the live issues in nursing today" (p. 11).

5. S. E. D. Shortt, "'Before the Age of Miracles.' The Rise, Fall and Rebirth of General Practice in Canada, 1890-1940," in Charles Roland, ed., *Health, Disease and Medicine: Essays in Canadian History* (Canada: The Hannah Institute for the History of Medicine, 1984).

6. Barbara Keddy et al., "Nurses' Work World: Scientific or 'Womanly Ministering'?", *Resources for Feminist Research* 16, 4: 38. In another article Keddy asserts that "the role of every nurse in that era was primarily that of housekeeper," an unusual conclusion given her evidence. See Keddy, "Private Duty Nursing Days of the 1920s and 1930s in Canada," *Canadian Woman Studies* 7, 3: 102.

7. Marianne Gosztonyi Ainley, ed., *Despite the Odds: Essays on Canadian Women and Science* (Montreal: Véhicule Press, 1990). While it is true that a contribution dealing with nursing may not have been available for this collection, nursing is not even mentioned in the introductory essay as an area needing study or even theoretical consideration. Such exclusion is not unusual in the Canadian literature. For example, see *Canadian Woman Studies/Les cahiers de la femme* 5, 4 (Summer 1984). This issue on "Science and Technology" focusses on women in male-dominated occupations and the struggles for equal education, funding and recognition in those fields. It also includes essays on the effects of technology on women, such as in clerical work.

8. Susan Reverby, "A Legitimate Relationship: Nursing, Hospitals and Science in the Twentieth Century," in D. Lon and J. Folden, eds., *The American General Hospital* (Ithaca, New York: Cornell University Press, 1989); and Reverby, *Ordered to Care: The Dilemma of American Nursing* (New York: Cambridge University Press, 1987).

9. The Winnipeg General Hospital was the city's largest health care institution, which was responsible not only for local citizens, but also for many patients from less well served rural areas of Manitoba, Saskatchewan and western Ontario. The WGH also served nursing students from other provincial training schools who were required to work on specific WGH wards in order to have been trained in all the branches of nursing. In addition, students from the WGH completed rotations at the Margaret Scott Mission (for public health nursing training) and at the Municipal Hospitals (for infectious disease training). Because the WGH played such a pivotal role in nurse education in Manitoba,

and in the region, this study of nursing work at the WGH reflects the broader experiences of nurses at other institutions, and in fact in other Canadian cities. For further discussion of Winnipeg's representativeness as a case study of Canadian nursing in the 1920s and 1930s see Kathryn McPherson, "Skilled Service and Women's Work: Canadian Nursing, 1920-1939" (Ph.D. dissertation, Simon Fraser University, 1990).

10. For example, at the Vancouver General Hospital only six RNs were employed in 1909, 17 in 1919 and 37 by 1939. Kathryn McPherson, "On the Wards: Hospital Nursing in Vancouver, 1900-1950," unpublished paper presented to the B.C. Studies Conference, Victoria, B.C., 1986.

11. Only a small minority of RNs pursued public health nursing. Weir's study concluded that in 1929 only 1,521 of Canada's 18,174 RNs or 8.4% were employed in public health work. Weir also estimated that up to 75% of Canadian nurses worked in private duty. George M. Weir, *Survey of Nursing Education in Canada* (Toronto: University of Toronto Press, 1932), 55-56.

12. The analysis of nursing practice is based primarily on evidence housed in the WGHAA Archives, Winnipeg, Manitoba. This research base includes three nurses' notebooks (Furby Thorolfson, *Notebook*, 1924-1927, Winnipeg, Manitoba; Dorothy Nicholson, *Notebook*, 1926-1929, Winnipeg, Manitoba; and Violet Erickson, *Notebook*, 1929-1933, Winnipeg, Manitoba); student lecture notes (*Senior Lecture Notes*, 1 October 1910 to 16 January 1911; Violet Erickson, *Lecture Notes*, 1929-1933, Winnipeg, Manitoba); and the oral history collection "Nurses and Their Work: Oral Histories of Nursing, 1920-1940." Copies of the tape-recorded interviews are also housed at the Public Archives of Manitoba. Private Collections of Myrtle Bowman (Ruby Bowman, *Notebook*, 1925-1928; Myrtle Bowman, *Notebook*, 1928-1931), Mary Sheperd and Wilma Nichol were also utilized, as well as selected records of the Misericordia School of Nursing Alumnae Association Heritage Room Collection. I have purposely avoided basing my descriptions of nurses' work on educational curriculum guides because of their prescriptive, rather than descriptive, nature.

13. Nurses' Alumnae *Annual* (1928): 69-73. "Winnipeg General Hospital School of Nursing" (pp. 70-72) lists the "practical experience and theoretical instruction" given as tabulated from the year 1924-25. WGHAA Archives. Nurses' oral testimonies and popular culture make frequent references to the various stages of apprenticeship.

14. Samples of lectures notes reveal instructors' initials and occasional comments, as do some of the student notebooks consulted. Erickson, *Lecture Notes*; M. Bowman, *Notebook*.

15. Erickson, *Lecture Notes*.

16. Beryl Seeman, interview by author, tape recording, Winnipeg, Manitoba, 8 July 1987.

17. Some procedures, such as samples and smears, were sent to the hospital laboratory for analysis; other tests such as the Wasserman, Dye, Ewald Breakfast, Reigal Meal, and Functional Renal Mosenthal tests were performed on the ward. M. Bowman, *Notebook*; Erickson, *Notebook*; R. Bowman, *Notebook*; Thorolfson, *Notebook*.

18. While most surgical procedures were performed in the operating rooms, some continued to occur on the wards.

19. Research on nurses working in Nova Scotia during these years revealed the same emphasis on fomentations and poultices. See Keddy, "Private Nursing Days of the 1920s and 1930s in Canada," 99-102.

20. Erickson, *Notebook*, describes the procedure for preparing a non-sterile fomentation.

21. Seeman, tape recording; see also Mary Duncan, interview by author, tape recording, Winnipeg, Manitoba, 22 June 1987; Violet McMillan, interview by author, tape recording, Winnipeg, Manitoba, 23 June 1987; Vera Chapman interview by author, tape recording, Winnipeg, Manitoba, 2 July 1987.
22. Harriet Pentland, interview by author, tape recording, Winnipeg, Manitoba, 13 June 1986. See also McMillan, tape recording; Thorolfson, *Notebook*; Erickson, *Notebook*. If being boiled for sterilization, gloves had to be covered with water and weighted down, dried inside and out, examined for punctures, and unless requiring repair were then powdered and wrapped for transfer to the autoclave. Silk Guyon Catheters were damaged by Lysol or boiling and thus required disinfecting in "Bichloride of Mercury 1-1000 or in Formalin 1/2%" followed by rinsing with sterile cold water before using. Other rubber articles—Mackintoshes, medicine droppers, duodenal, stomach and rectal tubes and catheters—and glassware all demanded specific regimens for cleaning and storing.
23. Pentland, tape recording.
24. Erickson, *Notebook*, stated that post-operative genital care was required "after urination and defecation following repair of perineum, scraping and washing out of uterus, childbirth and abortion."
25. *Ibid.*
26. *Ibid.*
27. McMillan, tape recording; Seeman, tape recording.
28. In 1926 the WGH House Committee allocated \$55 per floor to equip the private wards with flat silver. WGH House Committee, *Minutes*, 4 January 1926, PAM Winnipeg General Hospital. Helen Smith recalled a reduced patient-nurse ratio on private wards, and the china cups in which private patients were served their tea: Helen Smith, interview by author, tape recording, Winnipeg, Manitoba, 3 August 1988. Myrtle Crawford stated that private patients had a choice of menus, and their food trays were set attractively, with cloth tray covers and cloth napkins, Crawford, tape recording.
29. WGH House Committee, *Minutes*, 22 October 1928.
30. "The Training," WGH *Blue and White* (1923): 27.
31. Given the complex debate regarding the changing historical definition and practice of "science," a note of clarification is required here. In "History of Science and History of Medicine," John Harley Warner reminded us that "science always has been a weighted term." Historians of science have viewed the biological sciences as vague and imprecise compared to the "mathematically grounded physical sciences," and believed that medical practice often failed to meet the criteria of scientific enquiry at all. See John Harley Warner, "History of Science and History of Medicine," *Proceedings: Conference on Critical Problems and Research Frontiers in History of Science and History of Technology* (Madison, Wisconsin: History of Science Society, 1991): 395-422. On the other hand, the medical profession did win, in the late nineteenth century, the right to serve as arbiter of scientific knowledge with respect to health care. Whether that right was based on the ideological authority of science or the efficacy of treatment, physicians wielded their social and political power with might. For the purposes of this paper, medical science refers to the body of knowledge developed and employed by the medical profession in the late nineteenth and early twentieth centuries. It is this definition that is used here to measure nurses' engagement with "science" as it was defined in the particular historical epoch.
32. *Senior Lecture Notes*, 1 October 1910 to 16 January 1911. The emphasis on bacteriology was not unique to the WGH training program. Documentation from nurses in other parts

of North America substantiate this fact. For example, Mary Anderson left her home in North Sydney, Cape Breton, to train as a nurse in New York during the early 1920s. She recalls her bacteriology course and learning how to "catch" bacteria in agar. Mary Anderson, interview with Anne Warren, Vancouver, B.C., February 1989. B.C. Women's History Collection, SFU Archives, Burnaby, B.C.

33. Erickson, *Lecture Notes*.

34. R. Bowman, *Notebook*.

35. R. Bowman, *Notebook*; Thorolfson, *Notebook*.

36. *Ibid.*

37. See Harry Braverman, *Labor and Monopoly Capital: The Degradation of Work in the Twentieth Century* (New York: Monthly Review Press, 1974), 113–114, for a discussion of the distinction of conception from execution.

38. See Thorolfson, *Notebook*, 1924.

39. During the same period, the experiences of hospital nurses, on and off duty, were also influenced by other models of social organization. One is that of the convent. While rules guiding the behaviour of nurses on and off duty did not entirely cloister the young women enrolled in the various schools, feminine respectability was demanded and parallels to female religious orders were not accidental. At the same time, the regular practice within hospital nursing schools of uniform inspection and standing at attention drew on the military model to instil obedience and discipline. As well, anthropological studies have emphasized the cross-cultural importance of ritual in the healing process. I would like to thank Kathleen McMillan and the members of the Ontario Society for the History of Nursing for bringing this latter point of comparison to my attention.

40. One nurse tells of a patient requiring a doctor's order to sleep with the blankets untucked. McMillan, tape recording.

41. Winnipeg General Hospital, *Reports and Accounts*, 1920–1939.

42. Winnipeg General Hospital, *Reports and Accounts*, 1921, 16.

43. Certainly nurses were central to institutional survival, though few historians of medicine have integrated nursing work into their studies or collections.

44. In the 1940s, "the pent-up demand for new [health care] facilities and technology exploded," prompting the federal government to get involved in financing Canadian health services, and hospitals, once peripheral to legitimate care, became the cornerstone of the health care system. George M. Torrance, "Hospitals as Health Factories," in David Cobern, C. D'Arcy, P. K. New and G. M. Torrance, eds., *Health and Canadian Society: Sociological Perspectives* (Toronto: Fitzhenry and Whiteside, 1981), 257.

45. Reverby, *Ordered to Care*.

46. Hospital administrators constantly bemoaned the fact that they could not retain RNs in staff positions. Graduates might accept a staff position for a short time, but then quit to seek work in the private health care market.

47. McMillan, tape recording. Erickson, *Notebook*; Thorolfson, *Notebook*.

48. McMillan, tape recording. Retired nurses commented frequently on the length of time that parturient women stayed in bed following delivery during the interwar years, and agreed that the more recent trend of having new mothers "up and about" soon after childbirth has been a positive one.

49. R. Bowman, *Notebook*.

50. Many graduate nurses interviewed insisted that a massage and a cup of hot milk before bed accomplished what sedatives now do for hospital patients.
51. Students also assisted with many home births during their apprenticeship with the Margaret Scott Mission, or the Victorian Order of Nurses (VON). During the 1930s some students were placed with the VON to acquire the home nursing and district nursing experience offered since the 1920s by the Margaret Scott Mission. Chapman, tape recording.
52. Isabel Cameron, interview by author, tape recording, Winnipeg, Manitoba, 1 July 1987.
53. This uncertainty led Cameron's classmate to rephrase the song "we're always blowing bubbles in the air" and sing instead "we're always having babies in the bed." Ibid. For example, Grace Parker was called to attend a birth during her training at the Margaret Scott Mission, only to arrive and discover the woman did not have a doctor. By the time the interns from WGH arrived the baby was born. Grace Parker, interview by author, tape recording, Winnipeg, Manitoba, 25 June 1987.
54. Cameron knew enough to slap a newborn she had just delivered, but that was all she knew. Ibid. Other nurses shared similar experiences. Olive Irwin regretted not receiving better obstetrical instruction when as a VON nurse she had to deliver alone a baby with its umbilical cord wrapped around its neck. Olive Irwin, interview by author, tape recording, Winnipeg, Manitoba, 3 August 1988. See also, Florence Paulson, interview with author, tape recording, 1 July 1987.
55. Paulson, tape recording.
56. James Crampton, "It's Been a Healthy 75 years: Pioneer Public Health Nurses Remember the Old Days," *Winnipeg Free Press Weekly*, Tuesday, 17 December 1991, 4. This story, based on an interview with retired public health nurses Mary Wilson and Jessie Williamson, includes a photograph of the two women holding one of the public health nurses' black bags, with its contents laid out on a sterile apron.
57. Erickson, *Notebook*.
58. Erickson, *Notebook*; R. Bowman, *Notebook*.
59. See for example Ann M. Forrest, Lady Superintendent, The Queen Alexandra Sanatorium, Long, Ontario, "Increase of Tuberculosis Among Nurses," *Canadian Nurse* 27, 11 (November 1931): 578-581; H. B. Cushing, M.D., Montreal, "Erythema Nodosum Among Nurses," *Canadian Nurse* 23, 6 (June 1928), 286-287.
60. Erickson, *Lecture Notes*.
61. Forrest, "Increase of Tuberculosis Among Nurses."
62. Paulson, tape recording; Anne Ross, interview with author, tape recording, 4 August 1988; Olive Irwin, tape recording.
63. Susan Port Benson, *Counter Cultures: Salewomen, Managers and Customers in American Department Stores, 1890-1940* (Urbana: University of Illinois Press, 1986), 6.
64. Ingibjorg Cross, tape recording.
65. See for example, Crawford, tape recording.
66. Crawford, tape recording.
67. Dr. Biglow, *Letter to W. Mitchell* (June 1937). Private Collection, W. Nichol, Brandon, Manitoba.
68. Dr. Biglow, *Letter to W. Mitchell*.

69. Braverman, *Labor and Monopoly Capitalism*. For a review of the deskilling of male clerical workers see D. Lockwood, *The Black Coated Worker* (London: Allen and Unwin, 1966).
70. For a discussion of the feminization of deskilling of clerical work in Canada see Graham Lowe, *The Administrative Revolution: The Feminization of Clerical Work* (Toronto: University of Toronto Press, 1987).
71. Barabara Melosh, *"The Physician's Hand": Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982), 25.
72. This was especially true given the early twentieth century efforts to make housework scientific. For a description of the domestic science programs in Canada see Barbara Riley, "Six Saucepans to One: Domestic Science vs the Home in British Columbia, 1900-1930," in Barbara Latham and Roberta Pazdro, eds., *Not Just Pin Money* (Victoria: Camosun College, 1984).
73. See McPherson, "Skilled Status and Women's Work." See also Coburn, "I See and Am Silent."
74. Seeman, tape recording.
75. Crawford, tape recording.
76. "Medical Definitions," WGH *Blue and White* (1936), 36.
77. WGH *Blue and White* (1927), 62.
78. WGH *Blue and White* (1931), 61. See also the Misericordia Hospital School of Nursing, *Blue and Gold Year Book* (1931). Misericordia Hospital School of Nursing Alumnae Association Heritage Room, Winnipeg, Manitoba, 1926, 51.
79. WGH *Blue and White* (1923), 20.
80. WGH *Blue and White* (1928).
81. WGH *Blue and White* (1926), 53.
82. See for example, D. L. Brewster, *Student Notebooks*, Montreal General Hospital and Montreal Maternity Hospital, circa 1925. McGill University Archives, MG 3084. See also, Toronto General Hospital School of Nursing, *Yearbooks*, Toronto General Hospital Archives.
83. *Ibid.*, 1931, 25.
84. David Gagan's *"A Necessity among Us": The Owen Sound General and Marine Hospital, 1891-1985* (Toronto: University of Toronto Press, 1990) includes some references to nursing work in early chapters of the study, but does not pursue the theme throughout the study. American historian Charles Rosenberg acknowledges nurses' contribution to hospital work stating: "In 1800, as today, nurses were the most important single factor determining ward and room environment." However, he goes on to state that nursing would play only a minor role in his monograph because it was subordinate to the role of the medical profession in shaping the modern hospital. Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, Inc., 1987), 9.
85. See Ainley, *Despite the Odds*. See also Veronica Strong-Boag, "Canada's Women Doctors: Feminism Constrained," in L. Kealey, ed., *A Not Unreasonable Claim: Women and Reform in Canada, 1880-1920* (Toronto: Canadian Women's Educational Press, 1979), 109-130.
86. This, of course, was a primary reason for many nursing educators and leaders to battle for university schools of nursing wherein a discrete body of knowledge could be

developed. According to professionalizing strategy, this was an important element in gaining professional status.

87. Manitoba, Provincial Board of Health, *Regulations Respecting Public Health Nurses* adopted at a meeting of the Board held on 12 June 1919, pp. 10 and 13. WGHAA Archives.

88. George Weir, *Survey of Nursing Education in Canada*.

89. Londa Schiebinger, *The Mind Has No Sex? Women in the Origins of Modern Science* (Cambridge, Mass.: Harvard University Press, 1989).

90. The best known example of this orientation is Elizabeth Fox Keller's *A Feeling for the Organism: The Life and Work of Barbara McClintock* (New York: W. H. Freeman and Company, 1983). The term "different voice" was coined by Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge, Mass.: Harvard University Press, 1982). For a review of the various approaches to women and science see Sue V. Rosser, "Feminist Scholarship in the Sciences: Where Are We Now and When Can We Expect a Theoretical Breakthrough?" in Nancy Tuana, ed., *Feminism and Science* (Bloomington: Indiana University Press, 1989).

91. See for example, Riley, "Six Saucepans to One"; Patricia Saidak, "The Conception of the Home Economics Movement in English Canada, 1890-1919: In Defense of the Cultural Importance of the Home," M.A. thesis, Institute of Canadian Studies, Carleton University, 1987.

92. T. Kuhn's 1970 publication, *The Structure of Scientific Revolutions* (Chicago: University of Chicago Press) presented a powerful argument for thinking about science as a paradigm rather than an absolute truth. Kuhn asserted that scientific paradigms are accepted, or rejected and replaced, as the best available explanation for the natural world according to the beliefs and values of the day. As beliefs change so too are new explanatory paradigms of "science" introduced. This has led many historians to emphasize the legitimizing function that science has played, particularly in areas such as medicine. Authors such as Sam Shortt and Colin Howell have claimed that medical professionalization was based on claims of scientific knowledge more than on any proven record of treatment. See S. E. D. Shortt, "Physicians, Science, and Status: Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century," *Medical History* 27, 1 (1983): 51-68. See also Colin Howell, "Reform and the Monopolistic Impulse: The Professionalization of Medicine in the Nineteenth Century," *Acadiensis* XI, 1 (Autumn 1981): 3-22 and "Elite Doctors and the Development of Scientific Medicine: The Halifax Medical Establishment and 19th Century Medical Professionalism," in Roland, ed., *Health, Disease and Medicine*.

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“Larger Fish to Catch Here than Midwives”: Midwifery and the Medical Profession in Nineteenth-Century Ontario*

J. T. H. CONNOR

Women assisting other women before, during, and after childbirth—the practice of female midwifery—probably constitutes the oldest, most traditional, and culturally widespread health care activity. Typically, female birth attendants would comfort the woman in labour, help with the delivery of the child, sever the umbilical cord, dispose of the after-birth, and perhaps further aid the mother by performing household chores for several days surrounding the birth. Although important exceptions existed, usually midwives’ experience and reputation were the main criteria for determining their worth, rather than formal education or training. Despite this ancient and diverse heritage, social and cultural historians, as well as historians of medicine, have focussed their attention on the evolution of female midwifery in Anglo-America, especially during the nineteenth and early twentieth centuries. What interests these scholars are the many tensions and changing agendas that developed in this period with respect to childbirth practices and attendants. Issues that have been explored include the general shift from traditional practices to scientific, obstetrical medicine; the impact of technological innovations and interventions during childbirth; the supplanting of lay practitioners by professional physicians; the apparent domination of males over females; and the influence of different socio-economic environments on some of the aforementioned shifts. Indeed, the historiography of female midwifery crystallizes broader historical trends inasmuch as matters pertaining to elites versus social groups, feminism, professionalization, and comparative development have been addressed.¹

This discussion attempts to comprehend the early evolution of Ontario’s midwives. As will be shown, although considerable midwife activity existed in nineteenth-century Ontario, it would be incorrect to characterize female midwives as comprising a movement. Moreover,

while tensions between physicians and midwives existed, this paper argues that Ontario doctors displayed considerable tolerance of, if not occasional support for, midwives; furthermore, legislation that negatively affected midwives was not expressly calculated to bring about their demise. It will also be argued that medical technology, although it did have an adverse effect on female midwifery, did not appear to have been employed primarily to oust midwives. Thus it is generally argued here that the demise of this form of health care practice in nineteenth-century Ontario resulted from the confluence of several forces and was not solely the result of pressure brought to bear by the province's male doctors. Moreover, the interpretation of this discussion presents Ontario's experience of midwifery as different from that of Quebec and Newfoundland—provinces having the most complete histories yet published on the subject.² In brief, this essay, if nothing else, demonstrates that the "midwifery debate" in nineteenth century Ontario was anything but black and white; it was much more nuanced and ambiguous than simply male physicians vs. female midwives. To be sure, one physician might well rail against a midwife, but it would be misleading to exaggerate these disputes—as one contemporary physician remarked, there were larger fish to catch than midwives.

In articulating this argument several points of contrast and comparison emerge with respect to other essays in this volume. Dealing as it does with the nineteenth century, this discussion pushes back the time frame of the study of women as health care providers in Canada. In so doing it identifies some of the gender issues and also those of professionalizing that became more fully articulated in the following century. While midwifery was not legal for a great deal of the nineteenth century, it is evident that some male physicians were tolerant of midwives and their activities; other medical practitioners were, however, antagonistic toward these women. It also becomes evident that midwives in nineteenth century Ontario did not appear to have become organized or developed champions (male or female) for their cause; this finding stands in contrast to later women's health care movements that clearly spawned leaders and lobbyists to advance their aims, as others discuss in this book. Nevertheless, despite this lack of formal organization, midwives could often garner the support of their community and the press demonstrating their acceptance and legitimacy within a segment of nineteenth century Ontario society. Notwithstanding such occasional overt support for Ontario midwives it appears that, generally speaking, Victorian Ontario society, including medical practitioners, were ambivalent towards the practice of female midwifery—a result that is not inconsistent with Dianne Dodd's analysis of popular midwifery in the

twentieth century in this volume. Indeed when one situates the "midwifery debate" on the larger map of nineteenth-century epidemics, medical discoveries, politics, legislative battles, sectarian movements, and institutional rivalries, it pales in significance somewhat. Recall that for much of the nineteenth century, Ontario physicians and society at large were more concerned with issues such as licensed physicians vs. unlicensed physicians, homoeopaths and other sectarian physicians vs. "regular" physicians, urban elite physicians vs. rural general practitioners, the cycle of opening, closing, and reopening of proprietary medical schools, and the impact of a staggering array of new medical and surgical techniques and technologies. Indeed, it was not until the early decades of the twentieth century that many of the ongoing debates of the previous century (such as standards of education, funding, and licensing) were resolved and the medical profession of Ontario settled into some semblance of professional homogeneity, relative security, and general public esteem.³

For the history of female midwifery in nineteenth-century Ontario several research problems exist, however. First, there is a dearth of primary source material written by midwives themselves: no archival or published accounts of midwives' experiences appear to have survived, if written at all. Second, as there were no midwives' journals or associations in Ontario, another possible direct source of information is unavailable for study. Consequently, and unfortunately, the voice of the midwife herself is silent; indeed, much of what we know on this topic in Ontario results from physicians' accounts. A third problem centres on what actually constituted a "midwife" in nineteenth-century Ontario. Was the term "midwife" applied by contemporary doctors and laypersons equally to formally trained and self-taught persons? Might "midwife" also have indicated a helpful neighbour woman who actively assisted in the birthing process, or perhaps even a curious onlooker who happened to be present while the child was being born? Because of this likely indiscriminate use of the term "midwife" in Ontario, a fourth problem arises in attempting to estimate how many midwives actually existed in the province during the nineteenth century. In her study of the history of nursing in Ontario, Judi Coburn estimates there were eight midwives in 1851; sixteen in 1861; twenty-one in 1871; and sixty-one in 1881. (Interestingly, these data show that the number of midwives was increasing over the century and not decreasing.)⁴ However, Coburn's figures are based on census data—but how discriminating was the original governmental survey? Did it include trained and/or "full-time" midwives, for example, as well as casual "ad hoc" midwives? Exacerbating these problems is that of legislation. As will be

shown, owing to the varying legal status of female midwifery in Ontario during much of the nineteenth century it is likely that many practising midwives—of whatever background—might have been reticent to declare themselves as such. Interestingly, too, a recent survey of estate records of nineteenth-century health practitioners in Ontario failed to turn up evidence of the occupational category of “midwife,” suggesting that neither legal bodies nor women themselves formally employed such a term.⁵ Thus to offer any information on the number of midwives in Ontario during this period is fraught with difficulty. In sum, because of these several inherent methodological difficulties the following discussion might appear to be skewed to the historical advantage of physicians. On the contrary, it is one of the aims of this article to identify some of the many factors involved in physician–midwife relations in an effort not to present an overly dichotomized argument. To be sure, examples will be cited that illustrate clear confrontation between these two groups of health care providers, but it is hoped that an overall picture will emerge that clearly shows that complex and interconnected relationships could and did exist.

Legislation and Female Midwifery

Apart from these problems with sources, there does exist concrete information regarding female midwives and legislation. The first law regulating medicine in Upper Canada, passed in 1795, made specific mention of midwifery and declared that “no person . . . shall be permitted to vend, sell, or distribute medicines by retail, or prescribe for sick persons, or practise physic, surgery or midwifery within the Province, for profit, until such persons or persons shall be duly approved of by a board of surgeons.”⁶ Much has been made of this early legislation concerning its apparent prohibition of female midwifery. Writing in the early 1820s the acerbic Robert Gourlay claimed that this law was “absurd,” “cruel” and “meddling” for it meant that a “poor woman in labour could not have assistance from a handy sagacious neighbour, without this neighbour being liable to be informed upon and fined!”⁷ Subsequent commentators⁸ have also cited this law and Gourlay’s comments as evidence of the medical profession’s antagonism towards and desire to eradicate female midwives from the province. But Gourlay and his successors failed to take into consideration a crucial phrase contained in the original legislation that specified that the legal prohibitions applied only to those persons who practised “for profit”; thus indeed there was no legal impediment to prevent a “handy sagacious

neighbour" in aiding a "poor woman in labour." Furthermore, as circulating currency was extremely scarce in the province at this early time, it would be highly improbable that any midwife who practised "for profit" would have received payment in the form of money; typically if any exchange took place it would have been in kind or goods, thus making it difficult or impossible for any legal authority to press charges against the apparently illegal female practitioners. In sum then, this law probably did little to restrict the practice of female midwifery within the province; although to be sure it might have inhibited the migration of some midwives into Upper Canada.

Probably as a result of the ineffectiveness of the 1795 law, subsequent medical legislation passed in 1815 stated that while it did restrict medical and surgical practitioners in the province "nothing in this Act contained shall extend or be construed to extend to prevent any female from practising midwifery in any part of this province, or to require such female to take out such license as aforesaid."⁹ A similar exemption appeared in the several provincial medical acts that followed. Only the Act of 1839 omitted this clause, but this legislation was disallowed in 1840, whereupon previous laws again took effect—legislation that did not discriminate against female midwifery. With the passage of the new Medical Act of 1865 the midwives' exemption clause was again omitted; thus, strictly speaking female midwifery was illegal. However, the intent of this new legislation and subsequent amendments to it, was to punish those persons who deliberately and falsely portrayed themselves as licensed, registered doctors—something that midwives probably neither desired nor needed to do.¹⁰ Therefore, for the remaining third of the nineteenth century (and indeed for the twentieth century, too), there were no direct restrictions pertaining to midwifery, in short this practice was never really illegal. By the same token, neither was it legal, which meant that midwives could be found guilty of "practising" medicine, that is, obstetrics, without a medical licence. Thus while midwives could practise with impunity from the 1790s to the 1860s, for the remainder of the nineteenth century and beyond their activities fell into a legal grey area.

Special mention should be made of specific legislative activity concerning the legal status of midwives. In the autumn of 1873 a draft of a bill to amend the Ontario Medical Act was prepared. While most of the proposed amendments were designed to address a variety of "house-keeping" issues, a wholly new idea was also put forward. Briefly, through the creation of territorial division medical associations, it was envisaged that local physicians could have more control over the regulation of

medicine within their own regions. In particular, it was proposed that midwives could be licensed by a board of examiners appointed by members of these local associations. Thus midwives, "upon satisfactory proof of competence" and upon their payment of an annual fee, would be granted a licence to practise within a specified district. This licence could be revoked if the woman was found incompetent or guilty of misconduct, but it also exempted her from any penalties that the Medical Act may otherwise have imposed.¹¹ Although this amendment never became law, its very framing demonstrated that some physicians did recognize the merits of midwives. However, offsetting such support were the comments of the *Canada Lancet* editor, who felt that such a provision was "scarcely necessary," especially as there were "few women who aspire to that office except in the largest cities, and besides, there are at present no favorable opportunities for the education of women in this department."¹² Several years later when the Medical Act was again considered for amendment, several municipal councils within the province submitted petitions in support of the idea that female midwifery be formally recognized; no bill or amendment in support of such a move was put forward, however.¹³

Two decades later, debate about the legalization of midwives again surfaced. Owing to discussion of this issue in the United Kingdom, the editor of the *Ontario Medical Journal* (official organ of the province's medical association) stated how there were no specific laws prohibiting or supporting midwives in Ontario. Under such conditions midwifery was "open to public competition, as if it was something any ignoramus, mule [*sic*, male?] or female could dabble in with impunity." Accordingly, often the actions of "unqualified midwives" led to disastrous results for both babies and mothers. Inasmuch as this editor apparently had no argument over the legalization of midwives in the United Kingdom, one may assume that his criticism of Ontario midwifery centred not so much on its existence or practice per se; rather, the issue was one of qualifications and regulation.¹⁴

The last political battle in the nineteenth century over midwives came with the election of several members of the Patrons of Industry party, which brought to the Ontario legislature in the early 1890s a new voice of reform within provincial politics. A party with strong rural support, the Patrons sought to challenge the Ontario establishment on a variety of fronts, the medical profession being but one.¹⁵ It is difficult to pin down the Patrons's exact political position vis-à-vis doctors, however. On the one hand doctors (as well as lawyers, liquor dealers, merchants and "all persons of proved immoral character") were

excluded from membership in their organization,¹⁶ while on the other the Patrons declared that they "never had any warfare with the medical profession, but they have boldly declared that the privileges given to the [Ontario Medical] Council have not been such as should be confined by any body of men outside of the law courts where justice ought to be procurable by the humblest citizen of the realm."¹⁷ Perhaps the most accurate evaluation of the Patrons's attitude towards doctors was that they opposed them as a monopoly, not as a profession, and in particular they opposed the Medical Council of Ontario because it was the power behind this supposed monopoly.¹⁸

Of special concern here, however, was the introduction of the Haycock Bill in the spring of 1895 (named after the leader of this group—J. L. Haycock). This proposed legislation challenged Ontario doctors in five areas: licensing exams and fees set by the Ontario College of Physicians and Surgeons; the College's practice of disciplining physicians (i.e., its self-policing function); the registration fee administered by the College; the College's right to approve physicians' fee schedules; and finally, the status of midwives within the province.¹⁹ This last aspect of the bill strove to license midwives and place them under municipal control, removing them from any legal grey area. That the medical profession found the Haycock Bill objectionable in its entirety is not surprising, not simply because its passage would have significantly altered their position within society, but perhaps more importantly, because the bill was a poorly drafted piece of potential legislation. Following is the section of the proposed bill that pertained to midwives:

16.—(1) Any person, being a woman, who, within six months after the coming into force of this Act, produces before any local board of health a certificate signed by the head of the municipality or by two justices of the peace that she is a person of good character, and who proves by evidence taken on oath before such board that she has successfully performed the office of midwife in at least ten cases of confinement before the passing of this Act, shall be entitled, upon payment of a fee of \$1 to the treasurer of the municipality, to a license, under the hand of the chairman of the board, to practise midwifery in the municipality for two years from the date of such license, and the said board may at the expiration renew such license upon the production of similar evidence of good character.²⁰

It would appear that for the Patrons, then, the primary requisite of a midwife was to be of "good character" and experience; no mention was made of training²¹ or proof of examinations. Furthermore, although there was a requirement of ten confinements, the legislation

as presented did not identify what sort of proof was acceptable to show that the candidate had indeed attended ten confinements. When voted on, the entire bill was a dismal failure. Dr. R. B. Orr editorialized in the *Ontario Medical Journal* how the “gist of the bill was ridiculous in the extreme, both from the standpoint of benefit to the profession and benefit to the general public.”²² And, the *Toronto Globe* congratulated the collective action of the Ontario Legislature, noting that the original Ontario Medical Act “was passed for the protection of the public not for the purpose as some people suppose of creating medical practitioners of Ontario a closed corporation.”²³

Public and Professional Attitudes toward Female Midwifery

But what were the attitudes of the general public and medical profession to midwifery in Ontario during the period under study? Owing to the spotty nature of sources, our understanding of public attitudes must remain somewhat impressionistic; however, it appears that female midwifery was indeed accepted and supported by Ontarians at large. As early as 1810 the wife of the King’s Printer in York displayed a sign on the door of her residence proclaiming “Isabella Bennet, midwife from Glasgow.”²⁴ Eighteen years later “Mrs. Bennet, *Midwife*” announced in the York newspaper the *Colonial Advocate* that she was moving to new premises.²⁵ Other advertisements for midwives further indicate the apparent popular acceptance of female midwifery. From October 1829 to January 1830, Mrs. Sarah Tebbutt announced that having practised for several years as midwife in England, she was now “ready to attend families in that capacity in the Town or neighbourhood of York.” Interestingly, Tebbutt also noted that she “refers to Dr. Widmer,” a clear indication that midwife–physician relations could be cordial.²⁶ And, in 1842 Mrs. Mahon, a recently arrived Dublin-trained midwife, advertised her skills to the public. Noting that as she had had an “extensive and successful practice in her line of business among the higher and lowlier classes of ladies, for upwards of twenty years” she would “at all times be in readiness and cheerfully attend to any calls” and thus satisfy her clients as a result of her “real knowledge, experience and attention.”²⁷ Also in York during the 1820s, the Society for the Relief of Women made provisions for aiding pregnant women that included “comfortable clothing of all kinds, a midwife, and Physician (if required) and the best nourishment.”²⁸ Moreover, in the early 1830s diarist Mary O’Brien recorded how a midwife named Mrs. Fraser assisted after the birth of one of her children; also of note, Mary O’Brien herself acted as midwife

at least twice. (Despite her experiences, she also recorded in her diary that during the birth of another child she "began to be a little alarmed and to wish to see the doctor" suggesting that even at this early date some Ontarians perceived that during a difficult birth a physician should be consulted, presumably because he had superior medical and obstetric skills.)²⁹ Finally, during the mid-nineteenth century Susanna Moodie recalled how she "succeeded in procuring a nurse" to attend the birth of her second child while she lived in the Peterborough area.³⁰

Newspaper editorials and letters to the editor also indicate that female midwifery was embraced by the public. An especially illustrative incident is recorded in the pages of the Toronto *Globe* of 1874. In August of that year a Gravenhurst midwife was charged and found guilty of practising medicine (i.e., performing obstetrics) without a licence, for which she was fined twenty-five dollars and court costs. The circumstances surrounding this event caused a local uproar; however, the debate escalated when it became the subject of wider editorial commentary. According to the midwife, Jane Brines, a fifty-six-year-old widow and one of Muskoka's earliest settlers, she had attended the birth of the child of a Norwegian woman who spoke little English; no fee was apparently charged for this service. Shortly after this event Brines, at the insistence of the local physician, Dr. J. Adams, was charged with the illegal practice of medicine. In court, the Justice of the Peace reluctantly fined the midwife the least possible penalty, while sympathizing with her "as far as his duties would permit." (And in a further display of his ambivalence towards the case, the magistrate also found the physician guilty of contempt of court and fined him two dollars.) The midwife's friends and neighbours immediately came to the woman's aid and collectively paid her fine. The physician's perspective of this incident was, not surprisingly, somewhat different. Adams stated that there were several midwives in the district and, as far as he was concerned, they could practise with perfect impunity as long as they didn't interfere with his cases. This latter point appeared to be the crux of the issue, for Adams had been called to attend the pregnant woman but on his arrival the midwife already had matters in hand and told the physician twice to leave; it was on the grounds of this conflict that the physician proceeded with the charge.

Clearly, some understanding should be extended to both parties, but it was evident that it was the midwife who was seen as the victim in this case. Certainly the local community was behind her; so too was the *Globe*. Editorials entitled "Midwives Beware" and "Medical Oppression" left little doubt where it stood. One issue this case raised was the

propriety of men attending women, for the *Globe's* editor noted how it was "notoriously far more decent and becoming that women should be engaged on such occasions than men." A second issue was the more ready availability of female midwives over male physicians in rural areas, and also the former's generally recognized skills in childbirth. Yet another, was the "tyrannical act of the Legislature of Ontario, which gives a monopoly of the art of healing to one society." Commenting on the details of the case itself, the *Globe* felt that the overall outcome was an "undeniable triumph to the victim" as shown through the support the midwife received from her community, while for the physician it would prove to be a grave tactical error: Adams's action was a "mere piece of personal jealousy, which the neighbourhood has taken into its own hands and very decisively passed judgement upon."³¹

The following year, in response to the Ontario Medical Council's prosecution of several unlicensed medical practitioners, there appeared another series of letters and articles in the *Globe* condemning the medical profession. As these pieces referred to all manner of medical practitioners, midwives also figured in them.³² One *Globe* editorial was highly critical of the Council's action and described how it might be possible (perhaps recalling the Gravenhurst case) that an "elderly midwife" could end up in prison in the company of "the most degraded of her sex" simply for assisting "in the hour of another woman's agony."³³ And in another editorial the *Globe* advocated that midwives should challenge the medical profession by narrowly interpreting the pertinent legislation and thereby avoid prosecution. "She [the editorial noted] may hire herself by the day as a nurse for a couple of dollars more or less, and give her assistance when the crisis arrives. Who shall assail her? She has not *practised* for hire or reward. It is a pure piece of benevolence on her part; who shall lay hands on her?"³⁴

Assessing in greater detail the regular medical profession's attitude to midwives is easier as more material exists, but by the same token there is a wide disparity of opinion that hence calls for caution in its interpretation. To be sure, some Ontario doctors were openly antagonistic towards midwives; but there was also support for them. Perhaps the earliest published accounts in Ontario by a physician (as evidenced by his technical language) concerning female midwifery appeared in the *Kingston Gazette* in 1815. In a letter closing only with the signature "W," readers were informed how a pregnant woman died as a result of the "ignorance or trepidation" of a "female accocher [*sic*]." Thus "W" felt it was necessary for both magistrates and the public to "root out these pretenders."³⁵ Clearly it would appear as if "W" opposed midwives,

but as is evident from a subsequent letter to the *Gazette*, "W" had no objection to them *per se*—if they were trained and subject to examination, as was the case with physicians and surgeons.³⁶ Tacit support for midwives also came from Christopher Widmer, President of the York Medical Board who, in 1832, reported to the Lieutenant-Governor concerning the need to establish a lying-in (maternity) hospital in York. Dr. Widmer claimed that besides the obvious benefits afforded by such an institution, it also "might be made subservient to the instruction of students and midwives."³⁷ Generally speaking, Ontario doctors tolerated midwives and were prepared to work with them, but such working relationships could often be strained.

Details of other published case histories provide additional information concerning physicians' attitudes to midwives. An example of the work of one midwife is related by a Kingston practitioner. John R. Dickson recalled that in the summer of 1850 he attended a confinement where he met "an educated midwife" who had cared for the patient during the previous night. Far from being hostile to this woman, Dickson requested her assistance before and after the birth of the child. The first helpful act included a visual examination of the patient, while the second involved questioning of the husband and wife about the latter's health.³⁸ In all probability this professional relationship was a result of the "educated" state of the midwife, presumably a reference to her knowledge and intelligence, if not also to her experience and training, suggesting that a doctor might distinguish between "educated" midwives and occasional helpful neighbour women or ad hoc midwives.

However, contrasting this happy case was the experience of another Ontario doctor. In 1840 Dr. F. S. Verity was summoned by the husband of a woman who was experiencing a difficult and protracted labour; the services of a midwife had also been procured previously.³⁹

Upon examination [Verity stated] I found the right arm protruding through the vulva, wrapped in a piece of cloth "for fear of cold," as the midwife said, and carefully tied to the patient's thighs "for fear it should go back again." On learning the history of the case, I was very angry with the midwife, and asked why she had not sent for assistance sooner; when she coolly told me, that as long as she had "the smut" [ergot of rye] she did not expect to require any one's assistance. . . . "So you have been giving her this," I said. "Yes," she replied, "and I *always* give it, when the case is a long one, and I never knew it fail until now." My temper, I confess, was ruffled, and after rating her soundly, for her presumption and rashness in administering such a powerful remedy without a knowledge of its properties and the circumstances under which it was proper to give it, I left her.

As Verity had to wait until the action of the “smut” had dissipated, it was almost three hours later before he managed to deliver a “fearfully bruised,” dead infant. Commenting on this case, Verity wrote how it “serves to illustrate . . . the cruel treatment to which women are subject, in the hands of rash and ignorant Midwives.” Whereas it is possible that Verity was condemning all midwives’ actions in this comment, it is more likely that he referred only to midwives whose actions were similar to those discussed in this case. That is, in all likelihood for Verity, not all midwives were “rash and ignorant,” but some were, and therefore only they should be condemned.

A similar unfortunate experience was related by Charles Rolls, a Wardville doctor.⁴⁰ Rolls wrote that on one occasion he travelled twenty-five miles to attend a woman in labour and, on his arrival “found the house, as usual, filled with women, all eagerly on the *qui-vive*, to know whether the patient was to die or live; and the ladye-midwife amongst them, an old dame about eighty years of age; on enquiry from whom, I learned the patient had been in labour for two or three days . . . ; that she had delivered one child, and another was behind—the patient having frequently felt its motion.” After about ten minutes Rolls managed to remove the two placentae and the second, stillborn child. For this practitioner, there was little doubt that the stillbirth “was produced by the officious, meddling mismanagement of the attending midwife. At all events, had a regular competent physician been present from the commencement of labour, the patient must have been spared a great amount of pain.”

Such angry words suggest Rolls was hostile to midwives in general; but he was not. In another case history,⁴¹ Rolls explained that when he visited this particular patient she had already been in labour for forty-eight hours, and had been attended by “two women midwives” who, by the patient’s own account, had caused her much suffering and subjected her to “rough handling” (perhaps a reference to their attempt at performing external version). After some difficulty, Rolls managed to deliver the child successfully, despite the greatly weakened state of the mother. In his summation of the case, Rolls remarked on its clinical details, but more importantly, he also passed comment on the midwives’ actions, declaring that he

furnished the case for publication in your journal, as from a wish to show to the public and the Legislature how necessary it is that all, whether men or women, who are engaged in the practice of midwifery, should be thoroughly qualified by previous study and examination. There cannot be the least doubt had this patient been left without

further assistance . . . she must have been a corpse. . . . She had been attended by two professed midwives (one of whom is esteemed by the public quite a village oracle): and yet the poor creature had been allowed to remain in strong labour two days and nights, unassisted, . . . no attempt had been made in the right direction by these midwives, but the labour had been encouraged to proceed, and the woman tortured and worn out . . . they actually expecting to effect the accouchement by tugging at the arm, and wondering *what in creation* prevented the child from being born.

Rolls's anger is again evident, but the focus of his anger becomes clearer:

To women, as midwives, I have no objection, if they be properly qualified (as in the old countries) by previous education and examination; but to allow the ignorant persons, who at present are so frequently employed in the country parts of Canada, any longer to be so engaged, without proper qualifications, is, in my opinion (and I doubt not other physicians will generally coincide with me) unjust to the public, unjust to the profession who are called on to rectify their blunders, and, above all, most lamentably unjust to the poor suffering patients themselves, who are so painfully and often fatally deluded by them.

Thus Rolls had no quarrel with the principle of female midwives, nor with their practice either, so long as those who claimed to be skilled *were* skilled—presumably to those standards of midwives from the "old countries" (for example, France and Great Britain) that Rolls had learned to respect. (Rolls himself was educated in France and Britain; he obtained his licence to practise in Upper Canada in 1834.)⁴² Moreover, based on Rolls's testimony, the majority of those women who called themselves midwives in the "country parts of Canada" had little right to do so, for they possessed no qualifications or degree of skills similar to those female practitioners of the "old countries."

In another clinical example a Fingal, Canada West, physician recalled that in 1865 he attended a "case of accouchement" where he found the woman to be generally debilitated, with vaginal "parts" that were "*hot, tender, and swollen.*" During a difficult vaginal examination, the physician discovered some anatomical anomalies of the unborn child whereupon he deduced that the attending midwife "by some means or other, had pulled off the arm from the shoulder." After confronting the midwife with this supposition and his threatening to call for a constable, the woman "produced the *two arms of the child, with the clavicle and scapula attached to one, and the clavicle to the other; and confessed that by means of*

a noose, above the elbow of the child, connected to a towel around her shoulders, she had succeeded in extracting, first one arm without much trouble, and then the other after a great deal of difficulty." It was only with the aid of a consulting physician and after the patient had been anaesthetized that the Fingal doctor managed to turn and deliver the decomposing remains of the baby.⁴³ This case is remarkable on a couple of points. First, was the midwife's barbarous treatment (to use the physician's own expression) of the pregnant woman and unborn child. In all likelihood this case was an extreme one, but it does underscore the point that some midwives were truly ignorant of more humane solutions to complex birthing problems. To be sure, recommended midwifery practice as taught by Dr. E. M. Hodder in Trinity Medical College in the 1870s called for embryotomy, for as one student recorded in his notes, "Far better to perforate [the skull] . . . as our object is to save mother and let child go to pot."⁴⁴ But while the outcome for the child would be the same in both approaches, the physician's methodology using anaesthesia and more refined surgical techniques would likely be less damaging and less harrowing for the mother. Second, based on the information provided, the attending physician only *threatened* to have the woman arrested; no formal action appears to have been pursued.

To try and keep a sense of balance with respect to physician-midwife relations yet other, occasionally gruesome, examples should be cited. "Rusticus," another country practitioner who kept "jogging along" in his "secluded rural" practice, lamented how he had to compete with a local bonesetter and a neighbour who bled and also extracted teeth; a "host of illiterate midwives" also presented a problem for "Rusticus." But although this physician complained about these competitors, he was also disgusted over the incompetence of some of his medical colleagues. In particular, he related the case of "Dr. S." who bungled a delivery and forthwith left his books, instruments, and practice to escape the consequences. "Dr. S." apparently enjoyed a good obstetric practice until he encountered a problem birth in which there was an arm presentation for which he was unprepared. In an effort to facilitate birth, "Dr. S." had "recourse to the brutal expedient of cutting the presenting member with a common jack-knife and left the woman to her fate!" (Another colleague later effected the delivery, but both mother and child died.)⁴⁵ For "Rusticus," therefore, it was necessary to curtail or expose all acts of incompetence whether by "illiterate midwives" or brutal physicians. And another physician recounted *en passant* how he often shared obstetric cases with midwives, a few of which resulted in the death of the mother. Indeed, in one case of childbed fever, this physician stated that the death of the mother may

have been brought about by the midwife's inappropriate administration of castor oil to the mother; but he related this information in a non-accusing or blameful way.⁴⁶

These various clinical accounts involving Ontario doctors and midwives over a period of fifty years yield the following conclusions. First, they are further evidence that midwives were active in Ontario during much of the nineteenth century.⁴⁷ Second, they offer some insights into the actual procedures employed by midwives, which might include the administration of drugs, various surgical procedures, general perinatal examinations, and care of the newborn infant. Moreover, one case suggests midwives and other women helpers probably further aided the mother by offering psychological and social support—important "services" that male physicians might not be able or wish to offer to their patients. Third, there appears to have been a wide range of skills of these women, varying from compassion to ignorance. Fourth, while physicians were not generally against midwives, based on this sampling at least, there appears to have been a consensus that Ontario midwives could and should have been better experienced or trained. Finally, Ontario doctors showed a fairly high degree of tolerance towards those midwives who occasionally blundered; in their published reports doctors did not mention by name those women they criticized, nor did they appear to have taken legal action against them. (By comparison Ontario physicians often criticized their colleagues and others by name or by some other means of identification in the pages of medical journals.)⁴⁸

Additional insights about professional attitudes towards midwives are available in the non-clinical writings of Ontario doctors. In various published letters and editorials, physicians further articulated their varied opinions concerning this form of health care. Writing in January 1874 "A Correspondent" complained to the editor of the *Canada Lancet*⁴⁹ about the "meddlesome interference on the part of old women." In particular the physician objected to being undercut by midwives:

Where I am located I have to contend with two of these old bodies and a quack, who I must say have been pretty successful in their attendance on such cases. They charge \$2 (while I have \$5) for their attendance, and they get about 60 cases a year, which would amount in my hands to a very decent living for my small family.

Certainly implicit in this comment is a motive for the removal of midwives by regular doctors—especially those physicians who were

trying to establish their own practice. Thus the argument that some physicians were not tolerant of midwives on the grounds of economic imperatives must be recognized. And, in a subsequent *Canada Lancet* editorial,⁵⁰ the actions of midwives were also implicitly attacked. After commenting on the superior inventive skills of men vis-à-vis midwifery (“all the instruments of the obstetric armamentarium are the inventions of men”), the editorial continued:

But if woman [*sic*] could only be made intimately acquainted with the truth, that the cultivation of obstetrics by men has been to their advantage by immense odds over what could have been expected of its continued practice by women, what a debt of gratitude would the sex be sensible of owing to man, and how far it would go in overcoming whatever lingering repugnance there may be to the employment of the accoucheur. As it is we believe, the preference for the obstetric practitioner over the midwife is arrived at by every day exhibitions of his superior skill.⁵¹

Notwithstanding the paternalistic tone of this piece, of especial note in this passage is the phrase “lingering repugnance” to employing a male accoucheur, suggesting that some women preferred a midwife to a male doctor for reasons of gender and perhaps decorum rather than merely skill—a sentiment that this medical editor appeared not to appreciate fully.

In another letter, to the editor of the *Toronto Globe* in September 1875,⁵² “Country Practitioner” felt compelled to comment on the amount of “high falutin’ correspondence” and “buncombe and blathering” that had appeared in the *Globe* concerning doctors, licensing, and the practice of medicine. Respecting the drawbacks of female midwifery, “Country Practitioner” noted that in twenty years of medical practice he had “never yet met [a midwife] who had any knowledge of anatomy, who could act whenever the slightest complication occurred, or ever knew it had become necessary to send for a surgeon.” But, by the same token he readily admitted that for the period of the late 1850s to 1875 he knew of no occasion where any woman had been “prosecuted for acting as sage femme [wise woman—midwife]” excepting one incident in Gravenhurst in which the midwife “licked” the attending doctor and was charged with assault.⁵³ Moreover, he stated that during seventeen years of constant attendance at meetings of his county medical society, he had “never heard the subject of interfering with women who practised midwifery mentioned, much less discussed or proposed to be acted upon.” To be sure, this doctor had little respect for midwives, but

it would also appear that he did little to impede their practice. In a word he was ambivalent towards the concept of female midwifery. Also in this year, the executive council of the College of Physicians and Surgeons of Ontario displayed a similar show of mixed feelings towards midwives. These physicians had to respond to a petition from a Kingston midwife named Myers who had practised many years with great success and therefore wished to become a formally licensed midwife. While her petition was bound to be ineffective as no appropriate legislation existed, this case remains instructive. First, her application was supported by several Kingston "medical gentlemen"—another apparent indication that physicians and midwives could collaborate. Second, although Myers was ineligible to register because she lacked a medical diploma, the issue was debated at length by the executive with several members requesting that the midwife at least receive a "courteous answer" to her inquiry. Finally, the incident caused one of those present to resurrect the idea that the College should license midwives. Dr. Campbell noted that he had previously framed an amendment to the Ontario Medical Act that would have permitted territorial districts stipulated by the College to examine and license local midwives.⁵⁴

More letters by Ontario doctors also indicate that while some physicians were openly antagonistic towards midwives, others merely shrugged their shoulders. One doctor, writing in the *Canada Lancet* in March 1879 under the pseudonym "Justice," lamented that in the eastern counties of Ontario there were

one, two, or perhaps three midwives in every section giving their services at the modest rate of one dollar for each accouchement, thus taking the bread out of the mouths of those who have given their time and money to qualify themselves for the practice of the profession, and in many instances jeopardizing the health and prospects, and not unfrequently sacrificin [*sic*] the lives of their dupes.⁵⁵

Protests also arose over the actions of Dr. J. D. Macdonald, President of the College of Physicians and Surgeons of Ontario, who in 1879 ordered that unlicensed midwives were to be exempt from any College prosecution.⁵⁶ Another letter by "Protection" of London⁵⁷ complained that, in effect, the President of the College had "thrown the aegis of the [Medical] Council over a class of individuals who style themselves 'midwives,' although it is well known in all the communities which they infest, that nine-tenths of them possess in no shape or form, any license or document whatever, that any special instruction or knowledge has qualified them for such a title." In particular, what angered "Protection"

was the interpretation of legislation by the Medical Council and College President that the law exempted female midwives from prosecution; that is, males who practised midwifery without a licence could be charged, but not so females. For "Protection," this legal interpretation was both wrong and an outrage for it protected "a lot of 'pseudo-midwives,' who infest every city and town throughout the Province."

This College action clearly hit a nerve with some physicians. The London Medical Association engaged in spirited correspondence with Macdonald, excerpts of which were submitted to the *Canada Lancet* by the Association's secretary, Dr. S. Payne. According to Payne, President Macdonald defended the decision to protect midwives, by arguing that to pursue prosecutions was "indiscreet, and tended much to bring public indignation upon the college" and, further, the Medical Council "did not take that view of the dangers which may be expected to arise from the occupation of a mid-wife . . . but midwives were spoken of as a useful and harmless class of persons, whom it was unjust, and for us, most unwise to molest." The idea that midwives could be harmless caused Payne and his associates especial difficulty, thus he felt compelled to relate the details of three recent cases in which midwives encountered or caused problems (in all three instances the babies died; in two of these cases the mothers died).⁵⁸

Countering these anti-midwife sentiments were the opinions of other doctors, however. William Harris of Brantford criticized "Justice" by writing that as for "old women midwives' looking after a case of ordinary labour, few medical men would care to contend with them about their right to do so."⁵⁹ And, "Fair Play" in another response to "Justice," wrote that while he was firmly behind the move to prosecute unlicensed doctors, he also felt that midwives should be left alone; in his words there were "larger fish to catch here than midwives."⁶⁰ Supporting these points of view, and also the College's action was a surprising *Canada Lancet* editorial that, while noting that it frequently disagreed with the Medical Council, endorsed the pro-midwife position. "The persistent and continuous prosecution of a parcel of ignorant old women [the journal noted], cannot fail to bring the profession and the Council into contempt—especially as when, as one of our eastern correspondents says, there are 'larger fish to catch!'"⁶¹

These letters, case reports, editorials in the professional and lay press, and reviews of pertinent legislative acts all serve to increase our knowledge of female midwifery in Ontario. They indicate that for the first two-thirds of the nineteenth century female midwifery was not illegal in Ontario; while during the remainder of the century, although

the law did change, midwives might continue to practise with relative impunity. In fact as we have seen, the popular press encouraged midwives to continue their activity; so too did not a few doctors, including the President of the Ontario College of Physicians and Surgeons, tacitly approve female midwifery in the province. Of course, there also existed a vocal group of doctors who strongly opposed the midwives primarily on the grounds that they were untrained and ignorant of techniques often necessary during difficult or complex deliveries; they also objected to midwives because of the lower fees that such women charged their clients. Thus in the final analysis one can probably only say that in addition to a wide spectrum of midwife activities there was equally as wide a spectrum of medical opinion ranging from antagonism to ambivalence. It would therefore be problematic to argue that the Ontario medical profession acted *en bloc* to eradicate female midwifery. Also material presented shows that midwives operated widely in the province, in both urban and rural areas; but as stated earlier in this discussion it is not possible to offer an accurate figure of how many actually existed during the period of the late eighteenth to early twentieth centuries. Finally, if the accounts written by several doctors are taken at face value, they suggest that Ontario midwives were women of an advanced age: whether for or against female midwives, much of the material cited has repeatedly drawn attention to the old age of the attending women. While reference to their age was perhaps a subjective evaluation (and perhaps a derogatory one), it could suggest that Ontario's midwives were among an earlier generation of settlers, and further that their daughters or other younger settlers did not pursue the tradition of female midwifery as was the case in Quebec and Newfoundland, for example.

The Erosion of Female Midwifery

In her discussion of midwifery in Ontario, Lesley Biggs concludes that by the turn of the century the Ontario medical profession had made "considerable headway against female midwives, although it had not yet eradicated the movement entirely." To buttress her claim Biggs cites government statistics to the effect that only 3% of all births in Ontario (in 1899) were attended by midwives with the remainder of births being attended by physicians, or apparently by no one at all (16%).⁶² Clearly then by the close of the nineteenth century physicians were in attendance at the overwhelming majority of births in Ontario, and indeed midwives occupied a minor role in the birthing process. Accepting then,

as we should, that female midwifery had declined, what explanation may be put forward for its demise? It is unlikely that any one single reason should be invoked to explain the eventual decline of female midwifery in Ontario. At one level changing legislation vis-à-vis midwifery, although it did contain loopholes, probably intimidated some practising midwives and no doubt discouraged new ones from entering the field. Similarly if, as already suggested, midwives were much older women, then as they retired or died without training a new generation of replacements, female midwifery would very likely become extinct within the province. Of course, the arrival of European immigrants, some of whom must have had midwifery experience, may have augmented the ranks of midwives in Ontario; again, it is not possible to explore this issue further owing to lack of documentary evidence. In the final analysis, as midwives do not appear to have become organized or registered, or to have established their own training programs (as occurred in Britain, Europe, and the United States), their knowledge and skills were never disseminated.⁶³ Ironically, it is possible to speculate that any influx of new, European midwives might have actually been a disruptive influence because in certain rural communities midwife-client relationships were often fragile and “outsiders” were regarded with suspicion and were not quickly accepted.⁶⁴

General trends in the development of Victorian medicine have been cited, especially in American studies, as a major cause of the demise of female midwifery. The rise and proliferation of the modern general hospital that occurred at roughly the same period might well be imagined as an important factor; but such a supposition would be erroneous.⁶⁵ As Jo Oppenheimer has convincingly demonstrated, it was not until post-World War I that hospital births became ascendant.⁶⁶ Similarly we have the example of the testimony of one prominent Ontario general practitioner who noted that it was “not until well after the mid-twenties that hospital confinements became popular and I could refuse to accept pregnant patients unless they agreed to go into hospital.”⁶⁷

Other broad causal explanations should be tempered for Ontario, at least. Although discussed by the medical profession, the indiscriminate use of forceps, for example, appears not to have occurred in nineteenth-century Ontario medicine. Students at the Trinity Medical College in the early 1870s, while taught about instrumental labour, generally speaking were advised against its overuse. Rather, students were told “where head of child is making very slow but sure progress . . . leave it to nature,” for in cases where forceps were used there was a 1 in 13 chance of mothers dying, compared with 1 in 30

with no interference.⁶⁸ One analysis of the obstetric records of Dr. Walter H. Burritt, an Ontario physician who delivered 1,854 babies from 1835 to 1886, shows that in only 104 cases were forceps used. Thus on the average this contemporary practitioner used instrumental delivery twice every year; but the frequency of the use of forceps did increase over the period of Burritt's professional life from 1 in every 60 deliveries to 1 in 10 deliveries. (The most common reason for employing forceps was "want of [labour] pains" in 46 out of 104 cases, followed by "disparity—large head" in 27 out of 104 cases.)⁶⁹ Similarly, an analysis of the notebooks of Dr. Hugh MacKay of Woodstock for the period of 1873 to 1889 reveals that he used forceps in only 18 of 935 deliveries. And, like Burritt, MacKay used instrumental intervention only in particularly difficult cases, and he noted further that he generally "got along well" without their use.⁷⁰ However, a recent study of another physician's notebooks shows that his use of forceps did increase over the latter half of the nineteenth century. However, in her analysis of James Langstaff's use of forceps, Jacalyn Duffin notes how prudent he was in their use. She concludes that this "ordinary" Ontario physician did not abuse this procedure; she also presents material that illustrates Langstaff's disdain for a colleague's ignorance of proper forceps technique. Also noteworthy is one case where Langstaff did not employ forceps at the request of his patient.⁷¹

Corroborating evidence of physicians advocating the moderate use of forceps is found in contemporary medical journals. The editor of the *Canada Lancet* noted in 1879 that "in the very large majority of cases of all labors, the powers of nature are quite adequate to the safe, and generally facile, expulsion of the child." Moreover, this editorial criticized the overzealous practitioner "who rushes to the forceps, simply to economise his own time," and suggested that such a doctor should either take a partner or give up his practice altogether.⁷² Noteworthy too is an 1885 letter of complaint from a Hastings physician about an American medical colleague who advocated the use of forceps in every delivery. This Ontario doctor stated that "the proportion of cases really requiring instrumental aid are so few, that to carry them [forceps] always entails a deal of unnecessary trouble." He further claimed that in fifty-five years of practice he used forceps a dozen times.⁷³ Finally, in a contemporary review of the activities of the Toronto Burnside Lying-In Hospital for the nine-year period 1888 to 1897, Dr. Adam Wright noted that there had been 1,259 deliveries with eight deaths. In particular, when discussing "meddlesome" or "interventionist" practices he noted that in this major maternity *cum* teaching hospital catheterization was

“considered an evil” and the use of forceps was “discouraged”; in fact, Wright declared “no resident assistant is allowed to apply the forceps without the permission of the medical superintendent or a member of the visiting staff.” Moreover, hospital records showed that in the last 500 cases, labour had been assisted by the use of forceps only three times.⁷⁴

Another reason for physicians to be judicious in their use of forceps was the possibility of being charged with malpractice. The case of *McQuay vs. Eastwood*, while apparently an isolated incident, remains instructive in this regard. In 1886 a Toronto court heard the case of a Mr. McQuay who sued his wife’s physician, Dr. Eastwood of Whitby, for negligence and want of skill in the latter’s use of forceps during Mrs. McQuay’s confinement for childbirth. The evidence put forward stated that as a result of the physician’s actions, the mother suffered lacerations of the perineum and cervix which, it was advocated, led to septicaemia. The jury found for the plaintiff, awarding him three hundred and fifty dollars; but a later appeal by Eastwood saw the case dismissed. Briefly, because it was agreed that any case of septicaemia or puerperal fever could arise “spontaneously,” it was not possible to attribute the onset of infection directly to the physician’s use of forceps and any consequent injury. Furthermore, because the plaintiff’s lawyer specifically identified the use of forceps as the primary problem in the original suit, the appeal judges felt that the malpractice argument was not convincing. This case, however, was noted in the medical press, and may well have caused some physicians to think twice about the employment of forceps in cases in which there already was some element of doubt.⁷⁵

A more involved state of affairs prevails with respect to anaesthetic methods. In general, Ontario physicians induced anaesthesia in labour only rarely and with caution. Dr. Burritt’s obstetric notes reveal that chloroform was used only twice in 1,828 obstetrical cases; moreover, his records show that he first used chloroform in 1877—thirty years after it was initially introduced to the profession as an anaesthetic agent.⁷⁶ In the twenty-six years of medical practice recorded by Dr. MacKay, chloroform was used in 18 of 935 cases and then, only “slightly.”⁷⁷ And, in several thousand births James Langstaff used chloroform in only a handful of cases.⁷⁸ Also instructive is the 1885 editorial comment, which called for caution when administering anaesthetics during childbirth: noting that the use of chloroform and ether had “been quite fashionable . . . especially in American cities,” it reminded Ontario doctors that the “exhaustion caused by ordinary labour is soon recovered from, but not so the depression induced by chloroform or ether, which sometimes continues for days.”⁷⁹

That Ontario doctors used anaesthetic agents sparingly (perhaps unlike some of their American counterparts) appears to be the case, yet it has been propounded that the use of anaesthesia, and other "scientific" procedures, was somehow foisted upon women by male doctors to assert their superiority over midwives.⁸⁰ While this may certainly have been the case with some practitioners, there is evidence to suggest that other imperatives were involved. For example, according to one practitioner upon his entering the patient's room, the woman "begged of [him] most piteously to give her the chloroform, saying that she never yet experienced such agony as she was then enduring. She would barely allow me time for the necessary examination, so urgent was she to be relieved from suffering."⁸¹ Similarly, the prominent Ontario surgeon, William Canniff, declared in 1868 that it was his custom "to always carry with him chloroform when called to attend a case of midwifery, to be given *if desired by the patient*, and the number desirous of having it is steadily increasing."⁸² Such statements indicate that patient persuasion and desire for choice were factors in doctors' decisions to use anaesthetics. That is, often some women desired chloroform to ease their pain during labour; thus any "redefinition" process of childbirth was not wholly a physician-dominated act nor was it designed to eradicate midwives.⁸³

Similarly, the effect of another facet of the Victorian scientific revolution in medicine on midwifery, that of antiseptic/aseptic technique, should be reviewed. The adoption of antiseptic/aseptic practices (the collective practice of maintaining a clean or sterile operating environment—Listerism) by Canadian practitioners was a slow and, at times, noisy affair; for almost thirty years (until the 1890s) this topic was a prominent one in Canadian medical periodicals.⁸⁴ Indeed, many Ontario physicians vociferously opposed antiseptic practices; only in the last decade of the nineteenth century was some consensus forged.

Again in his analysis of Toronto's Burnside maternity hospital, Adam Wright noted that of the 1,259 deliveries during 1888 to 1897 there had been eight deaths, five of which were attributed to septicaemia. Although not wholly satisfied with the death rate, Wright was encouraged by the decreasing incidence of septicaemia owing to the introduction of aseptic procedures in 1891. Interestingly, Wright noted that aseptic midwifery in this institution was very much in the hands of the head nurse or matron "who is the most skilful midwife and the best teacher of aseptic and anti-septic nursing in midwifery that I have ever met."⁸⁵ And, one of the main problems encountered in instituting the new cleanliness precautions was the reaction of the "resident assistants"

who either ignored the rules or “obeyed the directions in a half-hearted way.” Hence, despite the “scientific” appeal of aseptic procedures, some institutions did not follow them until almost the close of the nineteenth century; and these practices were not necessarily well received, even by a new generation of doctors. In addition to this information, Wright’s comments also clearly indicate that he, for one, was still able to respect a midwife—as long as she was “skilful.” Finally, the *Canada Lancet* editorialized that “antiseptics may come and go, and all kinds of new-fangled theories and practices, but that obstetrician who has most faith in Nature, and also makes patience, discrimination, cleanliness, and moderate conservatism his guiding star, will be able to show a record second to none.”⁸⁶ In short, even by the late nineteenth century antiseptic/aseptic technique was just beginning to make inroads into general midwifery practice. At this time techniques were not sufficiently widespread to clearly discriminate against midwives—if they ever did. Indeed, based on Wright’s testimony the most proficient teacher of aseptic practices he had met was a midwife—a clear indication that this supposed means of exclusion for midwives was actually anything but that.

What, then, was the collective effect of these scientific developments on female midwifery in Ontario? To be sure, the use of forceps, anaesthesia and aseptic methods did indeed give Ontario physicians the “wherewithal to interfere in childbirth more than any midwife would dare.” And, there must have been some doctors who indeed did abuse these techniques perhaps to underscore the difference between them and midwives. But, based on the material presented in this discussion, the general professional attitude and response towards the new “technological obstetrics” were both cautious and judicious. Although there appears to be few grounds for arguing that Ontario doctors overtly used these new techniques in order to gain ascendancy over midwives who were practising in the province, with the gradual acceptance and eventual widespread implementation of such birthing technology, “instrumental interference” did mean that doctors were “separated” from midwives.⁸⁷

Altogether, then, the practice of female midwifery declined in nineteenth-century Ontario as a result of a combination of attrition and erosion. As midwives themselves got older they did little to ensure a future generation of practitioners; thus without an adequate supply of “new” midwives, numbers were bound to dwindle. Concurrent with this process were others that helped erode female midwifery within the province. As noted, changing legislation must have had some negative

effect upon midwives, but in itself it cannot be held solely responsible for their decline.⁸⁸ Similarly, medical technological developments in childbirth no doubt helped to replace the midwife in the birthing chamber, but again as there did not exist a medical consensus over the use of new obstetric techniques, such changes were only partially instrumental in displacing traditional female midwifery practices.

Although its practice declined by the end of the century, female midwifery clearly constituted an acceptable form of health care in Ontario throughout the nineteenth century. While many of the earlier midwives may have taken formal training before arriving in the province, many more acquired their skills primarily through observation, common sense, and personal experience. By all accounts female midwives appear to have been fairly widespread, but exactly how many there may have been at any time is impossible to say. Also, as there was no formally designated idea of what constituted a midwife in Ontario, it is likely that the term embraced a broad spectrum of practitioners who possessed a widely variable repertoire of skills. The very existence of such midwives permitted some pregnant women an element of choice in the gender and approach of their birth attendants. Similarly, the occupation of midwife often allowed these women practitioners an income, role, and status within their communities. But it was also likely that for many other Ontario midwives, their activities were an extension of routine domestic work inasmuch as their midwifery tasks constituted unwaged labour. And, probably as a result of the diverse nature of this group, physicians' attitudes to female midwives varied greatly too. We have seen that physicians could work along with some midwives and respect them for their skills and recognized their contribution to the health of many Ontarians; others, however, were severely critical of them. It has also been argued that for most of the nineteenth century provincial legislation did nothing to prevent female midwifery, while for the latter third of the century changed legislation could have dissuaded some midwives; but in practice they were free to continue. Sporadic midwife activity endured into the early twentieth century in remote and northern areas of the province, but for all intents and purposes the midwife had faded from Ontario's health care scene by this time.

Endnotes

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some of their unpublished research material with me; thanks, too, to C. Lesley Biggs, Judith Walzer Leavitt, Janet McNaughton, and the editors of this volume for their useful critiques of an earlier version of this paper.

1. For an overview of the varied medico-historical treatments of this topic from physicians' perspectives, see Harold Speert, *Obstetrics and Gynecology in America: A History* (Chicago: American College of Obstetricians and Gynecologists, 1980); James V. Ricci, *One Hundred Years of Gynaecology, 1800–1900* (Philadelphia: Blakiston, 1945). See also James V. Ricci, *The Development of Gynaecological Surgery and Instruments* (Philadelphia: Blakiston, 1949); Harold Speert, *Iconographia Gyniatrica: A Pictorial History of Gynecology and Obstetrics* (Philadelphia: F. A. Davis, 1973); Irving Cutter and Henry R. Viets, *A Short History of Midwifery* (Philadelphia: W. B. Saunders, 1964); Walter Radcliffe, *Milestones in Midwifery* (Bristol: John Wright and Sons, 1982).

On the development of midwifery see Jean Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth* (London: Historical Publications, 1988); and Betty Cowell and David Wainwright, *Behind the Blue Door: The History of the Royal College of Midwives, 1881–1981* (London: Bailliere Tindal, 1981); Jane B. Donegan, *Women and Men Midwives: Medicine, Morality, and Misogyny in Early America* (Westport, CN: Contributions in Medical History 2, Greenwood Press, 1978); Judy Litoff, *American Midwives, 1860 to the Present* (Westport, CN: Contributions in Medical History 1, Greenwood Press, 1978); Frances Kobrin, "The American Midwife Controversy: A Crisis of Professionalization," *Bulletin of the History of Medicine* 40 (1966): 350–363. See also Wanda Heistand, "Midwife to Nurse-Midwife: A History of the Development of Nurse-Midwifery Education in the Continental United States to 1965" (Ed.D. thesis, Columbia University, 1976); Catherine Scholten, "On the Importance of the Obstetrick Art: Changing Customs of Childbirth in America 1760–1825," *William and Mary Quarterly* 34 (July 1977): 426–445; Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* (New York: The Free Press, 1977); Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (New York: Oxford University Press, 1986). For the most recent comprehensive historiographic review of midwifery in the United States, see Judy Barret Litoff, "Midwives and History," in Rima Apple, ed., *Women, Health, and Medicine in America* (New York: Garland, 1990), 443–458.

2. For historical analysis of midwifery in Canada on a national level see [Jutta Mason], "A History of Midwifery in Canada," in *Report of the Task Force on the Implementation of Midwifery in Ontario* (Toronto: Task Force on the Implementation of Midwifery, 1987), 197–232. See also Beth Rushing, "Market Explanations for Occupational Power: The Decline of Midwifery in Canada," *American Review of Canadian Studies* 21 (1991): 7–27 and Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality," in Linda Kealey, ed., *A Not Unreasonable Claim: Women and Reform in Canada 1880s to 1920s* (Toronto: Women's Press, 1979), 131–149.

Regional studies of midwifery include Cecilia Benoit, "Traditional Midwifery Practice: The Limits of Occupational Autonomy," *Canadian Review of Sociology and Anthropology* 26 (1989): 633–649; Benoit, "Mothering in a Newfoundland Community: 1900–1940," in Katherine Arnup, Andrée Lévesque, and Ruth Roach Pierson, eds., *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries* (London: Routledge, 1990), 173–189; Benoit, *Midwives in Passage: The Modernisation of Maternity Care* (St. John's: Institute of Social and Economic Research, 1991); Janet McNaughton, "The Role of the Newfoundland Midwife in Traditional Health Care, 1900 to 1970" (Ph.D. dissertation, Memorial University of Newfoundland, 1989); Kathy Kuusisto, "Midwives, Medical Men and Obstetrical Care in Nineteenth-Century Nova Scotia" (M.A. thesis, University of Essex,

1980) cited in Veronica Strong-Boag and Kathryn McPherson, "The Confinement of Women: Childbirth and Hospitalization in Vancouver, 1919-1939," in Arnup et al., *Delivering Motherhood*, 75-107; Toby Gelfand, "Medicine in New France," in Ronald L. Numbers, ed., *Medicine in the New World* (Knoxville: University of Tennessee Press, 1987), 64-100 (see esp. p. 84); H el ene Laforce, *Histoire de la Sage-Femme dans la R egion de Qu ebec* (Quebec: Institut Qu eb ecois de Recherche sur la Culture, 1985); and Laforce, "The Different Stages of the Elimination of Midwives in Quebec," in Arnup et al., *Delivering Motherhood*, 36-50; C. Lesley Biggs, "The Case of the Missing Midwives: A History of Midwifery in Ontario from 1795-1900," *Ontario History* 75 (1983): 21-35. This article in a revised form has recently been reprinted in Arnup et al., *Delivering Motherhood*, 20-35 (all references to Biggs in this discussion will be to this more recent reference).

3. To date no scholarly survey of medical history for Ontario has been produced, but useful sources include Charles G. Roland, ed. *Health, Disease and Medicine: Essays in Canadian Medical History* (Toronto: Hannah Institute, 1984); S. E. D. Shortt, ed., *Medicine in Canadian Society: Historical Perspectives* (Montreal, Kingston: McGill-Queen's University Press, 1981, 1992); and J. T. H. Connor, "Minority Medicine in Ontario, 1795 to 1903: A Study of Medical Pluralism and Its Decline" (Ph.D. dissertation, University of Waterloo, 1989).

4. Judi Coburn, "'I See and Am Silent': A Short History of Nursing in Ontario," in Janice Acton et al., eds., *Women at Work: Ontario, 1850-1930* (Toronto: Canadian Women's Educational Press, 1974), 127-163 (see Table B, 163).

This problem of terminology is highlighted by comparing Ontario's situation with that of the province of Quebec. For example, in 1850 the *British American Journal* published a list of eleven names of midwives who were "duly licensed" for practice in the cities of Montreal, Quebec and Chambly, indicating clearly that there existed a class of women practitioners recognized as professional midwives by the College of Physicians and Surgeons of Canada East (see "Midwives Enregistered," *British American Journal of Medical and Physical Science* 5 [1850]: 194).

In Canada East, then, "properly qualified" midwives were identified as such. Since in Canada West/Ontario no such register of professional midwives ever existed, the term "midwife" in contemporary writing must be understood to refer to a wide spectrum of practitioners. For example, in the Peterborough area several midwives or birth attendants have been identified as existing. These women, however, variously have been described as "midwives," "nurse-midwives," "family doctor" and "practical nurse." At least one of these women was also known to have practised homeopathic medicine; many others also prepared the dead for burial. See John Walter Martyn, *The Past Is Simply a Beginning: Peterborough Doctors, 1825-1993* (Peterborough: n.p., 1993). Similarly, Jacalyn Duffin in her detailed study *Langstaff: A Nineteenth-Century Medical Life* (Toronto: University of Toronto Press, 1993) notes that although in fourteen obstetrical cases women assisted in the birth, none were described by Langstaff as a midwife—this despite the fact that Langstaff himself seemed to endorse the concept of midwives assisting in his practice (see 185-186).

For an excellent case study that underscores the importance of differentiating between types of midwives, see Charlotte G. Borst, "The Training and Practice of Midwives: A Wisconsin Study," *Bulletin of the History of Medicine* 62 (1988): 606-627.

5. Jennifer J. Connor and Jean Harris, "Estate Records of Health Practitioners in Ontario, 1793-1900," *Canadian Bulletin of Medical History* 10 (1993): 115-143.

6. Quoted in William Canniff, *The Medical Profession in Upper Canada, 1783–1850* (1894; reprint ed., Toronto: Hannah Institute for the History of Medicine, 1980), 20.
7. *Ibid.*, 22.
8. Biggs, "Case of the Missing Midwives," 21; Ronald Hamowy, *Canadian Medicine: A Study in Restricted Entry* (Vancouver: Fraser Institute, 1984), 14.
9. Quoted in Canniff, *The Medical Profession*, 31.
10. For a fuller discussion of this act see Elizabeth MacNab, *A Legal History of Health Professions in Ontario* (Toronto: Queen's Printer, 1970), 10–12; Hamowy, *Canadian Medicine*, 68–69.
11. "Draft of a Bill to Amend the Ontario Medical Act," *Canada Lancet* 6 (1873): 62–65.
12. "Draft of the Medical Bill," *Canada Lancet* 6 (1873): 69.
13. "Amendments to the Ontario Medical Act," *Canada Lancet* 9 (1877): 190.
14. "The Registration of Midwives," *Ontario Medical Journal* 2 (1893–1894): 6–7.
15. For further general information on the Patrons of Industry see S. E. D. Shortt, "Social Change and Political Crisis in Rural Ontario: The Patrons of Industry, 1889–1896," in Donald Swainson, ed., *Oliver Mowat's Ontario* (Toronto: Macmillan, 1972), 211–235; John D. Smart, "The Patrons of Industry in Ontario," (M.A. thesis, Carleton University, 1969).
16. Shortt, "Social Change and Political Crisis," 217.
17. "The Medical Council," *The Canada Farmers' Sun* (20 March 1895): 8.
18. See for example the various letters, editorials and articles against the Medical Council of Ontario that appeared in *The Canada Farmers' Sun*, especially 19 September 1894, 3 October 1894, 10 October 1894, 24 October 1894.
19. C. David Naylor, "Rural Protest and Medical Professionalism in Turn-of-the-Century Ontario," *Journal of Canadian Studies* 21 (1986): 5–20.
20. See G. Sterling Ryerson's letter to the President, Council and Members of the College of Physicians and Surgeons of Ontario, reprinted in *Canadian Medical Review* 1 (19 March 1895): 1–5.
21. Background to the state of knowledge of midwifery for M.D.'s at this time may be gained from examining W. S. Playfair, *A Treatise on the Science and Practice of Midwifery* (Philadelphia: Lea Brothers, 1885).
22. "The Act to Amend the Ontario Medical Act," *Ontario Medical Journal* 3 (1895): 251–252.
23. Editorial, *Toronto Globe* (1 April 1895): 4.
24. Quoted in Eric Hounsome, *Toronto in 1810 (Daily Life)* (Toronto: Coles, 1975), 72.
25. Advertisement, *Colonial Advocate* (1 May 1828): 6.
26. See, for example, advertisement, *Colonial Advocate* (8 October 1829): 3.
27. This advertisement appeared in the *Christian Guardian* from 22 September 1841 to 1 June 1842.
28. See Edith Firth, ed., *The Town of York 1815–1834: A Further Collection of Documents of Early Toronto* (Toronto: University of Toronto Press, 1966), 226–227.
29. Mary O'Brien, *The Journals of Mary O'Brien* (Toronto, 1968): 231–232. For a fuller discussion of Mary O'Brien and her diaries see Linda S. Siegel, "Child Health and

Development in English Canada, 1790–1850," in Charles G. Roland, ed., *Health, Disease and Medicine: Essays in Canadian History* (Toronto: Hannah Institute, 1984), 360–380.

30. Susanna Moodie, *Roughing It in the Bush* (1852; reprint ed., Toronto: McClelland and Stewart, 1962), 163.

31. Details of this incident are contained in a series of letters and editorials published in the *Globe* from mid-August to mid-September 1874; see 18 August, p. 2; "Midwives Beware," 19 August, p. 2; "The Midwives," 24 August, p. 2; "The Midwives [Letter]," 24 August, p. 2; "Midwifery Again [Letter]," 2 September, p. 2; "Medical Oppression," 2 September, p. 2; "The Last of the Gravenhurst Case," 10 September, p. 2; and "Midwifery Again [Letter]," 10 September, p. 2.

32. See for example "Medicus on the War-Path," *Globe* (24 August 1875): 2; "Medical Conservatism," *Globe* (27 August 1875): 2; "The Doctors and Our Corns," *Globe* (31 August 1875): 2. These issues also contained a variety of letters to the editor.

33. "Medical Monopoly," *Globe* (4 September 1875): 4.

34. "Medical Monopoly," *Globe* (13 September 1875): 2.

35. "W," *Kingston Gazette* (18 November 1815): 2.

36. "W," "To the Public," *Kingston Gazette* (11 November 1815): 2.

37. Quoted in Firth, *Town of York*, 236–237.

38. John R. Dickson, "A Case of Impregnation with Imperforate Hymen," *Upper Canada Journal of Medical, Surgical and Physical Science* 1 (1851): 109–110.

39. F. S. Verity, "Case illustrative of the difficulties to be encountered by the Practitioner of Midwifery in a rural practice," *Medical Chronicle* 2 (1854): 260–262. Similarly when another physician described an attending midwife he encountered on being "extremely ignorant," it is possible that his criticisms were directed solely at this particular woman and not all Ontario midwives in general. See R. W. Evans, "Case of Expulsion of the Foetus at Full Time with the Membranes Entire," *Canada Medical Journal and Monthly Record of Medical and Surgical Science* 1 (1852): 146–147.

40. Charles Rolls, "Case of Twins, in which, after the birth of the first Child, the second was retained by hour-glass contraction of the Uterus," *Upper Canada Journal of Medical, Surgical and Physical Science* 1 (1851): 152–153.

41. Rolls, "Case of Preternatural Labour," *Upper Canada Journal of Medical, Surgical and Physical Science* 1 (1851): 107–109.

42. See Edwin Seaborn, *The March of Medicine in Western Ontario* (Toronto: Ryerson Press, 1944), 89–90; Canniff, *The Medical Profession*, 77.

43. J. M. Pemwarden, "Barbarous Treatment by a Midwife," *Canada Lancet* 4 (1872): 273–274.

44. Alexander MacLaren Lecture Notebook, Trinity College, Toronto, 4th year, 1872–1873, Department of History of Medicine, University of Western Ontario, London, Ontario.

45. "Rusticus," "Correspondence," *British American Journal of Medical and Physical Science* 3 (1847): 81–82.

46. William Kerr, "On Ephemeral or Child-Bed Fever," *Canada Lancet* 6 (1873): 41–46. Similarly, James Langstaff is recorded as chastizing some of the women who assisted/attended his cases of childbirth, but his comments appear to be more collegial commentaries than malevolent criticisms. Indeed, it appears that Langstaff got on well with most of

these women and, therefore, had no problem with their presence during childbirth. See Duffin, *Langstaff*, 185–186.

47. In her discussion of female midwifery, C. Lesley Biggs uses the term “movement.” However, as no evidence has yet surfaced that would show Ontario midwives were organized or attempted to organize themselves with some coherent goal, the term seems inappropriate.

48. See, for example, “Malpractice in Midwifery,” *Canada Lancet* 6 (1874): 349. A different but related incident is worth recounting in this regard. In an exchange in one journal, a physician had to explain an error in his licence, which showed him competent in midwifery only, not physic, surgery and midwifery. For the journal’s editor, to be licensed in this field only was wholly unacceptable, for obstetric work demanded competence in the other fields. The administrative mistake was soon explained, but this minor row is revealing. It demonstrates that physicians might be critical not only of some women who practised midwifery, but also males who were perceived to be, in effect, men midwives. See “A Licence Faulty in Principle,” *British American Medical and Physical Journal* 6 (1850): 515–516, and “Correspondence,” *British American Medical and Physical Journal* 7 (1851): 42–43.

49. “A Correspondent,” “An Objection to a Certain Portion of the Proposed Medical Act,” *Canada Lancet* 6 (1874): 150.

50. “The Cultivation of Obstetrics,” *Canada Lancet* 7 (1875): 57–59.

51. *Ibid.*, 57.

52. “Country Practitioner,” “Midwifery and the Medical Controversy,” *Globe* (11 September 1875): 5.

53. This reference is, no doubt, to the previously described incident of the midwife who was fined for illegally practising medicine, not for assault.

54. “College of Physicians and Surgeons of Ontario,” *Globe* (14 July 1875): 4.

55. “Justice,” “What Has the Ontario Medical Board Done for the Profession?” *Canada Lancet* 11 (1878–1879): 262–263.

56. “The Ontario Medical Council,” *Canada Lancet* 12 (1879): 93.

57. “Protection,” *Canada Lancet* 12 (1878–1879): 138–139.

58. “Letter to Editor,” *Canada Lancet* 12 (1879): 168–169.

59. William T. Harris, Letter to Editor, *Canada Lancet* 11 (1878–1879): 291–292.

60. “Fair Play,” “Public Prosecutor,” *Canada Lancet* 12 (1879–1880): 136–137.

61. “Medical Protection,” *Canada Lancet* 12 (1879): 157.

62. Biggs, “The Case of the Missing Midwives,” 28.

63. An example of the dissemination process of the skills of midwifery may be seen in the case of three generations of French Canadian midwives. See Roger Paradis, “Henriette, *la capuche*. The Portrait of a Frontier Midwife,” *Canadian Folklore canadien* 3 (1981): 110–126.

64. I am grateful to Dr. Janet McNaughton who brought this insight to my attention based on her extensive knowledge of midwifery in Newfoundland. Although the argument as applied to nineteenth-century Ontario must remain unsubstantiated, it nevertheless is useful.

65. For background on the development of the hospital in Ontario, see [A. A. Allan], *The Hospitals of Ontario: A Short History* (Toronto: Department of Health, 1934); G. Harvey

Agnew, *Canadian Hospitals, 1920 to 1970: A Dramatic Half Century* (Toronto: University of Toronto Press, 1974); and David Gagan, *A Necessity Among Us: The Owen Sound General and Marine Hospital* (Toronto: University of Toronto Press, 1990).

66. See Jo Oppenheimer, "Childbirth in Ontario: The Transition from Home to Hospital in the Early Twentieth Century," *Ontario History* 75 (1983): 36–60.

67. William V. Johnston, *Before the Age of Miracles: Memoirs of a Country Doctor* (Don Mills: PaperJacks, 1975), 35.

68. Alexander MacLaren Lecture Notebook.

69. Melville C. Watson, "An Account of an Obstetrical Practice in Upper Canada," *Canadian Medical Association Journal* 40 (1939): 181–188; see 184.

70. Hugh M. MacKay Notebooks, Archives of Ontario, Toronto, Miscellaneous MSS collection, 1873, #6, MU 2118.

71. See Jacalyn Duffin, "A Rural Practice in Nineteenth-Century Ontario: The Continuing Medical Education of James Miles Langstaff," *Canadian Bulletin of Medical History* 5 (1988): 3–28. For a fuller discussion see her *Langstaff: A Nineteenth-Century Medical Life*, 185–186.

72. "Rabies Gynecologica," *Canada Lancet* 12 (1879): 87–88.

73. R. W. Clark, "The Use of the Forceps," *Canada Lancet* 18 (1885): 73. Clark's letter might suggest that American obstetric practices were greatly different from those of Ontario.

74. Adam Wright, "Notes on Methods and Results in the Burnside Lying-In Hospital, Connected with the Toronto General Hospital, Toronto," *Canada Medical Review* 6 (1897): 155–162.

75. See "McQuay et al. v. Eastwood," James F. Smith ed., *Ontario Reports* (Toronto: Rowell and Hutchinson, 1887), 12: 402–411; see also notices in *Canadian Practitioner* 11 (1886): 350, 383.

76. Watson, "An Account of an Obstetrical Practice," 186.

77. MacKay Notebooks.

78. See Duffin, *Langstaff*, 199–201.

79. "Meddlesome Midwifery," *Canada Lancet* 18 (1885): 25–26.

80. See, for example, Biggs, "The Case of the Missing Midwives," 31, 32.

81. James B. Johnston, "Chloroform in Midwifery," *British American Journal of Medical and Physical Science* 3 (1847–1848): 324–325.

82. Canniff, "A Few Thoughts Respecting the After-Birth," *Canadian Medical Journal* 4 (1867–1868): 385–388. See also J. F. Dewar, "A Case of Partial Placenta Praevia," *Dominion Medical Journal* 1 (1862): 103–106, in which he states that his pregnant patient "insisted" on the administration of chloroform as it had been her "habit" in her two former labours.

83. Women in America were instrumental in advancing anaesthesia in midwifery too. See Leavitt's "'Science' Enters the Birthing Room: Obstetrics in America since the 18th Century," in Judith Walzer Leavitt and Ronald L. Numbers, eds., *Sickness and Health in America: Readings in the History of Medicine and Public Health*, 2nd ed. (Madison: University of Wisconsin Press, 1985), 81–97. See also John Duffy, "Anglo-American Reaction to Obstetrical Anesthesia," *Bulletin of the History of Medicine* 38 (1964): 32–44, who argues that American physicians were not especially quick to embrace anaesthetic methods in childbirth.

84. See J. T. H. Connor, "Joseph Lister's System of Wound Management and the Canadian Medical Practitioner, 1867-1900" (M.A. thesis, University of Western Ontario, 1980); and Connor, "Listerism Unmasked: Antisepsis and Asepsis in Victorian Anglo-Canada," *Journal of the History of Medicine and Allied Sciences* 49 (1994): forthcoming. See George E. Armstrong, "Antiseptic Midwifery," *Canada Medical Record* 13 (1885): 169-171.
85. Wright, "Notes on Methods," 155.
86. "Meddlesome Midwifery," 26.
87. Wendy Mitchinson, "Historical Attitudes towards Women in Childbirth," *Atlantis* 4 (1979): 13-34 (see p. 26).
88. Conversely, of course, the enactment of any legislation that supported midwives would have helped to institutionalize this occupational group. But, as the case of midwifery in the Netherlands shows, legislative action that may be advantageous may be professionally highly restrictive too. See M. J. Van Lieburg and Hilary Marland, "Midwife Regulation, Education, and Practice in the Netherlands during the Nineteenth Century," *Medical History* 33 (1989): 296-317.
89. For a general discussion of women, labour and the economy of Ontario, see Marjorie Griffin Cohen, *Women's Work, Markets, and Economic Development in Nineteenth-Century Ontario* (Toronto: University of Toronto Press, 1988). Regarding midwives, Cohen notes how "surprisingly small" was the number of these practitioners compared to teachers and nurses, for example (p. 148).

6

Helen MacMurchy: Popular Midwifery and Maternity Services for Canadian Pioneer Women*

DIANNE DODD

Over the course of the nineteenth and twentieth centuries, male medical practitioners successfully asserted control over more and more aspects of the traditional mothering role.¹ The medicalization of childbirth, which saw a transition from midwifery with its emphasis on “natural” childbirth to physician-controlled and eventually hospital-based birthing, is one aspect of this phenomenon.² Recently, historians have begun to investigate the role played by middle-class women in this process, focussing on their efforts to provide birthing women with the undeniable benefits of medical science, while at the same time trying to minimize the alienation and loss of control that came with it.³ This paper will focus on the role of professional women. Did women physicians and nurses, subservient to the wishes of male physicians, desert the midwife, denigrating her skills and reinforcing her association with domestic labour, in order to secure for themselves a niche in the professional world, as the early historiography has suggested?⁴ By examining the role of Helen MacMurchy, one prominent Canadian woman physician, in improving maternity care for Canadian women in isolated areas, I hope to show that professional women’s relationship with their “untrained” sisters was somewhat more ambiguous. Like their male colleagues, middle-class women were motivated by the eugenics movement, which focussed on infant and maternal health as a means to both improve “the race,” and preserve the authority and prestige of the movement’s professional leaders.⁵ However, within this shared sympathy for professional solutions, there are gender-based differences worthy of investigation.

The deluge of official advice literature in the 1920s on child and maternal welfare, much of it written by professional women, certainly helped to propagandize medical professionalization,⁶ and undermine the role of midwives.⁷ There is one document, however, that is

something of an exception to the prevailing norm of telling mothers to call the doctor for every imaginable problem. In 1923, the newly formed federal Department of Health, issued a supplement to its widely read *Canadian Mother's Book*,⁸ part of the Blue Book series, written by Dr. Helen MacMurphy, Chief of the Department's Child Welfare Division. MacMurphy's advocacy of prenatal care, rest, nutrition, cleanliness, and especially physician-attended births,⁹ was impossible for outpost women to achieve because physician and nurse services were unavailable. The *Supplement* was written exclusively for outpost women and their "untrained" neighbours who often assisted at births because no one else was available.¹⁰

The *Supplement* was highly contradictory in tone and message and consequently quite revealing. Ostensibly a manual of advice on "what to do if baby arrives before the doctor does," it was in reality a "popular midwifery" guide. Its confused message indicates an author personally torn between a desire to ensure maternal safety through medical science, and the need to provide pioneer women with a safe alternative, given the paucity of medical services in isolated areas. MacMurphy's ambivalence stemmed from the difficult role she played in mediating the diverse and conflicting interests participating in the early twentieth century debate on midwifery and maternal mortality. Sympathetic to women's groups who sought to improve the level of care Canadian mothers received in the outpost communities, MacMurphy also had to placate the more powerful medical profession, who insisted on an obstetrical monopoly, and her employer, the federal government, who recklessly promoted western and northern settlement.

The *Supplement* also reflects a compromise position on midwifery. Shifting from an earlier preoccupation with infant mortality alone, the public health movement was, by the 1920s, focussing on maternal mortality. This came with the realization that reductions in the infant mortality rate, achieved from the 1890s to World War I, had occurred in the last eleven months of the first year of infant life. Deaths occurring in the first month of life, remained stubbornly high,¹¹ and were often accompanied by maternal deaths. Public health professionals such as MacMurphy advocated that the midwife be given training and supervision to teach her the essentials of asepsis, use of silver nitrate for the newborn's eyes, and the ability to recognize problems that required a physician, in order to provide adequate medical care for certain women.¹²

If the *Supplement* seems a paltry substitute for medical services—which it was—it also indicates the very constrained role MacMurphy was

allowed to play, as a public health representative concerned with women's issues. When viewed in the context of MacMurphy's career as a medical reformer, however, the *Supplement* points to women's contribution to health reform. Not only does it reflect MacMurphy's attempts to preserve, and to have recognized, aspects of women's traditional nurturing role in childbirth, but it also suggests that some professional women had a broader view of maternal health care than both private and public health physicians.¹³ Illustrating the contradiction between the public health message, which stressed preventive medicine through regular physician consultations, and the reality of restricted medical services,¹⁴ MacMurphy's *Supplement* also helped push the federal government to recognize health as a political issue.

Helen MacMurphy: Physician, Reformer, and Feminist

Helen MacMurphy was the daughter of Archibald MacMurphy, the controversial principal of Toronto's Jarvis Collegiate from 1872 to 1900. Enduring her father's autocratic rule, his known opposition to women teachers, and an exacting set of academic standards that propelled Jarvis to an elite status, Helen MacMurphy taught for twenty years in her father's school.¹⁵ Despite, or perhaps because of, her father's views, Helen focussed her philanthropic energies in local women's groups such as the Local Council of Women. Then, in 1901, at the age of thirty-nine, she received her medical degree from the University of Toronto, fulfilling a lifetime ambition to practise medicine. A woman of limitless energy, tremendous faith in education as a means to social reform, and no apparent taste for domesticity on the practical level, MacMurphy quickly rose to prominence as a eugenicist and public health advocate for infant and maternal health reform.¹⁶ She also maintained a private medical practice using the family home on Bloor Street as her office.

A political lobbyist of considerable talent, a charismatic speaker, and an upper middle-class professional with excellent social connections, MacMurphy goaded authorities into taking that important first step in recognizing social problems. As a result of these lobbying efforts, MacMurphy was appointed special investigator into infant mortality for the province of Ontario from 1911 to 1913, and provincial inspector of the "feble-minded" from 1906 to 1919. Then, in 1920, she was appointed to the Federal Department of Health's new Child Welfare Division where she wrote the famous Blue Books and turned her attention toward the problem of maternal mortality. Through popular

journals and advice literature, she also brought the new preventive medicine message to ordinary Canadian women, a role that was then thought to need a woman's touch. However, as a popularizer of medical ideas, conciliator of interests, and woman with maternal feminist sympathies, MacMurchy was somewhat isolated. Despite bringing many issues to light, she never achieved any major administrative role in the programs she helped create, but was sidelined in advisory positions dealing with issues perceived to be of special concern to women.

The *Supplement's* Message

The *Supplement* was divided into two segments, the first entitled "A Word to the Mother," which attempted to reassure her that all would be well "until the doctor arrived." The second, entitled "The Neighbour's Part," offered more detailed information on labour and childbirth. Clearly an anomaly given the strong emphasis on medical professionalization in the period, the document highlights some of the conflicting interests and priorities of those involved in its writing and distribution. MacMurchy wrote the *Supplement* in the hope, perhaps futile, of educating the lay midwife and thus saving lives among infants and new mothers in the outposts, without actually endorsing midwifery, a move that would have alienated the medical profession. Charging the midwife with incompetence and ignorance, refusing them any recognition or education, and blaming them for high maternal mortality,¹⁷ most physicians failed to distinguish between the various levels of skill and training among practising midwives. As Biggs has argued, physicians were able to undermine the midwife's expertise by characterizing the management of childbirth as a scientific venture requiring a medical professional.¹⁸ Obstetricians felt that allowing "untrained" women to attend births undermined the status and prestige of obstetrics as an emerging specialty, and hampered efforts to improve medical education and upgrade the level of practice.¹⁹ General practitioners were particularly anxious to eliminate female competitors who undercut fees and kept families from acquiring the services of a family doctor at the time of birth.²⁰

Whether the result of MacMurchy's own ambivalence, political pressure, or both, the *Supplement* reflects a strong sense of reluctance toward providing laywomen with medical information, and especially toward recognizing midwifery. Indeed the Health Department not only chose to keep quiet about its availability, but channelled its distribution

through the medical profession. At a 1923 meeting of the Dominion Council of Health, the advisory body for the Federal Department of Health, one health official had this to say about the *Supplement*:

There is an appendix to the *Canadian Mother's Book* intended for mothers in districts where they cannot get doctors or nurses to look after them. This book is to be distributed where proper help cannot be given to the mother in the way of nursing and medical attention. It is perhaps just as well not to give this book out broadcast. It is to be left to you gentlemen or any others who come in contact with those kinds of cases.²¹

"You gentlemen" referred to the provincial public health officials, all M.D.'s who dominated the discussion in the Dominion Council of Health, despite representation from labour, farm, and women's groups.

The *Supplement* was also published, not as a separate pamphlet, but as a supplement to the *Canadian Mother's Book*. The cover page inscription, printed in bold letters, "For Distribution by Doctors and Nurses Only," further separated it from the body of general advice literature coming out of the Department of Health in the 1920s. To further bolster medical authority, MacMurchy began her *Supplement* by asserting the need for medical attendance at childbirth.

The best nurse we can get and the best doctor we can get are needed when the Baby arrives. We should think of this when we build our Canadian home. The baby is coming. Try to settle within reach of medical and nursing aid. You need a Doctor and a Nurse. You should have them if it is possible.²²

For the benefit of her medical colleagues, MacMurchy assumed that all midwives were untrained, and ignored their use in urban areas among poor and immigrant women, although she must surely have been aware that competent midwives practised in Canada.²³ Further, the *Supplement* was not called a midwifery manual, and "the neighbour," to whom the bulk of the comments were addressed, was never referred to as a midwife. In fact, the word is never used.

Pandering to physicians' prejudices, MacMurchy portrayed the midwife as a frightened, ill-prepared helper, far from confident of her ability to deal with the vicissitudes of childbirth. MacMurchy assured her, somewhat patronizingly:

Perhaps you have never seen a birth. Never mind, there is a great deal you can do to help the mother and child.²⁴

MacMurchy even explained what a vaginal examination was, that is, "when the Doctor feels with his fingers inside the maternal passage to find out if everything is all right," and warned the attendant or any other unskilled person against doing this as it "may cause the death of the mother."²⁵ Although MacMurchy does not say so, this precaution was designed to prevent the introduction of bacteria, which could cause a potentially fatal infection. Performing vaginal examinations was the prerogative of medical practitioners who, in theory, were well versed in aseptic techniques. In practice, however, physicians' record on puerperal sepsis was arguably worse than that of midwives.²⁶

Despite these qualifications, MacMurchy's midwife is a well-intentioned helper. In fact, her portrayal is an uneasy mix of two opposing stereotypes—the ignorant meddler of medical propaganda²⁷ and the kindly, gentle and often competent neighbour of midwifery folklore.²⁸ Although MacMurchy could or would not legitimize the neighbour woman by calling her a midwife, the *Supplement* did give a subversive recognition of the midwife that is unique for the period, and somewhat remarkable given the widespread hostility toward her. MacMurchy remarked in her opening comments, "There is some woman in Canada who would be a help to you and would come. Get her in time."²⁹ MacMurchy assumed that the traditional birth attendant, would in fact be a "she" as she advised the helper to "take off your dress," "scrub your hands and arms clean with soap and hot water," and "put on a clean washdress and apron."³⁰ This unrecognized lay helper was also expected to stay for several days after the birth, as instructions were given for changing the pads and checking that the colour of the discharge changed from reddish to brownish to greenish in colour.³¹

MacMurchy's sympathetic view reflects loyalties divided between the medical profession and women. Middle-class women's groups such as the National Council of Women of Canada (NCWC), were also divided on the idea of preserving a role for the midwife. They generally accepted the medical view of childbirth as potentially dangerous and favoured doctor-attended births and prenatal checkups.³² Nonetheless, some local councils of the NCWC as late as 1924, condemned the high rate of maternal deaths in the northern and isolated parts of the country, and petitioned the government to train and license midwives for such districts.³³ If neighbour women were already helping at births in outpost homes, why not give them adequate training? Although seen as uneducated, unglamorous, and ill-equipped for emergencies, the

midwife could take on essential nursing and domestic duties, and was seldom prepared to interfere with the natural process of labour, avoiding the problem of "meddlesome midwifery"³⁴ as practised by some physicians—a problem that added to already high maternal mortality figures.

The NCWC's 1924 report on Maternity Nursing and Trained Midwives, revealed a Council divided on the question of midwifery.³⁵ Attempts to have midwifery recognized had met with little success in the past,³⁶ and in 1924 when Charlotte Hannington, Chief Superintendent of the Victorian Order of Nurses, made one last passionate appeal to the NCWC to train midwives, she was forced to resign.³⁷ Significantly it was the few women doctors on the NCWC's Executive who opposed midwifery.³⁸ Instead they favoured the Canadian Nurses Association (CNA) approach to solving the problem of maternal care, which recommended the establishment of outpost hospitals, and "the extension of training and supervision of nursing housekeepers to assist registered nurses in outlying rural communities." They also endorsed the idea of home nursing classes for rural women, and petitioned provincial governments to improve transportation services, and offer bonuses to physicians practising in rural areas.³⁹ Struggling for professional recognition, nurses stressed the need to staff outpost hospitals with fully qualified nurses. They also insisted that these nurses be well paid for their services to the community,⁴⁰ and that they be provided with assistants who would perform menial domestic tasks. Confronting the hostilities of doctors who preferred subservience to professionalism in their nurses and the public perception of the nurse as a glorified domestic worker,⁴¹ nurses were unable to take up the midwife's cause.

The fact that midwives themselves never entered into the debate on maternal mortality indicates the near decimation of the practice by the early twentieth century. A woman with little authority, scant expertise to draw on and virtually no recognition from the medical community, the midwife could command only irregular fees, if any at all. If she had received training, which was unlikely given the lack of schools in North America and the strong resistance to recognizing midwifery, she was further handicapped by legal restrictions. In Canada the practice of midwifery was officially outlawed, although this was impossible to enforce.⁴²

Support for midwifery was also weak among public health physicians. While a few advocates of midwifery, including MacMurchy, pointed to European statistics, which indicated that where trained and licensed midwives practised maternal mortality was much lower than in

the United States and Canada,⁴³ most were lukewarm to the idea of transferring this European institution to North America. There was some unease as well regarding the use of midwifery in rural areas, as this argument called for a two-tiered medical system divided on urban-rural lines.⁴⁴ The *Supplement* reflects the belief that midwives were an emergency stopgap measure only, warning mothers against using the *Supplement* as a substitute for the doctor. "No, it is only to help you until the Doctor comes,"⁴⁵ MacMurphy pointed out, although she almost certainly knew that in many cases no doctor would arrive.

To further complicate her position, MacMurphy was employed by the federal government, whose primary concerns such as economic growth and land settlement often conflicted with those of public health activists and women's groups. The NCWC, which was instrumental in pushing the federal government to establish the Department of Health in the first place,⁴⁶ had long demanded improvements in maternal and infant health care in Canada. In their 1923 report, the Public Health Committee of the National Council expressed its outrage at the federal government's policy of promoting the pioneering life as an act of heroic nation building, without addressing the health concerns of Canadian women:

If immigration increases, there is plenty of definite information from voluntary sources that goes to prove that only those willing to face the lack of maternal and nursing care should settle in our outlying districts. This lack should be given as much prominence as any glowing description of our natural resources. We women feel the disgrace of this situation all the more keenly because for over a quarter of a century we have been urging governments to recognize conditions and provide remedies.⁴⁷

The *Supplement* reflects this sense of impotent rage.

Despite her official position, MacMurphy could barely disguise her misgivings about sending women of childbearing age into isolated outposts where danger and hardship awaited them. Before advising the mother of what to do should she find herself alone at the time of birth, for example, MacMurphy tells the prospective mother, "Do not let this happen," either by going in good time to the nearest hospital or the home of a friend or relative, or by ensuring that the husband remains close at hand when the time of birth approaches.⁴⁸ In one of the later Blue Books entitled *How to Make Our Outpost Home in Canada*, MacMurphy again gave some uninspiring advice to prospective

pioneers, telling them, "Think twice before you go to live and make your home more than fifteen miles away from any Doctor."⁴⁹

Although lobbying by women's groups for improvements in maternal care was not ineffectual, it was veterans of the Great War who provided the catalyst to move the government to action. As the federal government's unique means of handling the maternity problem, the *Supplement* indicates the low priority given to maternal and infant welfare. It is significant that even this inadequate response occurred within the context of the problems encountered by some twenty-five thousand ex-soldiers whom the government had helped settle on farms.⁵⁰ The Soldier's Settlement Board, which administered this postwar program, set up a Home Branch, staffed by home economists, to help the wives of soldier-settlers adjust to farm life in Canada.⁵¹ In the course of their home visits, Home Branch officials learned first-hand of the lack of maternal care in rural and isolated areas.

In her Division's annual report for the year 1923, MacMurchy reported that "special requests have been made from time to time, especially by the Home Branch of the Soldier's Settlement Board, for a little book for mothers in outpost homes who fear that medical and nursing aid may not be available at the time of birth."⁵² As a result of this request, one thousand copies of the *Supplement* were printed, until, as MacMurchy noted, "we can ascertain whether or not a larger distribution is advisable."⁵³ The following year she reported that the *Supplement* had "apparently been found useful and satisfactory for the purpose for which it was intended." After several copies of the proof edition had been sent to a "number" of doctors and nurses, and to individuals who had special knowledge of outpost homes, some suggestions and improvements were incorporated into the text and a revised edition came out in February 1924.⁵⁴

Despite its many shortcomings, however, the *Supplement* did give recognition to a women's public health concern, and conveyed far more information about the process of labour and childbirth than was typical of popular medical books of the time. In translating medical knowledge into plain English for a lay public, MacMurchy, the former school-teacher, was at her best. She forgot none of the practical details. For example, an illustration of several knots to be used in tying the umbilical cord, appeared after the *Supplement's* title page. In keeping with a well-founded concern to prevent puerperal infection, a major cause of maternal mortality, MacMurchy insisted on strict cleanliness. The attendant was not only to don a clean dress and apron, and scrub her hands, arms and nails, she was also to scald, scrub and thoroughly clean all

pitchers, basins and dishes, and to put plenty of water on to boil.⁵⁵ If no clean sheets were available, MacMurchy advised using old newspapers and baking them in the oven to sterilize them. If a family member had any illness especially rash, “sores” or skin disease, the attendant was instructed to try to get them away to a neighbour’s for a few days. Flies were also to be banished from the birthing chamber.⁵⁶

MacMurchy then explained the three stages of labour, informing mother and attendant that a discharge of bloodstained mucus called “the show” would signal the beginning of the first stage, which ended when the uterus or womb was fully dilated and the waters broke. MacMurchy advised the attendant that once the pains got stronger and more frequent, and the mother felt like bearing down, she should ask the mother’s permission to look into the maternal passage. If the attendant could see a bluish-white body, round or sausage-shaped and protruding at each pain, then she could rest assured that “everything is going well” and that the waters would soon break to release the fluid surrounding the baby. This could come in a great gush, which might well flow onto the floor, but the well-prepared attendant would have placed a pan there to receive it.⁵⁷ MacMurchy estimated the average length of the first stage at six to sixteen hours for a first baby (but possibly as long as twenty-four) and from two to twelve for subsequent births.⁵⁸

During the second stage of labour the attendant was advised to give the mother a towel to pull on while she pushed, and watch for the baby’s head to appear, which should take approximately one-half to one hour for a first baby, or less for a second. MacMurchy then assured the birth attendant:

Don’t be frightened. It does not look like a head yet, only that you can see the hair, but the surface is ridged and squeezed up and you can only see about three inches of it.⁵⁹

Positioning the mother on her left side (unless she prefers to be on her back), the attendant was to wait for the head of the baby to appear at the outside opening, then help the mother, between pains, to turn on her back. When the face of the baby appeared, it would likely turn toward the mother’s right, and the attendant was instructed to use several cotton swabs dipped in clean boiled water to gently wipe out the baby’s mouth and nose, and to wash the lids of both eyes.⁶⁰

The attendant was then instructed to slip her right hand first finger round the baby’s neck:

If you feel the cord twisted around the neck, gently draw it down and pass the loop over the baby's head, so as to avoid the danger of the cord being caught and thus strangling the baby.⁶¹

About fifteen minutes after the baby's birth, when the beating and pulsating in the cord had stopped, and the baby had cried, MacMurphy advised the helper to tie the cord in two places by tying narrow tape that had been boiled into a reef knot,⁶² and cut it with a pair of clean scissors. If the end of the cord was not bleeding, she should then wrap the baby in a blanket and keep him by the fire for warmth.

Finally, MacMurphy explained the third stage of labour, as "expulsion of the afterbirth or placenta, membranes and cord" and estimated its duration from one half to three-quarters of an hour. The attendant and/or any helpers were instructed to massage the mother's abdomen with clenched fist(s) in order to prevent haemorrhaging and help the uterus to contract. She also warned the attendant to expect a gush of blood but assured her that if the uterus felt like a hard firm ball, all was well.⁶³ Once the afterbirth had been expelled, the attendant was to wash the mother with the boiled water, see that she got a hot nourishing drink and some rest, and nursed the baby within six hours of birth.⁶⁴

The traditional view of birthing as a natural process requiring little human intervention, save feminine nurturing and support, blended uneasily with the medicalized view of birth as a medical emergency and the *Supplement's* message mixed friendly encouragement with dire warnings. In MacMurphy's brief section, at the beginning of the *Supplement*, entitled "A Word to the Mother," MacMurphy warned against being left alone at the time of birth, giving the *Supplement* a tone that was often unsettling. Should an emergency occur, however, there were seven things for the mother to do. The first, which could be done well in advance, was to make up the bed with an underlay for protection that could be easily removed after the birth. Once labour began, the mother-to-be was advised to take an enema, a bath, and then go to bed. The fifth item on MacMurphy's list was probably the most difficult to achieve. The labouring woman was advised to "keep yourself cheerful" all the while dealing with the most horrible of emergencies that should never have happened in the first place!⁶⁵

In a slightly more practical vein, MacMurphy did explain the three stages of labour, advising the mother to bear down only after dilation of the cervix had occurred and only during pains. "Soon you will begin to feel the head of the child coming down," advised MacMurphy, and the mother's legs must be separated to make room for the baby.

The mother, having cheered herself and waited for nature to take its course, was then instructed to make sure, by seeing and feeling, that there was nothing obstructing the baby's breathing, and wait quietly for help to arrive.⁶⁶

At the same time as she advised the mother to let nature take its course, MacMurchy also told her to pray to Jesus for deliverance from the unspeakable horror of facing childbirth unassisted by a nurse or M.D.:

It is the mother and the powers of nature that bring about the birth; you will probably be all right. And you are not alone, after all. Remember how the Lord Jesus thought about mothers. He is thinking of you to-day, here alone, and He is near.⁶⁷

MacMurchy's attempt to strike a comforting tone is less than convincing. The appeal to prayer, nowhere else resorted to in her advice literature, surely conveyed the message that without professional help, the mother was in grave danger.

The *Supplement's* few suggestions for handling problems, which ended with an appeal to get the doctor—somehow!—reveal the frightening implications of reluctantly giving advice to a woman deemed hopelessly unqualified to handle any non-routine occurrences. MacMurchy offered advice on what to do if the baby did not cry at once. If holding him by the feet and giving him the proverbial slap on the bum did not work, the attendant was to try shaking him gently, tickling the baby's ribs, and/or dashing a few drops of cold water on his chest. If the baby still did not breath, the attendant was to cut the cord. If the baby's body bled freely, she would know that he was still alive, and should attempt artificial respiration. She should expand the baby's chest by lifting its arms out and up, and then bringing them down by its side gently, about twelve times per minute. The discouraged assistant was advised not to give up. "Keep on. You may save him yet. He may give a little gasp, and live, any time within an hour or more."⁶⁸

Unusual presentations were also discussed, the attendant being assured that chance was on her side, as the safest presentation, that is, head first, occurred in 97% of cases.⁶⁹ Another 2% of births were breech, that is, when the lower part of the baby's body was born first, MacMurchy explained. In general, the attendant was to let nature take its course. However, if the limbs began to move convulsively, she was instructed to lift the baby's body, bend its legs upward, and press on the mother's abdomen during pains, to assist the birth. The remaining 1% of births, which included a number of other parts presenting, were not

discussed in the *Supplement*, except to tell the attendant that if a hand presented, mother and helper were in trouble and the doctor was to be sent for.⁷⁰

The *Supplement's* final section assured the "neighbour woman" that birth was a natural process:

Never lose hope or courage when you are with a mother. Nature is equal to almost all difficulties. Do not be in a hurry. Do not use force. Be quiet. Be gentle. Be kind. Be very patient. Nature needs time to bring about the birth.⁷¹

However, this advice was accompanied by some very uncom-forting words:

Usually all goes well when the baby comes, even if the doctor is late. But if the Mother has been in labour over twenty-four hours at the birth of a first baby, or even a shorter time especially if it is not the first baby, and she seems to be getting weak and looking ill and anxious, and there is no sign of the baby coming, and the pains are not as strong as they were, you must get help for her somewhere, somehow, or she may die of exhaustion before your eyes. No doubt the husband has tried telegraph and telephone already. Try again. Send a messenger on horseback to the nearest neighbour who has a motor to go and get the doctor. Send a message to the nearest Radio outfit. S.O.S. The Mother's life must be saved.⁷²

Distribution of the *Supplement*

The *Supplement's* significance lies less in a question of numbers reached, than in the undercurrent of its message, which is essentially a weak response to demands for obstetrical information and services. There is, in fact, little evidence on the *Supplement's* distribution, although one would not expect to find a lot, given the restrictions placed on its distribution. While there were many organizations that could have been active in distributing or using the manual, such as the Red Cross and the Victorian Order of Nurses (VON), no reference to it has been found in any of their records or publications.⁷³

However we do know that the *Supplement* was used, at least in the 1920s. MacMurchy's Division sent the Blue Books to new Canadians in the 1920s,⁷⁴ and it is possible that the Supplement was routinely sent to those destined for outpost areas. It was certainly sent to those who asked for it. One woman physician who had practised in Prince Rupert, B.C.,

in 1938 recalled being summoned to a maternity case in which the inhabitants of an isolated village were using the *Supplement* to deliver a "difficult case." As often happened, the physician arrived after the birth took place.⁷⁵ There is also one reference to a letter in the Department of Health files indicating a request for the book. In 1937 the Canadian Welfare Council, a voluntary agency that took over the work of MacMurphy's Division when it was disbanded upon her forced retirement in 1934, received a letter from the wife of an Anglican missionary.⁷⁶ This couple was about to depart for an Indian settlement near the mouth of the Mackenzie River where the nearest hospital was 110 miles distant. She says in her letter:

Some years ago, Dr. MacMurphy issued a little pamphlet, on exactly what to do if you had to deliver a baby without a doctor's help. For five years we have been near a doctor and I am going back to where I will have to take up a certain amount of midwifery work again. The little pamphlet was splendid. I translated it into Cree at one time. I only had one copy and have lost it. Can you get me one?⁷⁷

Although Dr. Heagerty, Chief Executive Assistant of the Department of Pensions and National Health immediately recognized the pamphlet as MacMurphy's *Supplement*, he was unable to find a copy. He suggested that the Council advise the woman to contact the VON and request permission to attend a few confinements and/or obtain suggestions as to appropriate textbook reading.⁷⁸

While the *Supplement* was used during MacMurphy's tenure in the Child Welfare Division from 1920 to 1934, it appears to have been out of print and out of circulation by the late 1930s, when the midwife option was no longer being considered,⁷⁹ and the political strength of newly enfranchised women was declining.

What is clear is that a demand for obstetrical information existed. The same year that the *Supplement* was published, the Red Cross, which also had close ties with the Soldier's Settlement Board, instituted a Home Nursing Course. Working largely with volunteer nurse-instructors, the Red Cross co-operated with groups such as the Women's Institutes, to offer courses for one dollar per student with a maximum of twelve students per class.⁸⁰ The course consisted of twelve two-hour sessions, providing practical demonstrations, classroom instruction, and a manual to serve as a home reference guide. One section of this manual, called *Maternity Nursing*,⁸¹ covered material very similar to that found in MacMurphy's *Supplement*. Intended to teach women what to do in an "emergency" delivery, as the thousands of non-

physician-attended deliveries were coming to be called, the text was prefaced with the usual caution against taking on professional privileges:

In an emergency case or in a case of an outpost home where a doctor cannot possibly be obtained, the following information will be useful in helping the home nurse to meet the situation as best she may: but no home nurse should ever presume that she is competent to take charge of a maternity case, except under the supervision and direction of a doctor. No one can foretell the case when the services of a doctor will make a difference of the gravest importance to the mother or the baby or both. Therefore it is deplorable negligence not to secure the services of a doctor if this is at all possible.⁸²

Advertisements for the Home Nursing Course promised Canadian women knowledge and skill that might prevent suffering and save lives, enumerating many of the skills to be learned. Emergency delivery of an outpost baby was not mentioned, however.⁸³

The information in the Red Cross home nursing manual probably reached a much broader audience than MacMurphy's *Supplement*. In 1924 alone, 243 classes were taught, reaching some 3,000 women. By 1929, the Red Cross boasted sponsoring 1,234 classes with a student enrolment of 17,333.⁸⁴

The *Supplement's* message foreshadowed and reinforced future developments. Innovative for its time, the *Supplement's* information was eventually incorporated into maternal advice literature. Beginning in 1940, future editions of the *Canadian Mother and Child* (revised from the *Canadian Mother's Book*) discussed emergency birth.⁸⁵ However, the *Supplement* also reinforced the growing trend toward transporting outpost women to the nearest hospital as the only acceptable resolution to a conflict that pitted women's needs against professional privileges. Modern advice literature for outpost women now focussed on dealing with the out-of-town hospital experience.⁸⁶ Advice on what to do if the baby arrived en route to the hospital was much less extensive than was the case in the *Supplement*. No instructions were given to tie or cut the cord for example, as it was assumed the baby would be immediately taken to hospital.⁸⁷

As well, the downgrading of the midwife's role to that of housekeeper was solidified in the 1920s. Whereas the midwife had once done everything,⁸⁸ a nurse to supervise patient care, and a homemaker to temporarily replace the new mother's domestic labour in the household. As if

in accordance with the CNA's recommendations, the Red Cross had institutionalized these changes. In addition to its Home Nursing Course, the organization had established forty-five outpost hospitals and a visiting homemaker service.⁸⁹

The Maternal Mortality Campaign

The *Supplement* also reflects MacMurphy's ameliorative approach to reform. Vacillating between a reluctant endorsement of the midwife's role, and the ideal of doctor-attended births, MacMurphy's attempts to reconcile women's needs with professional prerogatives often appear pathetic. When viewed as part of MacMurphy's career-long campaign to educate doctors and the public on the importance of improving maternal and infant health care, however, the *Supplement* illustrates Canadian women's contribution to maternal health reform.

MacMurphy used her post with the Child Welfare Division to lobby the medical profession for support in her attack on maternal mortality, employing a mix of flattery and coercion. There may be a connection between the publication of the *Supplement* in 1923 and the Canadian Medical Association (CMA) "request" for a study on maternal mortality in 1924 that was orchestrated by MacMurphy, for instance. As she had done with infant mortality and with the issue of the feeble-minded earlier, MacMurphy manoeuvred herself into the position of official reporter/investigator. In 1924 the Dominion Council of Health, the Department's advisory council, met in Ottawa. On their agenda was a Memo on Maternal Mortality presented by MacMurphy, in which preliminary estimates of Canada's rate of maternal mortality were announced. In classic "pass-the-buck" style, MacMurphy was then sent down the street to deliver the same paper to the Conference on Medical Services. Arranged by the CMA, this meeting took place in the House of Commons under the patronage of the Minister of Health, 18 to 20 December.⁹⁰ That august body of physicians then duly resolved, with little discussion, to formally request that the Federal Department of Health undertake an inquiry into maternal mortality. They then continued on with their discussion of medical education.⁹¹

Once appointed, MacMurphy put the concerns of women's groups and public health activists into the language of science, giving them credibility with those in authority to act. MacMurphy set out to document the extent of maternal mortality, compare that mortality rate with other countries, investigate the number of births that occurred

without medical or nursing aid, and decide whether medical fees were too high.⁹² She studied all maternal deaths occurring from 1 July 1925 to 1 July 1926, and used physician questionnaires to obtain more information than the death certificates could provide. In the period studied, MacMurchy found that 1,532 deaths had occurred, or 6.4 maternal deaths per 1,000 live births, indicating that official statistics underreported maternal mortality.⁹³ MacMurchy also outlined the major causes of maternal death—puerperal infection (sepsis), toxemia, haemorrhage, dystocia or prolonged labour, and shock.⁹⁴ The study confirmed in statistical, scientific terminology the fact that Canadian women were dying in childbirth from preventable causes. MacMurchy was clearly targeting doctors with this report. On the title page of MacMurchy's ensuing report, entitled *Maternal Mortality in Canada*, MacMurchy indicated that the study had been requested by the CMA.⁹⁵ Despite the fact that the National Council of Women also called for such a study in the same year,⁹⁶ this information was not similarly noted. Coming from a health department official and a physician who used physician input to arrive at her data, this information could not be ignored. But just to be sure, MacMurchy had a copy of the report sent to every physician in Canada. MacMurchy also had copies of the first edition of the *Supplement* sent to a "number of" nurses and doctors for feedback. By involving physicians in the research exercise, she attracted a larger audience within the medical profession for her health propaganda.

MacMurchy bolstered doctors' claims to an obstetrical monopoly. One of the questions she set out to study was the number of maternal deaths associated with lack of medical care, no doubt hoping to expose the danger of outpost conditions. However, a surprisingly low 14% of the deaths were associated with "unattended" births.⁹⁷ Undaunted, MacMurchy stressed that 1,342 or 90% of these dead mothers had received no prenatal care,⁹⁸ concluding that indeed doctors were vital to maternal health. However, she also shamed the medical profession for complacently accepting the appallingly high rate of maternal mortality and made demands of the profession in regards to improving maternal health care. Physicians were accused of using forceps too often, of being careless about prenatal checkups or not doing them at all, and of charging fees that many Canadians could not afford.⁹⁹ She also criticized medical education in obstetrics as inadequate, and suggested that physicians took maternal welfare too lightly. In typical bureaucrat fashion, MacMurchy expressed these complaints largely through other people. For example she quoted the Ontario Red Cross Director of Nursing Services as saying, "How can we make it possible for

patients to call a doctor as often as our nurses feel is necessary when each trip represents a financial outlay of \$25 to \$50?"¹⁰⁰

While most physicians saw the ideal of medical attendance at childbirth as sufficient to ensure maternal safety, conceding that improved obstetrical education would help, MacMurchy and other women reformers saw it as one aspect of a larger program that included nursing care, preventive medicine, rest, and nutrition.¹⁰¹ In fact, her report is innovative in revealing the role played by secondary causes in maternal death, such as exhaustion, poor nutrition, and other health complications. These accounted for the discrepancy between MacMurchy's and the official figures. More than half of these 1,532 mothers were in poor health long before the baby was born, said MacMurchy,¹⁰² stressing the need for more help in the home. She quoted letters describing the pitiful conditions under which some mothers lived and died, all too frequently of sheer exhaustion.¹⁰³

Although MacMurchy dared not directly implicate physicians in high rates of maternal mortality, MacMurchy's praise of public health nurses had important implications. Although nurses were trained to wait for the illusive doctor to arrive, many were playing a role not dissimilar to that of the neighbour woman in the *Supplement*, being placed in the position of having to deliver babies with neither adequate training nor authority. VON nurses, for example, were pressured by women, both for reasons of economy and modesty to take maternity cases, although officially they had to advise pregnant women to see a doctor. Many patients did not, waiting until they were in active labour to call the nurse, who would deliver the baby as an "emergency case."¹⁰⁴ The order attended 16,000 maternity cases,¹⁰⁵ out of a total of 50,000 in 1922.¹⁰⁶ Yet the VON had to officially disavow any connection with midwifery and assume a subservient tone vis-à-vis the medical profession in order to survive as a service. Graduate nurses who staffed the Red Cross Outpost Hospitals also did obstetrical work,¹⁰⁷ and biographies of public health nurses indicate that midwifery skills were valued in most communities.¹⁰⁸

While MacMurchy refused to endorse midwifery, it is clear that she valued the important role played by the neighbour women in providing basic nursing, and taking over household management so that the mother could rest. MacMurchy published statistics on the VON's record on maternal mortality, in a pamphlet entitled *Maternal Care*,¹⁰⁹ giving voice to their boasts of lowering maternal mortality through good nursing care. In 1928, for example, of 14,070 maternity cases attended by VON nurses all over Canada (of which 4,201 were

“emergency” cases), the rate of maternal mortality was 1.6 per 1,000 live births.¹¹⁰ This compared favourably with the official Canadian rate of over 5 per 1,000 live births.

MacMurphy’s career indicates that rather than abandoning midwifery, she unsuccessfully attempted to elevate its status through professionalization. In her pre-war investigation into infant mortality for the Ontario government, MacMurphy advocated the training and licensing of midwives.¹¹¹ But in the intervening ten or fifteen years, the prevalent view among public health professionals had changed. By the time the Blue Books were written in the 1920s, MacMurphy scarcely mentioned midwives and the refusal to use the term in the *Supplement* certainly indicates a reluctance to lend any legitimacy to the traditional female birth attendant. She did not, however, explicitly prohibit their use, as did other publications on maternal welfare.¹¹² Then, in a 1933 article for *Canada Lancet and Practitioner*, MacMurphy compromised by advocating the nurse–midwife.¹¹³ Canadian nurses, who vehemently objected to midwifery, were more sympathetic to the concept of the nurse–midwife, a trained graduate nurse who specialized in obstetrical nursing. The name change from midwife to nurse–midwife is a very significant one, as it represented an effort to combine the positive aspects of traditional midwifery with nursing, an emerging if not fully recognized profession.

Medical Services

Caught in a medical system that insisted on a medical monopoly on obstetrics and prenatal care but failed to provide services to all Canadians, the pioneer woman highlighted a major discrepancy between ideal and reality. Although histories of the Canadian health insurance program have pinpointed the catastrophic Depression years as the catalyst for this social and medical reform, one could argue that its origins lie in an earlier period. Public health rhetoric of the 1920s certainly clashed with the economic reality of private medical practice, crystallizing demand for medical services. MacMurphy’s excerpts from the letters¹¹⁴ of angry Canadians protesting the lack of medical help for maternity cases and its high costs,¹¹⁵ as well as specific complaints from the Soldier’s Settlement Board, indicate that Canadians responded to this contradictory advice.

The maternity needs of outpost women were merely the tip of the iceberg, made politically visible by eugenics-inspired concern for

infant and maternal mortality. In the short run, the gap between the ideal of doctor-attended deliveries for all Canadian women and the reality of the "untrained" midwife forced a tentative endorsement of midwifery in isolated areas. However, in the long run, MacMurphy's poignant portrayal of the unmet needs of Canadian pioneer women helped generate discussions on methods of improving general medical accessibility. At the Dominion Council of Health meeting, when MacMurphy's initial maternal mortality figures were announced, they were greeted at first with shock and disbelief. However, the officers ended a serious and thorough discussion of maternal mortality by considering the idea of "state medicine."¹¹⁶ In the prairie provinces, where the doctor shortage was most acute, the first steps toward publicly sponsored medical insurance were taken.¹¹⁷ In the 1920s, Saskatchewan instituted a municipal doctor scheme, whereby a municipality could hire a physician to treat all town residents, paying his or her salary out of tax revenues.¹¹⁸ By the early 1940s this system operated in sixty-seven municipalities in Saskatchewan, five in Manitoba and three in Alberta.¹¹⁹ The first hospital insurance plan was instituted in Saskatchewan, and that province also pioneered in state-sponsored medical insurance schemes, later copied on the national scene. Alberta approached the problem of maternity care by offering a restricted form of hospital insurance, only for maternity cases, beginning in 1944.¹²⁰

Conclusion

The *Supplement* reflected, in a poignant way, MacMurphy's often pathetic attempts to reconcile the interests of isolated women patients with those of professional and government elites. As a limited concession to women's demands for improved obstetrical information and services, prompted by the problems of ex-soldiers, the *Supplement* may be viewed as a weak excuse for inaction, disguised as educational material. Committed to professionalism and medical science, and anxious to shed the stigma of untrained domestic work closely associated with the denigrated North American midwife, professional women compounded this ineffectual response. All of this serves to confirm Strong-Boag's thesis that professionalism constrained feminism.¹²¹

Within professional women's conservative defence of professional privilege, however, emerges a particular strategy for representing women's interests. As far as their marginal role and precarious status allowed, professional women attempted to rehabilitate the traditional

role by professionalizing it, and advocated a health regime that stressed prevention, nursing, rest, and nutrition, as well as physician-attended births.

Such efforts were not entirely unsuccessful. Highlighting the contradictions in the public health message, the *Supplement* must be seen as part of women's contribution to larger social and medical reforms. Such efforts seem less meagre when viewed in light of the restricted role women were allowed to play.

Endnotes

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1. Katherine Arnup, Andrée Lévesque, Ruth Roach Pierson, *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries* (London and New York: Routledge, 1990); Ann Oakley, *The Captured Womb, A History of The Medical Care of Pregnant Women* (Blackwells: Oxford, 1984); Wendy Mitchinson, *The Nature of Their Bodies; Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto Press, 1991); Jane Lewis, *The Politics of Motherhood, Child and Maternal Welfare in England, 1900-1939* (London: Croom Helm, 1980); Barbara Ehrenreich and Deirdre English, *For Her Own Good, 150 Years of Expert Advice to Women* (New York: Anchor, 1979).

2. Judith Walzer Leavitt, *Brought to Bed, Childbearing in America, 1750-1950* (New York: Oxford University Press, 1986); C. Lesley Biggs, "The Case of the Missing Midwives": A History of Midwifery in Ontario from 1795-1900," in *Delivering Motherhood*, 20-35; Jo Oppenheimer, "Childbirth in Ontario: The Transition from Home to Hospital in the Early Twentieth Century," in *Delivering Motherhood*, 51-74.

3. Leavitt, *Brought to Bed*.

4. Buckley has argued that nurses' hostility toward midwives, their aspiration for a professional status closely tied with the image of upper-class womanhood, contributed to the demise of the midwife and threatened maternal and infant safety among poor and isolated women. Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality," in *A Not Unreasonable Claim*, ed. Linda Kealey (Toronto: The Women's Press, 1979), 131-150. Veronica Strong-Boag suggests that professionalism constrained the

feminism of Canada's early women physicians. Strong-Boag, "Canada's Women Doctors: Feminism Constrained," in *A Not Unreasonable Claim*.

5. Angus McLaren, *Our Own Master Race* (Toronto: McClelland and Stewart, 1990), 28–45.

6. Strong-Boag, "Intruders in the Nursery, Childcare Professionals Reshape the Years One to Five, 1920–1940," in *Childhood and Family in Canadian History*, ed. Joy Parr (Toronto: McClelland and Stewart, 1982), 160–178; Nora Lewis, "Reducing Maternal Mortality in British Columbia: An Educational Process," in *Not Just Pin Money*, ed. Barbara K. Latham and Roberta S. Pazdro (Victoria: Camosun College, 1984), 337–355; Katherine Arnup, "Educating Mothers: Government Advice for Women in the Interwar Years," in *Delivering Motherhood*, 190–210; Dianne Dodd, "Advice to Parents: The Blue Books, Helen MacMurchy, M.D., and the Federal Department of Health, 1920–1934," *Canadian Bulletin of Medical History* 8, 2 (1991): 203–230.

7. For a discussion of midwifery in Canada, see Buckley, "Ladies or Midwives?"; Biggs, "The Case of the Missing Midwives," *Delivering Motherhood*, 20–35; Appendix I, "A History of Midwifery in Canada," *Report of the Task Force on the Implementation of Midwifery in Ontario* (Toronto: Government of Ontario, Ministry of Health, 1987), 197–232; Cecilia Benoit, "Traditional Midwifery Practice: The Limits of Occupational Autonomy," *Canadian Review of Sociology and Anthropology* 26, 4 (1989): 633–649, and J. T. H. Connor's contribution to this collection. For American sources, see Judy Barrett Litoff, *American Midwives, 1860 to the Present* (Westport: Greenwood Press, 1978); Frances E. Kobrin, "The American Midwife Controversy: A Crisis of Professionalization," in *Women and Health in America*, ed. Judith Walzer Leavitt (University of Wisconsin Press), 318–326.

8. Helen MacMurchy, *Supplement to the Canadian Mother's Book* (Ottawa: Department of Health, n.d.).

9. MacMurchy, *Maternal Mortality in Canada* (Ottawa: Department of Health, 1928), 5–29. Similar advice was provided in her Blue Books, published by the Federal Department of Health.

10. For insight into the experience of these mothers, see Meryn Stuart, "Ideology and Experience: Public Health Nursing and the Ontario Rural Child Welfare Project, 1920–1925," *Canadian Bulletin of Medical History* 6, 2 (1989): 111–131; Stuart's article in this collection; Cynthia Abele, "'The Mothers of the Land Must Suffer': Child and Maternal Welfare in Rural and Outpost Ontario, 1918–1940," *Ontario History* LXXX, 3 (September 1988): 183–205.

11. In her report on maternal mortality, MacMurchy reprinted a chart indicating that in New Zealand infant mortality in the first month of life had not improved from 1905 to 1920, while infant mortality among babies who survived the first month had fallen dramatically. MacMurchy, *Maternal Mortality in Canada*, 59.

12. Litoff, *American Midwives*, 92–93.

13. Dodd, "Advice to Parents."

14. Public health nurses in particular were faced with these contradictions and devised means to deal with them. See Stuart, "Ideology and Experience"; *Report of Task Force on Midwifery*, 215–218.

15. Harvey Medland, *Minerva's Diary: A History of Jarvis Collegiate Institute* (Belleville: Mika Publishing Company, 1979), 46–69.

16. For more on MacMurchy's career see Dodd, "Advice to Parents"; McLaren, *Our Own Master Race*, 28–45; Suzann Buckley, "The Search for the Decline in Maternal Mortality:

The Place of Hospital Records," in *Essays in the History of Canadian Medicine*, ed. Wendy Mitchinson and Janice Dickin McGinnis (Toronto: McClelland and Stewart, 1988), 148–163; David McLennan, "Beyond the Asylum: Professionalization and the Mental Hygiene Movement in Canada, 1914–1928," *Canadian Bulletin of Medical History* 4 (1987): 7–23; Kathleen McConnachie, "Methodology in the Study of Women in History: A Case Study of Helen MacMurchy, M.D.," in *Ontario History* LXXV, 1 (1983): 61–70.

17. Biggs, "The Case of the Missing Midwives," 31. For an alternate view of physicians' attitudes toward midwifery, see J. T. H. Connor's contribution to this collection.

18. Biggs, "The Case of the Missing Midwives," 32.

19. Beverly Boutillier, "An Intelligent Handmaid and not an Interloper.' Gender, Medical Authority and the Founding of the Victorian Order of Nurses for Canada," Paper presented at 1991 Canadian Historical Association meeting.

20. Strong-Boag, "Canada's Women Doctors," 111–112.

21. Minutes of Meeting of the Dominion Council of Health, 11 to 13 December 1923, National Archives of Canada, Microfilm A9814.

22. MacMurchy, *Supplement*, 139.

23. Given that estimates of non-physician-attended births accounted for 30% to 40% in the early 1920s in the U.S., the number is likely to be higher in Canada. Litoff, 114.

24. MacMurchy, *Supplement*, 143.

25. MacMurchy, *Supplement*, 146.

26. *Report of the Task Force on Midwifery*, 203.

27. It was not uncommon for doctors to refer to midwives as "some neighbour woman, generally an old dirty witch who claims to have 'papers from the old country.'" MacMurchy, *Maternal Mortality in Canada*, 52.

28. *Report of the Task Force on Midwifery*, 201–206; Biggs, "The Case of the Missing Midwives."

29. MacMurchy, *Supplement*, 139–140.

30. MacMurchy, *Supplement*, 143.

31. MacMurchy, *Supplement*, 156.

32. By the early twentieth century, this faith in the ability of medical science to reduce the risks and pains associated with childbirth for both mother and baby was widespread, despite evidence that actual improvements lagged far behind. Leavitt, *Brought to Bed*.

33. National Council of Women Yearbook, National Archives of Canada, 1924, 73.

34. Wendy Mitchinson, *The Nature of Their Bodies*, 152–230.

35. National Council of Women Yearbook, 1924, 71–74.

36. Buckley, "Ladies or Midwives?"

37. *Report of the Task Force on Midwifery*, 215–217.

38. National Council of Women Yearbook, 1924, 74.

39. *Ibid.*

40. Executive Meetings, 10 September 1923, 30 October 1923 and 1 December 1923, National Archives, Canadian Nurses Association, MG 28 I 248, Microfilm M4606.

41. Barbara Melosh, *"The Physician's Hand": Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982); Susan Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850-1945* (Cambridge: Cambridge University Press, 1987).
42. See Biggs, "The Case of the Missing Midwives," 21 and Connor, this collection. In the U.S., the midwife was often prohibited from performing many necessary functions—from vaginal examination to applying silver nitrate to the newborn's eyes to prevent ophthalmia neonatorum. Also, Litoff, *American Midwives*, 78, 97.
43. MacMurchy, *Maternal Mortality in Canada*, 60; Litoff, *American Midwives*, 78, 97.
44. National Council of Women Yearbook, 1924, 71-74.
45. MacMurchy, *Supplement*, 139.
46. Buckley, "Ladies or Midwives?"
47. National Council of Women Yearbook, 1923, 60.
48. MacMurchy, *Supplement*, 139-140.
49. MacMurchy, *How to Make Our Outpost Home in Canada* (Ottawa, Department of Health, 1927), 19.
50. Largely in the western provinces some soldier-settlers were provided with Dominion lands, although many received only loans for livestock and equipment purchases. *Soldier Settlement on the Land* (Ottawa: Report of the Soldier Settlement Board, 31 March 1921); Robert England, *Twenty Million World War Veterans* (London: Oxford University Press, 1950), 31-39.
51. Requests for aid were directed to charitable organizations such as the Patriotic Fund or Red Cross. *Soldier Settlement on the Land*, 17, 39-41, 66, 74, 80, 85-86, 91-92, 101-102, 109-111, 119, 123-125, 131, 138-139, 146.
52. Report of the Department of Health for 1923 (Ottawa: Federal Sessional Papers No. 19), 43.
53. *Ibid.*, 43.
54. Report of the Department of Health for 1924 (Ottawa: Federal Sessional Papers No. 19), 39.
55. MacMurchy, *Supplement*, 143-144.
56. MacMurchy, *Supplement*, 144.
57. MacMurchy, *Supplement*, 148.
58. MacMurchy, *Supplement*, 146-148.
59. MacMurchy, *Supplement*, 149.
60. MacMurchy, *Supplement*, 149-150.
61. MacMurchy, *Supplement*, 150.
62. MacMurchy, *Supplement*, 151.
63. MacMurchy, *Supplement*, 154-155.
64. MacMurchy, *Supplement*, 156.
65. MacMurchy, *Supplement*, 140.
66. MacMurchy, *Supplement*, 139-143.
67. MacMurchy, *Supplement*, 142.
68. MacMurchy, *Supplement*, 153.

69. MacMurchy, *Supplement*, 153.
70. MacMurchy, *Supplement*, 154.
71. MacMurchy, *Supplement*, 157.
72. MacMurchy, *Supplement*, 160.

73. Interested organizations such as the Canadian Nurses Association, Canadian Medical Association and the National Council of Women do not discuss the *Supplement*. No reference can be found to it in the *Canadian Journal of Public Health*, *The Canadian Nurse* or the *Canadian Medical Association Journal*. The records of the Victorian Order of Nurses, the holdings of the Canadian Red Cross Archives, Ottawa, were searched, as well as several biographies of public health nurses. For example, Marion Royce, *Eunice Dyke, Health Care Pioneer* (Toronto, Charlottetown: Dundurn, 1983); Alvine Cyr Gahagan, *Yes Father, Pioneer Nursing in Alberta* (Manchester: Hammer Publications, 1979). See also National Archives, National Council of Women of Canada, MG 28 I25; National Archives, Victorian Order of Nurses, MG 28 I171; National Archives, Canadian Nurses Association, MG 28 I 248. There are at present only two copies of the *Supplement* in Canada, both in the National Library.

74. Report of the Department of Colonization and Immigration for Year Ending March 31, 1927 (Ottawa: Department of Colonization and Immigration, 1928), 63.

75. Dr. Pugsley, interview by author, Ottawa, February 1990.

76. Letter from Fyvie Young, Secretary, Division of Maternal and Child Hygiene, Canadian Welfare Council, to J. J. Heagerty, Chief Executive Assistant, Department of Pensions and National Health, dated 23 March 1937, National Archives of Canada, Department of Health Records, RG 29, vol. 991, file 499-3-2 pt. 3.

77. *Ibid.*

78. Letter from Heagerty to Young, dated 24 March 1937, National Archives of Canada, Department of Health Records, RG 29, vol. 991, file 499-3-2 pt. 3.

79. The number of midwife-attended births had fallen dramatically in North America from 1900 to 1930 due to immigration restrictions, acceptance of the medicalized view of childbirth, as well as a fall in the birth rate. Litoff, *American Midwives*, 97.

80. Mabel Crews Ringland, "Home Nursing Brought to Your Door" (reprinted from *The Canadian Countryman*), *Canadian Red Cross Bulletin* (January 1924), 2.

81. *Manual for Home Nursing Classes* (Toronto: Canadian Red Cross Society, 1923), 77-88.

82. *Manual for Home Nursing Classes*, 82.

83. Advertisement, "To the Women of Canada," Canadian Red Cross Society Archives, Ottawa.

84. Canadian Red Cross Annual Report, 1929 (Toronto: Canadian Red Cross Society), 26-27.

85. Ernest Couture, *The Canadian Mother and Child* (Ottawa, Department of Health, 1940).

86. Northwestern Ontario Women's Health Information Network, *Long Distance Delivery* (Helmsman Press), 58. Thanks to Meryn Stuart for bringing this source to my attention.

87. *Ibid.*, *The Canadian Mother and Child* (Ottawa: Department of National Health and Welfare, 1967), 161-167.

88. Litoff, *American Midwives*, 74.

89. McKenzie Porter, *To All Men: The Story of the Canadian Red Cross* (Toronto, McClelland and Stewart, 1960), 54–65.
90. MacMurchy, "Classification of Maternal Deaths," *Canadian Journal of Public Health* XXII, 1 (August 1931): 412–419; MacMurchy, *Maternal Mortality in Canada*, 6–7; Minutes of Meeting, December 15–17, 1924, Dominion Council of Health. National Archives. Microfilm C-9814.
91. Conference on Medical Services in Canada, 18 to 20 December 1924 (Ottawa, 1925), 87–104.
92. Conference on Medical Services in Canada, 1924, 89.
93. The Dominion Bureau of Statistics reported a maternal mortality rate of 5.6 for 1925. See George Emery, "Fatal Pregnancies in Ontario, 1920–1935: A Reappraisal of the Published Vital Statistics," paper presented 28 May 1990 at Canadian Historical Association Annual Meeting, Victoria, B.C.
94. MacMurchy, *Maternal Mortality*, 26.
95. MacMurchy, *Maternal Mortality*.
96. MacMurchy, *Maternal Mortality*, 55.
97. MacMurchy, *Maternal Mortality*, 23. As estimates of the number of unattended or midwife-attended births in the U.S. at this time ranged from 30% to 40%, it is clear that the absence of a physician at the birth was not a major cause of maternal death. Litoff, *American Midwives*, 114.
98. MacMurchy, *Maternal Mortality*, 27.
99. MacMurchy, *Maternal Mortality*, 13–14, 24–29.
100. MacMurchy, *Maternal Mortality*, 12.
101. Buckley argues that MacMurchy paid little attention in her maternal mortality report to non-medical factors involved in maternal deaths. A closer examination of her career, however, indicates that MacMurchy's view of maternal health was broader than that of most male physicians. See Buckley, "The Search for the Decline in Maternal Mortality."
102. MacMurchy, *Mother* (Ottawa: Department of Health, 1928), 13.
103. MacMurchy, *Maternal Mortality*, 55–56.
104. *Report of the Task Force on Midwifery*, 211, 213; Boutilier, "An Intelligent Handmaid."
105. *Report of the Task Force on Midwifery*, 209–211.
106. "VON Director General's Report, Comparative Statistics, 1898–1922," National Archives of Canada, Victorian Order of Nurses, MG 28 I 171, vol. 9, file 10–7.
107. In Ontario, for example, between 1922 and 1933, 3,600 births occurred at the Red Cross's twelve outpost hospitals, eleven nursing stations, and one hospital railway car. *Report of the Task Force on Midwifery*, 217.
108. Cyr Gahagan, *Yes Father*, chap. 8 (pp. 86–97), for example, describes this nurse's first baby case, of which there were many more. Interestingly she was not adverse to using many of the techniques one might think of as being reserved for doctors. At her first case, a difficult one, she used pituitrin to hasten a slow labour and chloroform to relieve pain. In another case, however, she describes calling in a doctor to deliver a large stillborn by forceps. She recalls her fear and sense of helplessness, knowing that if the doctor had not made it, the woman would have died.
109. MacMurchy, *Maternal Care* (Ottawa, Department of Health, 1931).

110. The VON counted against its mortality rate any death occurring after a patient was removed to hospital. *Report of the Task Force on Midwifery*, 221.
111. MacMurchy, *Infant Mortality, Special Report* (Ontario Sessional Papers No. 60, 1911), 21.
112. For example, a pamphlet published by the Toronto Department of Public Health in 1922 told women, "Do not engage a midwife, it is illegal." *Report on the Task Force on Midwifery*, 214. See also *The Child* (Metropolitan Life Insurance, 1912), 7, which gives similar advice. Thanks to Denyse Baillargeon for bringing this source to my attention.
113. MacMurchy, "A Job for Supernurses," *Canada Lancet and Practitioner* 81, 5 (November 1933), 131-132.
114. MacMurchy, *Maternal Mortality*, 55.
115. Letter from Mrs. Leonard Renaud, Wawkewawa, Ontario, to Department of Health, dated 10 July 1935, RG 29, vol. 991, file 499-3-2 pt. 2; Letter from Mrs. Alex Denman to Department of Health, dated 7 January 1937, RG 29, vol. 991, file 499-3-2 pt. 3. See also MacMurchy, *Maternal Mortality*, 11.
116. Minutes of Meeting, 15 to 17 December 1924, Dominion Council of Health.
117. Malcolm G. Taylor, *Health Insurance and Canadian Public Policy* (Montreal: McGill-Queen's University Press, 1978), 69-104, 239-330; Robert S. Bothwell, John R. English, "Pragmatic Physicians: Canadian Medicine and Health Care Insurance, 1910-1945," in *Medicine in Canadian Society*, ed. S. E. D. Shortt (Montreal, McGill-Queen's University Press, 1981), 479-494; C. David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966* (Kingston: McGill-Queen's University Press, 1986); Dodd, "Advice to Parents."
118. MacMurchy, *Maternal Mortality*, 23-24.
119. Taylor, *Health Insurance*, 6.
120. Taylor, *Health Insurance*, 90.
121. Strong-Boag, "Canada's Women Doctors."

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Care of Mothers and Infants in Montreal between the Wars: The Visiting Nurses of Metropolitan Life, Les Gouttes de lait, and Assistance maternelle

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(TRANSLATED BY SUSAN JOSS)

Motherhood, that is, childbearing and child rearing, constitutes one of the main components of modern homemaking. Indeed, it was precisely that responsibility, assigned exclusively to women, that justified the existence of a domestic environment separate from the world of business, and the assignment of women to that environment and the activities pertaining to it. This new separation of social roles, brought about by industrialization and based on the concept of the breadwinner–homemaker couple, was accompanied by the emergence of a glorification of motherly love and the mother–child relationship and the designation of motherhood as the primary and exclusive vocation of women.¹

Ironically, while women were said to be endowed with an innate maternal instinct that made them alone able to devote themselves entirely to the care of young children, the field of obstetrics and infant care began to be invaded by a host of new “experts,” particularly social reformers and physicians. At the end of the nineteenth century, by which time midwives had been practically eliminated, at least in urban areas,² women’s knowledge of child rearing began to be looked down upon, and women were urged to seek and follow the advice of a doctor, both concerning their pregnancy and about child care. Scientific discoveries about hygiene and the spread of disease lent credence to these recommendations, which were presented as the most effective way to combat infant mortality.³ Those who neglected to consult the doctor and who preferred bottle-feeding were soon to be strongly upbraided and deemed responsible should their children die.⁴

However, it took several decades before the medical profession had complete control over child care and obstetrics in all social classes. It was relatively easy to convince well-to-do women to submit to medical

checkups throughout their pregnancies and to follow the recommendations of their physician with regard to hygiene and the feeding of newborns. Indeed, middle-class feminists and public-health physicians collaborated closely in promoting the cause of public health and reducing infant mortality.⁵ It was much more difficult to induce working-class women to consult a physician, mainly because of the cost involved. Shortly before World War I, various organizations were created with a view to providing maternal care to those who could not afford such a luxury, and they seemed to play a crucial role in the medicalization of delivery and infant care.

Indeed, according to the reports of thirty Montreal working-class women who were married between 1919 and 1934, they rarely consulted the doctor more than once or twice during their pregnancies.⁶ However, the interviews showed that almost all of them had availed themselves of the free medical services offered by one of the organizations that will be studied in this paper. These are the visiting nurse program of the Metropolitan Life Insurance Company, used by more than one third of the women in the sample (twelve out of thirty), the Gouttes de lait clinics, which almost all of them visited (twenty-seven out of thirty), and the Assistance maternelle program, which helped a few respondents who were particularly poor (three out of thirty). The reports of these women show that it is by these means that medicine succeeded, not without some difficulty, in educating poorer women about its new standards in this area. To illustrate this process, we shall briefly review the history of these three organizations, defining their objectives, the services offered and the clientele they targeted, and then consider the assessment of them, by the women in my sample, as well as their opinions on medicine and the medical profession.

The Visiting Nurses of Metropolitan Life

Thanks to premiums as low as five cents per week and to its system of weekly collection by agents, the Metropolitan Life Insurance Company succeeded from the beginning of the century in attracting a working-class clientele, both in the United States, where it was founded, and in Canada. To combat the high mortality rate of its members, and at the instigation of a New York philanthropist, Dr. Lee Frankel, the company decided in 1909 to create a Welfare Division that would disseminate information on precautions to be taken against the infectious and contagious diseases that were ravaging its clientele.⁷

In that same year, this time at the suggestion of Lilian D. Wald, a friend of Frankel's who was the nurse responsible for the Henry Street Settlement in New York, the company agreed to carry out a three-month, experimental program of visiting nurses for its sick policyholders in a poor district of Manhattan. The nurses would visit the policyholders at the suggestion of the agents who collected the policyholders' premiums at their homes every week, and who were thus able to identify those who needed particular care. The experiment was so successful that the company had no choice but to gradually extend it to its entire clientele. By the end of 1909, thirteen American cities were benefiting from this service; five years later, it was operating in 1,804 American and Canadian cities. In the mid-1930s, when it reached its fullest expansion, the service was available in over 7,000 municipalities throughout North America. When the company finally discontinued the service in 1953, over twenty million policyholders had received over one hundred million visits from these nurses.⁸

Despite the high cost of the visiting nurse program, it proved very worthwhile, as in 1918 the company found that the mortality rate of its policyholders had dropped by 18% in seven years, even taking into account the deaths due to the influenza epidemic following World War I. During those same seven years, the company estimated that 18% of the nurses' visits had been to pregnant women before and after delivery, which resulted in a drop in infant mortality of 46.5% among the company's policyholders compared to a drop of only 10.8% in the general population.⁹ In the 1920s and 1930s, over 30% of visits were devoted to pregnant and post-partum women.¹⁰

In Canada, the company set up its first visiting nurse programs in Montreal and Halifax in 1910, that is, one year after the service was introduced in the United States. The following year it was expanded to Quebec City, Toronto and Winnipeg. Wherever it could, be it in Canada or the U.S., the company provided this service through local visiting nurse associations, paying a fee to the association for each visit made on the company's behalf. In areas where no such service existed, the company hired nurses directly. Thus, in Montreal, the Victorian Order of Nurses (VON) was approached to serve the company's English-speaking clientele, while the *Sœurs de l'Espérance* looked after some of the French-speaking clientele until 1923, when they terminated their association with the company.¹¹ The amount of paperwork involved, and the large proportion of maternity cases that they were expected to handle, were given as reasons for discontinuing the association;¹² for its part, Metropolitan Life was frustrated that the nuns were unable to

cover the entire city due to lack of personnel, which forced the company to resort to arrangements that were often awkward, such as sending nurses from the VON, who did not speak much French, to visit Francophone patients.¹³ To solve its difficulty in recruiting French-speaking personnel once and for all, the company finally decided to get involved in the training of public-health nurses by making a financial contribution towards the founding, in 1926, of the School of Applied Public Health, affiliated with the Faculty of Medicine of the Université de Montréal, which became its main source of nurses.¹⁴

When the service was set up in 1909, it was intended exclusively for policyholders who were suffering from acute illnesses. The growing interest of government authorities in the phenomenon of infant mortality, both in the U.S. and Canada, convinced the company to liberalize its policy. In 1914 it decided to allow eight postnatal visits to any mother who requested them, provided that she had held an insurance policy for one year. Later, beginning in January 1916, pregnant women were also entitled to two prenatal visits, and then to four beginning in 1920, provided that the pregnancy was reported before the sixth month. Finally, in 1922, the number of prenatal visits was increased once again; expectant mothers could benefit from a maximum of eleven prenatal visits—one per month from the first to the seventh month of pregnancy and two during the eighth and ninth months, plus eight postnatal visits during which the nurse also cared for the newborn.¹⁵ In order to receive prenatal visits, the patient had to have consulted her physician first; for postnatal visits, Metropolitan Life's visiting nurses had standing orders that authorized them to take care of new mothers without any specific recommendation from an attending physician.¹⁶

During prenatal visits the nurses' duties consisted of informing the patient about hygiene during pregnancy and the importance of a sound diet and plenty of rest. They taught the rudiments of child care, insisted on breast-feeding and tried to encourage the patient to visit her physician regularly and to have urine samples analyzed to avoid problems of albuminuria and eclampsia. Towards the end of the pregnancy, the nurses also had to show the patient what articles to prepare for the birth (which took place in the home) to ensure that conditions were as hygienic as possible. The nurses did not attend the birth, as the company felt that this would have taken up too much of their time, but they made at least eight postnatal visits. At each visit they would give a bath to the mother and to the baby, check the condition of the breasts and the perineal area, clean and put a dressing on the baby's umbilical

cord and provide any other care prescribed by the physician, in addition to continuing to educate the patient.¹⁷

The creation of a visiting nurse service by a private company such as Metropolitan Life was a specific response to an economic necessity. Its program of maternal and child care was strictly limited to its working-class policyholders¹⁸ and its main objective was to reduce the costs associated with fetal and neonatal mortality. The company targeted this segment of its clientele because it believed, as did all the social reformers of the time, that the poorest women were also those who had the greatest need for care and counselling during pregnancy. The service was designed to educate them about hygiene and nutrition but also to induce them to consult a physician more regularly.

Les Gouttes de lait

Les Gouttes de lait¹⁹ was undoubtedly the best known of the three organizations studied, although their origins are less well known. The first clinic was created in 1901 by a small group of Montreal doctors at the instigation of a reporter for the *La Patrie* daily newspaper, Madeleine (Mrs. Huguenin), and of Mrs. Justine Lacoste-Beaubien.²⁰ The newspaper undertook to sponsor the project. Their initial objective was to combat infant mortality by distributing high-quality milk to mothers in the poor neighbourhoods of Montreal who could not (or did not wish to) breast-feed. The first clinic was located on Ontario Street, at the corner of Plessis; it was obliged to close down after just a few months due to lack of funds. The idea was revived two years later, this time at the instigation of Anglophone and Francophone physicians who founded the Pure Milk League. Financed in part by the City of Montreal, the League was successful in opening four distribution offices that operated only during the summer months, when diarrhea was most prevalent among babies.²¹ From 1910 onwards there were more successful attempts to organize Les Gouttes de lait on a permanent basis. In that year, three independent clinics were set up, one by Mgr. Le Pailleur in the parish of Saint-Enfant-Jésus, a second by the Fédération nationale Saint-Jean Baptiste, affiliated with the Hôpital Sainte-Justine, which had been founded just three years earlier,²² while the English-speaking community set up a third. In 1911, ten new clinics were added, endowed with a municipal grant of five hundred dollars each. As early as 1913, the centres multiplied, generally one per parish. In that same year, the first convention was held of representatives of all the French-speaking

Gouttes de lait clinics, under the chairmanship of Dr. S. Lachapelle, for the purpose of reviewing the problems facing the organization and means of expanding it. The following year the centres reorganized under the administration of the Bureau central des Gouttes de lait de Montréal, consisting of the director of the public health office and members elected by local committees. This central office was supposed to organize new local committees, oversee the operation of the Les Gouttes de lait and distribute funding, which was now centralized. The local committees, consisting of the parish priest, attending physicians and volunteer women, were responsible for providing consulting services, distributing the milk and providing assistance to mothers.²³ In 1927 the Bureau central des Gouttes de lait was replaced by the Fédération d'hygiène infantile.

In 1915 there were twenty-eight Gouttes de lait clinics in Montreal, including five English-speaking Milk Depots, which still concentrated essentially on the distribution of high-quality milk. In 1919, the health department of the City of Montreal set up fourteen baby clinics (also known as Gouttes de lait) staffed with graduate nurses. Ten years later, there were twenty-seven of them. From the early 1920s onwards, whether public or private, Les Gouttes de lait seemed to focus more on medical checkups of infants than on the distribution of milk, which was by then widely pasteurized (this was mandatory by 1926). Thanks to parish priests, who promoted Les Gouttes de lait from the pulpit, and to columns in newspapers like *La Patrie*, all mothers in working-class neighbourhoods, not just the poorest ones, were invited to bring in their babies for regular checkups during their first few years of life. Often the clinics were located in premises loaned by the parish, which also recruited volunteer women to look after administrative duties, while the city's public health department paid the physicians and nurses. Beginning in the 1930s, the municipal clinics also offered prenatal consultations during which women learned how to care for and feed their children and were given advice on general matters of hygiene.²⁴ In 1935 Montreal had forty-two baby clinics operated by the city's health department, seventeen Gouttes de lait clinics operated by the Fédération d'hygiène infantile and thirteen clinics sponsored by the Child Welfare Association, for a total of seventy-two. They had evolved from a clean milk distribution service, aimed at the needy, into a consulting service open to all mothers, except the most well-off, who could afford to consult their family physician. These consultations focussed on educating mothers and detecting illness in children. No treatment, except for vaccinations, was administered or prescribed at these clinics.

Assistance maternelle

The poorest mothers in Montreal could avail themselves of the service of an association founded in 1912 by Caroline Leclerc Hamilton (also a founding member of the *Fédération nationale Saint-Jean Baptiste*) called *Assistance maternelle*. This organization, which is still in existence, adopted the goal of combating infant and maternal mortality by helping destitute women during and after their pregnancies. Despite the opposition of certain priests who, it seemed, saw no necessity for such work, Mrs. Hamilton succeeded in setting up parish-based committees, which grew in number from eighteen in 1917 to thirty-eight in 1936.²⁵

Each parish committee organized a workroom, set up sewing circles and took care of cases that were referred to it, often by other charitable organizations such as the *Société Saint-Vincent-de-Paul*. The volunteer women on these committees visited the homes themselves (usually to confirm the dire poverty of the individuals in question), distributed food, furniture, and clothing, including the baby's layette, and taught the mothers principles of hygiene and child care. They also provided free medical care before, during, and after delivery.

To accomplish the latter activity, the organization equipped itself from the very beginning with a dispensary where physicians provided free consultations to these mothers, two afternoons per week. The dispensary moved several times into ever larger premises, and eventually operated five days per week. Indeed, the medical care of these mothers took on increasing importance as the years went by, as even the home visits were taken over by nurses hired by *Assistance maternelle*, replacing the volunteers who had no medical training. From the 1920s onward, women who came in for a checkup were invited to enjoy a snack while a nurse lectured them on prenatal hygiene, the feeding of newborn babies, and child care.²⁶

From 1922 to 1926, *Assistance maternelle* had a small ten-bed hospital for the care of widowed or abandoned mothers or the treatment of serious cases requiring care that could not be provided at home. Over those four years, the hospital admitted 601 patients.²⁷ After that, the organization simply paid the cost of delivery when necessary, be it at the mother's home or in a city hospital. In 1924, the organization provided assistance to 824 mothers and distributed 374 layettes; in 1932, one of the most difficult years of the Depression, it helped 4,194 mothers and supplied over 2,000 layettes.²⁸

By various means, and by targeting specific clientele, these three organizations worked principally to prevent infant mortality in order to reduce the social and private costs associated with it. Through brochures, lectures, home visits or checkups in clinics, all three sought to educate mothers about hygiene and nutrition, as the ignorance and negligence of working-class women were then considered the primary causes of the high mortality rates among small children. The restrictions that were attached to the free services provided by Metropolitan Life and Les Gouttes de lait (e.g., the requirement that women first consult a physician in order to be entitled to prenatal visits by the nurses of Metropolitan Life, and the lack of treatment for sick children at Les Gouttes de lait) also indicate that one of the objectives of these organizations was to induce women to consult a physician during their pregnancies and for childhood illnesses. Thus humanitarian motives, not devoid of financial considerations, were accompanied by a desire to extend the reach of the medical profession.

Mothers, Doctors, and Nurses

Were the educational efforts of these organizations effective? Did the women welcome the advice that was given to them? How did they feel about the health professionals, doctors, and nurses, who tried to get them to adopt new behaviours during their pregnancies and in the way they cared for their children? The testimony drawn from interviews sheds some light on these questions.

It should first be pointed out that, contrary to the wishes of physicians, most of the women in the sample did not consult a medical practitioner until the sixth or seventh month of pregnancy. If everything went smoothly, they did not see him again until the delivery. A few of the women interviewed had never met the doctor before then; on the other hand, a few others had several checkups during their pregnancy. These were either women who were better off financially (in just a few cases) or the most destitute, i.e., those that were cared for by Assistance maternelle (in three cases). The testimony of one respondent indicates that the physicians affiliated with that organization insisted that patients submit to regular medical care in exchange for the material support provided:

They gave us a large flannelette blanket, two sheets and pillowcases, and clothing for the baby: three nighties, three undershirts, a dozen diapers, little socks and little woollen sweaters. They made up a package for us.

Then, they kept an eye on us. You know, you had to go once a week. In my case, they gave me a bassinet, and bottles. We went to Assistance maternelle in the afternoon. There we had a snack, the doctor was there, the nurses gave us advice just like when people go to prenatal courses today. Since I was obliged to drink a lot of milk, they sent me to the Poupart company where I was given two quarts of milk free of charge. I didn't pay for them; they did.²⁹

Assistance maternelle also paid for the hospital deliveries of two of the three women in the sample who used its services. The testimony of one of them implies that these women served as case studies for the young doctors who came to examine the patients before and after delivery: "There were lots of doctors around me, around the bed, and they examined us. The doctor was there and explained why the delivery had been difficult."³⁰ This respondent did not appreciate being treated in such a fashion. She also complained that she never received the layette that had been promised her, on the pretext that this was her first child and her husband was working. (Because of the Depression his wages were only \$10 per week.) On the other hand, none of the respondents complained of the medical care to which they were obliged to submit. However, their comments suggest that they attached greater importance to the material assistance provided in the form of linens, clothing and various supplies for the baby and the snacks provided during their visits, than they did to the advice offered during the lectures that they were obliged to attend. Indeed, their memories of those lectures were rather vague, which would indicate that the information provided did not leave much of an impact.

Twelve of the thirty women interviewed received visits from Metropolitan Life's visiting nurses during one or more of their pregnancies. As they did not see a doctor until around the sixth month, they could only receive a portion of the prenatal visits allowed by the company's regulations. According to their reports, the main subject of these visits was the preparation for the delivery, and the nurses seemed to focus mainly on the cleanliness and asepsis of the linens and accessories:

From the seventh to the ninth month, she [the nurse] came to show us how to make quilts for the delivery. She made us take newspapers, sterilized in the oven, and we bought cheesecloth.³¹ She had us alternate layers of newspaper and cheesecloth. We quilted them together with large stitches. She had us make small ones and large ones.³²

In those days when we had insurance from Metropolitan Life, the nurses would come. When we were pregnant, they would come visit us, and explain what to do, and had us make newspaper quilts. We took several layers of newspaper, along with a piece of cotton, pillowcases, or old sheets, and we sterilized them with an iron. That made it very clean, and then we sewed it all together around the edge with large stitches. To make sanitary napkins we took a piece of sterilized cotton and put cotton batting. When we gave birth at home everything was ready. When the doctors came into the house they were not revolted; the towels and absolutely everything were clean. She [the nurse] came and showed us how to prepare our breasts for having the baby, and then she had us make our quilts, so that everything was ready.³³

We prepared a tray with everything the baby would need. We put a bar of soap, and stuck safety pins into it. The diapers in those days were not like they are today. It was easier to get the safety pins through them if you poked them into soap first. We had a whole lot of jars with clean lids to hold boiled water. And for the umbilical cord, for the navel, there were cloths of real linen. We cut out squares with holes in the middle to thread the umbilical cord through. We wrapped it all up in a clean cloth and then put it in a cool oven to sterilize it. Then that was wrapped up in another clean cloth. All this was on a tray. When the nurse came [in the days following the birth] she used the tray with a pot full of water that had been boiled to give us our sponge bath.³⁴

According to another respondent, the tray also had to hold oil, powder, cotton batting, etc. These preparations were certainly more complicated than those performed by other women who did not benefit from this service; as one of the respondents, already quoted above, pointed out, "Let me tell you, we worked hard in those days when we had a baby, and we were not rich either!"³⁵

The preparation of all these materials did indeed take a lot of time, but only one of the respondents disliked the service specifically for that reason: "It was a whole lot of bother, get out this, get out that," she said.³⁶ The others quite appreciated the services of Metropolitan Life's visiting nurses, not for the advice they gave on hygiene during pregnancy or on nutrition, which they never mentioned, but because these preparations, although time-consuming, gave them a sense of security and saved a lot of work at the time of the delivery:

Even if I had asked my mother [how to prepare for the delivery], she did not even know because, in her day, they used whatever they had on hand. They did not take as many precautions as we did. We took precautions. I made quilts; I cut up old sheets, laid a thick layer of newspaper in

between, and sewed it all around; it saved a lot of laundry. We even made our own sanitary napkins. I made dozens and dozens of them, and then we threw them away. It saved a lot of laundry.³⁷

[The quilts and the home-made sanitary napkins,] those were meant to be thrown out. When we gave birth, it made a mess, right? So, this saved you a lot of work. Because we got a lot of sheets and other things dirty. They [the nurses] changed our bed every day. Otherwise, if we had had quilts [store-bought ones], you didn't throw those ones away, you washed them.³⁸

They also appreciated the daily visits by the nurse during the eight or nine days they had to stay in bed after the birth: "When we had a baby, the nurse from Metropolitan Life came every day. She bathed us, bathed the baby and showed us how to bathe the baby. My dear, it was wonderful!"³⁹ The interviews showed that it was not always easy for these women to get help after the birth. Death, distance or responsibility for a still growing family were reasons that only a minority of the respondents benefited from the assistance of their mother or mother-in-law after the birth. For those women in particular, there is no doubt that the reassuring presence of the nurse was a valuable source of support. It should be pointed out that the nurse took care of the mother and baby only, which was not true of relatives (mother, mother-in-law, sister, cousin, etc.) who, when they were able to help out, generally devoted some of their visits to household chores that had been put on hold.

Only a few of the respondents took advantage of the prenatal consultations offered by *Les Gouttes de lait*. According to their reports, the purpose of these consultations was to teach them how to care for the new baby and to show them how to prepare the material they would need for the birth; generally speaking, the latter instructions resembled those given by the nurses from Metropolitan Life. However, the vast majority of the respondents did visit *Les Gouttes de lait* with one or more of their children, who were examined, weighed and vaccinated, and the young mother received advice on nutrition and infant care.

Although almost all the respondents took advantage of this service, not everyone was pleased with it. For various reasons, some mothers did indeed appreciate it, particularly in the case of a first child: "I found that it helped young people who didn't know anything, like myself," declared one respondent.⁴⁰ "It was very useful," stated another, "they gave the children their shots, which saved us a visit to the doctor."⁴¹ "It was our only opportunity to have the children weighed," added another.⁴² On the other hand, many respondents emphasized

that the clinics involved significant inconvenience. One respondent explained, "I didn't care for it much because when we got there, the baby was subjected to a change in temperature: they took off all his clothes. Some of the children there had colds, others had whooping cough."⁴³ Apart from the risks of contagion, many respondents also pointed out that, when the second or third child came along, it became more difficult to get to the clinic: "But after that, with three (children), I stopped going to Les Gouttes de lait. I would have had to take all three."⁴⁴ Since the baby was given a rather cursory medical examination and the clinics restricted their medical activities to screening, going to Les Gouttes de lait with several children was considered a useless extra bother. Moreover, after one or two pregnancies, the mothers had gained some expertise in the diagnosis and treatment of common childhood diseases:

When the children were sick, we were the ones who took care of them. We knew what it was, all the children went through it. For measles, we kept them in the dark; we learned this on our own, by word of mouth. I had older sisters; watching them, I learned these things automatically, I guess.⁴⁵

Although it seems to be an exception, the report of one respondent also shows that conflicts could arise between the mothers and the health professionals on how to care for the baby:

As for me, I never enjoyed going to Les Gouttes de lait. At Les Gouttes de lait, they told us "Hey, don't give that to your baby, he will die; don't give that to your baby, it will make him sick. Give him this, don't give him that." They used to make the children sick with all that. I went with my children. The nurse didn't want me to give the baby solid food before the age of nine months. The baby was crying day and night. No matter how much milk I gave him, I could not fill him up with that. So, I started giving him solid food. When she found out, she told me not to go back to Les Gouttes de lait because I was an unnatural mother who didn't want to raise her children properly.⁴⁶

There was another respondent who preferred to go to the English-speaking clinic because she found the staff there did not lecture as much.

Although the advice given by Les Gouttes de lait was much appreciated by young mothers who were inexperienced or lacking help from other sources, it would seem that it became less important after the second or third child was born, as the women then felt that they had

acquired sufficient expertise to care for the baby on their own. Since serious health problems were not treated at *Les Gouttes de lait*, many respondents saw no need to make regular visits, which took up a lot of their valuable time. Despite the wishes of the clinics' promoters, who insisted on the necessity of regular medical visits for all children, few women in our sample took all their children there on a regular basis.

The competence of the health professionals and the practicality of their knowledge were also questioned by the respondents. Most of the women admitted that they would not have relied only on a midwife to have their babies, as many of their mothers had done, because they felt it would be too risky. In this respect, it would seem that the medical establishment's claims about the incompetence of midwives, compared to the "modern" knowledge and techniques that only doctors could provide, carried the day. This did not prevent the respondents from criticizing, sometimes harshly, the practices of certain obstetricians. For example, during her first delivery, one respondent, to whom the doctor had given ether, reported she was too drowsy to push, and the doctor had to use forceps, nearly pulling off the baby's head: "It was real butchery," she said. "If the doctor had been competent, he might have saved him."⁴⁷ Another, whose perineum was torn during her first delivery, recalled indignantly that the doctor had told her that there was no point in sewing it back: "We'll do that for you when you're finished having children," he told her.⁴⁸ Many women also pointed out that despite the doctor's fee, which was between \$10 and \$25 (more than a week's salary for some), often he did not arrive until the child was already born: "When the doctor arrived, only the lower portion of the child's body remained to come out."⁴⁹ "With my second, the doctor arrived three quarters of an hour after the baby was born!"⁵⁰ Furthermore, the doctors did not wash the baby, leaving that "duty" to a woman, whether private nurse, midwife (usually a neighbour, so called due to her experience with childbirth) or relative who had come to help out the mother. Given these circumstances, it is not surprising that some of them questioned the usefulness of having the doctor come, although not until after the fact.

The women were particularly skeptical about the performance of modern medicine with respect to the fight against infant mortality, which was still high at the time. In speaking of her first child, who died of complications of jaundice, one respondent said, "That child would not have died if he had been born today."⁵¹ Another explained, "In those days, women had fifteen or sixteen children and lost five, six, sometimes more. They died in babyhood. In those days, the doctors

didn't know anything."⁵² Many respondents also asserted that they had cured their children using traditional medicines, after applying the doctor's recommendations to no avail. In at least two cases, premature infants were saved thanks, not to a doctor's care, but to that of a mother-in-law or a neighbourhood midwife: "The old women said, 'That child will not live.' It was my mother-in-law who saved him. He had no fingernails, and was not pleasant to look at. He was lying in his bassinet and my mother-in-law had surrounded him with hot water bottles," said one respondent.⁵³ According to another respondent, Paregoric, a medicine that was popular at the time, was even dangerous for children: "It made them sleep so soundly that we were afraid they were dead."⁵⁴ Whether well-founded or not, these criticisms show that medical science and its practitioners had not yet won everybody over, and that women were quite critical about the invasion of these so-called "experts," especially into the realm of child rearing. Despite the position of the medical establishment, which held women responsible for infant mortality, the women generally considered that this was an inevitable phenomenon, given the state of medical science at the time—thereby throwing the ball back into the other court.

The same reticence is revealed in the small proportion of women who breast-fed their babies. Despite numerous preachings in favour of nursing, the only effective way to combat infant mortality according to the "experts,"⁵⁵ half of the women interviewed did not breast-feed, and of those who did, many stopped after the first month. The report of one respondent who did nurse seems to show that, contrary to the claims of the medical profession, breast-feeding was not necessarily a panacea against infant diarrhea. "We had a lot of problems with stomach upsets. He was born with diarrhea; I was never able to stop it. I lost him after seven weeks."⁵⁶

A lack of breast milk, due to the poor health of these women or to malnutrition, as well as the numerous inconveniences associated with the practice, explain why women did not nurse more often or for longer periods. The amount of attention the mother had to give to the baby, the impossibility of doing anything else at the same time, and the isolation in which nursing had to take place so as not to transgress the rules of modesty, all contributed towards many mothers giving it up, especially when there were other children demanding their care and attention. Most of the women did know, however, that nursing could help postpone the next pregnancy, and those who nursed for a long time generally did so for that reason.

Conclusion

The organizations studied in this article, particularly the visiting nurses of Metropolitan Life and Les Gouttes de lait, wanted above all to educate women about hygiene and nutrition and convince them of the necessity of regular medical care for themselves and their children. The reports of the women in our sample show that, in fact, the women attached little importance to the educational efforts of these organizations, although they did succeed in inducing the women to adopt certain practices and accept certain services from health professionals, particularly from nurses.

Of the three organizations studied, the visiting nurses of Metropolitan Life seemed to be the most appreciated by the women who benefited from their services. The majority of women who held an insurance policy from that company called upon the visiting nurses regularly for all their pregnancies, whereas, after the second or third child, most felt that the advice received at Les Gouttes de lait was not worth the bother of going. Contrary to the consultations offered by Les Gouttes de lait, the visiting nurse service, which went to people's homes, was certainly better suited to the circumstances of mothers for whom getting around town was a problem. This explains, in part, its popularity. But more importantly, the advice and care provided truly met their needs. For one thing, the nurses' instructions resulted in the delivery taking place in a hygienic environment that reduced the risk of infection and puerperal fever (risks of which the women were well aware and feared above all else), besides reducing the amount of housework associated with a home birth. For another, the postnatal visits helped prevent discomfort or more serious complications that might otherwise develop, and enabled the women to rely on a professional while they recuperated.

Only three respondents used the services of Assistance maternelle—too few to enable us to draw any definitive conclusions. However, it may be noted that, here again, the services offered seemed to be evaluated according to whether they met the women's material needs. Finally, we must emphasize the women's extreme ambivalence towards doctors. For one thing, they did not seem to attach much importance to regular medical consultations throughout their pregnancies, the behaviour the medical profession wanted them to adopt. Despite all the awareness campaigns and pressures that were applied, including making them feel guilty, these women did not change their practice of waiting until the latter part of their pregnancy. Admittedly, their

finances did not allow them to indulge in frequent medical visits, let alone pay for the blood and urine analyses that were recommended; but it is striking that this did not seem to worry them unduly. The frequency of their pregnancies, which made them a familiar phenomenon, undoubtedly had something to do with it. As one of the respondents said, "having children was part of life."⁵⁷ On the other hand, it does seem that they were unwilling to take the risk of doing without a physician during the delivery, although, in practice, the doctor often played only a minor role. It should also be noted that doctors and medicine in general were the subject of several rather angry comments, while this was not true of the nurses, and that the women did not have much faith in the doctors with respect to pediatric care.

In short, although they did not absolutely refuse any type of medical care, nor systematically reject the advice and instructions they were given, the women in our sample showed a certain skepticism towards what the health professionals told them. The professionals succeeded in influencing certain behaviours, but only inasmuch as the women themselves felt a need for these changes or believed that they would be beneficial. Their acceptance of visits from Metropolitan Life's nurses and their decision to visit Les Gouttes de lait, especially for their first children, clearly show this. The efforts of doctors and nurses to oversee women's pregnancies and care of children were not wasted, however: witness the growing hospitalization of births during and, especially, after World War II and the generalization of pediatric care that occurred at about the same time.

Endnotes

1. Views of motherhood have already been the subject of numerous writings and analyses. For a view of the Quebec context, see Andrée Lévesque, *La norme et les déviantes. Des femmes au Québec dans l'entre-deux-guerres* (Montreal: Éditions du Remue-ménage, 1989).

2. Hélène Laforce, *Histoire de la sage-femme dans la région de Québec* (Quebec: IQRC, Collection Edmond-De-Nevers no. 4, 1985), 99.

3. Infant mortality remained particularly high in Quebec until World War II. In the working-class districts of Montreal at the turn of the century, nearly one infant out of three died during its first year of life. In 1922, the infant mortality rate was still 213 per thousand in those same districts. It did not start to really decrease until the end of the 1920s, when the pasteurization of milk was made mandatory, dropping from 133.7 per thousand to 59.3 per thousand between 1928 and 1940. Terry Copp, *The Anatomy of Poverty. The Conditions of the Working Class in Montreal, 1897-1929* (Toronto: McClelland and Stewart, 1974), 93; "The Health of the People: Montreal in the Depression Years," in A. E. Shepard and

Andrée Lévesque, eds., *Norman Bethune, His Time and His Legacy* (Ottawa: Canadian Public Health Association, 1982), 129.

4. Carole Dion, *Les femmes et la santé de la famille au Québec 1890-1914* (Master's thesis in History, Université de Montréal, 1984); Laforce, *Histoire de la sage-femme*, 99 ff.; Lévesque, *La norme et les déviantes*, 25-59; Veronica Strong-Boag, "Intruders in the Nursery: Childcare Professionals Reshape the Years One to Five, 1920-1940," in Joy Parr, *Childhood and Family in Canadian History* (Toronto: McClelland and Stewart, 1982), 160-177; Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality," in Linda Kealey, ed., *A Not Unreasonable Claim: Women and Reform in Canada, 1880-1920* (Toronto: The Women's Press, 1979), 131-149; Katherine Arnup, Andrée Lévesque and Ruth Roach Pierson, *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries* (London and New York: Routledge, 1990).

5. For example, the Fédération nationale Saint-Jean Baptiste, the voice of Montreal middle-class feminists, was closely involved in the founding of Hôpital Sainte-Justine, the Milk Depot network and the visiting nurse program that will be discussed later.

6. These interviews were carried out as part of the research for my doctoral thesis, published under the title *Ménagères au temps de la Crise* (Montreal: Remue-ménage, 1991).

7. Dr. Frankel's first target was tuberculosis, which was killing twenty percent of the company's members each year. 3,500,000 copies of a brochure, written in twelve languages and describing methods for preventing the illness, were distributed by the company's agents. James Marquis, *The Metropolitan Life. A Study in Business Growth* (New York: Viking Press, 1947), 186-188. For a history of the company's visiting nurse program in the United States, see Diane Hamilton, *The Metropolitan Life Insurance Company Visiting Nursing Service (1909-1953)* (Doctoral thesis in Nursing, University of Virginia, 1987). For Quebec, see Denyse Baillargeon, "Les infirmières de La Métropolitaine au service des assurées enceintes" (in progress).

8. Metropolitan Life Insurance Company (MLIC), *More Than a Century of Health and Safety Education*, Health and Safety Division, Archives of the Metropolitan Life Insurance Company (hereinafter referred to as AMLIC), Ottawa, 1981, 1.

9. Marquis, *The Metropolitan Life*, 207. These seemingly spectacular results should be taken with a grain of salt, as they do not take into account the fact that the poorest segments of the population, which were at the greatest risk, were most likely not insured by the company.

10. See Baillargeon, "Les infirmières de La Métropolitaine."

11. MLIC, *Metropolitan Life Insurance Company Nursing Service in Canada*, Health and Safety Division, AMLIC, Ottawa, 1; Yolande Cohen and Michèle Gélinas, "Les infirmières hygiénistes de la ville de Montréal: Du service privé au service clinique," *Histoire sociale/Social History* XXII, 44 (November 1989): 219-246.

12. Cohen and Gélinas, "Les infirmières hygiénistes," 225, 227.

13. Emma Roque, "History of Met Nursing Service in the Province of Quebec," Health and Welfare File, AMLIC, Ottawa, 1942, 1.

14. The school was financed by the provincial government, the City of Montreal, the Antituberculosis League and Metropolitan Life, which contributed nearly \$73,000 between 1926 and 1933. (MLIC, *MLIC Nursing Service in Canada*, 2-5, 7 and Dominique Gaucher, "La formation des Hygiénistes à l'Université de Montréal, 1910-1975: De la santé publique à la médecine préventive," *Recherches Sociographiques* XX, 1 (January-April 1979): 65-66.

15. MLIC, *Developments in Nursing Service Since 1909*, Health and Welfare Files, AMLIC, Ottawa; Hamilton, *The MLIC Visiting Nursing Service (1909-1953)*, 85-86.
16. Lee Frankel, *The Visiting Nurse Service Conducted by the MLI for the Benefit of Its Industrial Policy-holders*, Speech to International Congress on Hygiene and Demography, 1912, Health Education Files, AMLIC, New York, 6; MLIC, *Nursing Manual*, 1933 edition, Welfare Division Files, AMLIC, New York, 5; Marguerite Taschereau, "Le service de l'infirmière de la Métropolitaine," *La Garde-malade canadienne-française (GMCF)* XIV, 11 (November 1941): 500.
17. Taschereau, "Le service de l'infirmière," 501; see also Adeste Martin, "Contribution de l'infirmière de la Métropolitaine dans le domaine de l'hygiène," *GMCF* VIII, 7 (July 1935): 430; Mrs. L.-E. Warren, "Comment venir en aide aux mères de famille," *La Bonne Parole* X, 7-8 (July-August 1922): 6-7; MLIC Nursing Service, *The Services of the Metropolitan Nurses Are Yours for the Asking*, Health and Welfare File, AMLIC, Ottawa (booklet for the company's policyholders), March 1933.
18. Only holders of so-called "industrial" (i.e., payable on a weekly basis), monthly (premiums paid monthly) or group (designed for industrial workers) insurance policies were entitled to visits from the company's visiting nurses. Holders of "regular" policies (whose premiums were paid annually) did not have access to the program.
19. The French term "Gouttes de lait" will be used throughout to denote institutions known in English-speaking Canada as Milk Depots. As Milk Depots changed their name to Well Baby Clinics when their focus shifted away from supplying pure milk to a much broader range of health services for infants, we have decided to retain the French name, Gouttes de lait, as it did not experience a similar name change with a shift in function.
20. Collectif Clio, *L'histoire des femmes au Québec depuis quatre siècles* (Montreal: Éditions Quinze, 1982), 262; J. E. Dubé, "Les débuts de la lutte contre la mortalité infantile à Montréal. Fondation de la première goutte de lait," *Union Médicale du Canada* LXV (1936): 879 ff.
21. Dubé, "Les débuts de la lutte," 1088 ff.
22. Rita Desjardins, *L'hôpital Sainte-Justine, Montréal, Québec, 1907-1921* (Master's thesis in History, Université de Montréal, 1989).
23. Dubé, "Les débuts de la lutte," 1098-1102.
24. Dion, *La femme et la santé*, 96, 146 ff.
25. Yvonne Martineau, *L'Assistance Maternelle à Montréal* (Master's thesis, School of Social Work, Université de Montréal, 1948), 4, 15.
26. *Ibid.*, 23-24.
27. *Ibid.*
28. *La Presse*, 8 April 1925 and *La Patrie*, 20 February 1934.
29. Quote from interview no. 25.
30. Interview no. 13. According to Hélène Laforce, towards the end of the nineteenth century and into the early twentieth century, doctors in need of "guinea pigs" demanded access to the patients of maternity wards for single mothers in order to acquire obstetrical expertise. Around 1940, they officially claimed the clientele of Assistance maternelle. The experience of this respondent seems to indicate that the use of these women for teaching purposes was tolerated as early as the beginning of the 1930s (Laforce, *Histoire de la sage-femme*, 114-115).

31. This respondent was somewhat better off than the others; she is also the only one to mention the purchase of cheesecloth for making quilts. This detail suggests that the nurses adapted their instructions to suit the income level of the women they visited.

32. Interview no. 15.

33. Interview no. 2.

34. Interview no. 29.

35. Idem.

36. Interview no. 14.

37. Interview no. 29.

38. Interview no. 2.

39. Idem.

40. Interview no. 15.

41. Interview no. 5.

42. Interview no. 13.

43. Interview no. 20.

44. Interview no. 23.

45. Idem.

46. Interview no. 25.

47. Interview no. 16.

48. Interview no. 2.

49. Interview no. 7.

50. Interview no. 23.

51. Interview no. 2.

52. Interview no. 29.

53. Interview no. 11.

54. Interview no. 5.

55. Numerous articles published in the women's pages of *La Patrie* urged mothers to breast-feed and established a direct correlation between breast-feeding and infant mortality. See, for example, "La majorité des maladies infantiles sont évitables," *La Patrie*, 23 May 1931, 25; also Lévesque, *La norme et les déviantes* and Dion, *Les femmes et la santé*, 97 ff. According to the latter author, a study of papers from conferences and other publications of the medical profession reveals that physicians attributed exaggerated benefits to breast-feeding.

56. Interview no. 2.

57. Interview no. 24.

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8

“No Longer an Invisible Minority”: Women Physicians and Medical Practice in Late Twentieth-Century North America*

DEBORAH GORHAM

The contributors to this volume have explored several aspects of the history of women as healers in Canada during the last century. Some general themes emerge from their work. First, although physicians even in the 1990s remain reluctant to acknowledge the fact, healing has never been coterminous with medicine. Moreover, as the modern health care system has developed in Canada from the late nineteenth century, women's traditional connection with healing has been maintained. While Canadian medicine even today continues to be male-dominated in terms of numbers and of power, and medicine itself still remains at the pinnacle of the late twentieth-century health care system, the overwhelming majority of health care workers—79%—are women.¹

One of the most significant achievements of the contributors to this volume is to emphasize that during the period that medical men transformed their occupation into the modern, scientific medical profession, a parallel process took place in nursing—the most important of the modern health care occupations dominated by women. Modern nursing in Canada, like modern medicine, aspired to professional status and to connecting both its training and its practice to science. But, as our contributors demonstrate, the professionalization of women's work as healers did not take place without struggles with the medical profession. From the late nineteenth century, Canadian medical men proved willing to absorb women healers into the modern institutions they created, but only if the women would do so on the physicians' terms. Thus, while as J. T. H. Connor correctly points out, they did not engage in any organized conspiracy, medical men nonetheless used their collective influence to banish the traditional midwife from Canada. And my reading of the contributions of Boutilier, Stuart, McPherson and Baillargeon to this volume is that modernized nursing was acceptable to physicians only if nurses remained their subordinates.

The nurses themselves, while asserting their claims to professional status, did so in a way that accommodated medicine's assumptions of primacy and accepted and even capitalized on gender difference. Thus, nursing underwent professionalization, but in a "womanly" way, and professionalization, while it raised the status of nurses, did not carry with it the same implications concerning power, authority or knowledge that were associated with the professionalization of medicine. If modern nursing became associated with curing as well as caring, as Katherine McPherson cogently argues, the medical profession nonetheless assumed that caring was subordinate to curing, and would be delegated wherever possible to the modern nurse. In sum, by the mid-twentieth century, the modernization of health care meant that caring like curing became professionalized, but the gendered nature of the distinction between caring and curing became if anything more sharply articulated than it was in earlier periods.

But what of the small minority of women who chose to become physicians? The woman physician does appear in the pages of this volume, but pioneers like Dr. Helen MacMurchy remained remarkably few in number. After their initial success in gaining the right to train, during the first three-quarters of this century, women as a group made little progress in establishing themselves as physicians in Canada and there was remarkably little visible pressure for change.² During the middle years of the century, Canadian medicine was overwhelmingly dominated by white males from relatively affluent backgrounds. However, in recent years, this situation has changed radically, at least as far as gender is concerned, and in our own period we are witnessing a truly dramatic shift in the gender balance of medical students and young physicians. The statistics indicate that while the shift was not yet noticeable, it began in the middle of the 1960s. In 1959 "women accounted for 6% of Canadian medical school graduates, in 1981 for more than 33% and in 1989 for 44%."³ In the 1990s, the shift in gender balance has been decisive. There are annual fluctuations in the numbers of women admitted to medical schools in Canada and across North America, but we can safely assume that a drop back down to the 6% figure of the 1950s is not likely to occur. Moreover, while women by no means as yet dominate the profession—the fact that much of the increase has taken place so recently means both that most of Canada's women physicians are relatively young, and that men still comprise the majority of the profession—if present trends continue, in terms of numbers women will reach parity with men in a few decades. At the present time, women make up some 22% of the total number of practising physicians in Canada. Their number should reach 35% by the

turn of the century,⁴ and today in medical and non-medical circles observers are commenting with increasing frequency (and often with alarm) on the declining numbers of men entering the medical profession in Canada and in the United States.

This concluding paper explores the implications of this recent decisive increase in the numbers of women entering the medical profession. What effect has the change had on medical schools? And what might this significant increase in the numbers of women physicians mean to the health care system as a whole, and to women as health care consumers? In this chapter I explore possible answers to these questions both by drawing widely on evidence from the United States as well as Canada, because the change in gender balance among young physicians is occurring across North America, and from one specific source, namely the Faculty of Medicine at the University of Ottawa.

The University of Ottawa's medical school, one of five in the province of Ontario,⁵ was founded in 1945. As it approaches the half-century mark, its history reflects this decisive shift in gender balance. A striking graphic record of the increase in the numbers of women is provided by the collection of photographs of graduating classes going back to the founding of the school that adorns the walls of the foyer of Guindon Hall, the University of Ottawa's Health Sciences building. The viewer progressing through this gallery of the school's history notices that women's faces in the early class pictures are rare. Their number gradually increases, until in recent years the photographs are of groups of women and men in roughly equal numbers. The formal statistics bear out this visual impression. Among the earliest graduating classes, there were never more than between one and four out of average classes of forty-five students and by 1971, female enrolment at the school had only reached 9%. By 1979, it was 24% and in 1989-1990, it had reached 43.8%.⁶

If photographs of the school's faculty members were displayed along with those of its students, the viewer would be reminded of the limitations of these changes. As one might expect, gender ratios in medical school faculties have changed much more slowly than student populations. In 1982, only 3.5% of full professors at medical schools in the United States were women⁷ and 1988 statistics did not show much improvement.⁸ Data for 1986-1987 reveal a similar situation in Canada. Only 13.8% of full-time faculty members were women, and the higher the rank, the smaller their number.⁹

Gender and Medical Training in Transition

In the mid-1960s, when the numbers of women medical students began to increase, these women were entering a profession that was not only male-dominated but one whose history of modernization throughout Europe and North America demonstrated active hostility to women.¹⁰ Writing of the situation in the United States in the late nineteenth and early twentieth centuries, Penina Glazer and Miriam Slater comment: "As medicine was modernized, the rewards of participation and the concern with exclusivity increased." The new opportunities for physicians "were hedged about with biases and restrictions against lower classes, against minority ethnic groups, and certainly against women."¹¹ Such a concern with "exclusivity" dramatically manifested itself in a notorious incident in the annals of women's struggle to enter the medical profession in Britain. When the University of Edinburgh reluctantly admitted five young women to its medical school in 1869, the hostile male medical students attempted to drive the women out of their anatomy class. On 18 November 1870, in the "Riot at Surgeons' Hall" they blocked the women's entrance into the lecture theatre and as a gratuitous insult introduced a sheep into the classroom, saying that they understood that "inferior animals" were no longer to be excluded.¹²

By the middle decades of this century, young women medical students were not confronted with forms of hazing as outrageous as the University of Edinburgh sheep, but the biases against women, the existence of what feminists now call a "chilly climate" certainly still existed. The best that the few women who did participate in medical training could hope for was to be ignored. By this I mean that in the post-war period, the image conjured up by "medical student" within the profession itself and in the wider society, was of a young white male from a middle- or upper-class background.¹³ Those who did not fit this norm, whether they were members of minority ethnic or racial groups, or women, were accepted on sufferance, and expected to act as much as possible like the norm. Their difference was covertly assessed as a deficiency that it behooved them to hide if possible or at least to minimize. Dr. May Cohen, recollecting her training at the University of Toronto's Faculty of Medicine in the early 1950s, says of her experience during those years: "At that time there was a 10% quota with respect to the number of women permitted to enter any class and those of us who succeeded in getting through that barrier could only feel extremely grateful for our good fortune. We were not about to make waves and so

accepted, without protest, sexist remarks, [and] our apparent invisibility when references to the class were directed only at males."¹⁴

There is plenty of evidence to indicate that, while as individuals they may have been accepted, as a group women were ignored in this fashion at the University of Ottawa medical school during its early years. There were some outstanding women physicians who did achieve distinction at the school, such as Dr. Margaret Beznak, who headed the Department of Physiology in the 1960s.¹⁵ But Dr. Beznak's career was the exception that proves the rule. In the University of Ottawa Faculty of Medicine's early years, there were few women faculty and even fewer women students, and from my reading of early Calendars and Reports it is evident that there was virtually no recognition that this situation represented gender discrimination. The few women who did train during the school's first decades were regarded not so much as a minority, but as rare anomalies. I could find no indication that the school's administration, or its faculty, or its students questioned the overwhelmingly masculine composition of the school or of the profession for which it was training its students.¹⁶

While faculty and male fellow students could simply ignore the handful of women among them, for the women medical students themselves the conflict between the professional role that medical students are trained to adopt and the norms of femininity was as acute during the post-Second World War period as it was at any time during the history of the modernization of medicine. Historians of medicine and theorists of gender difference have analysed the stratified and masculine nature that medicine took on as it professionalized in the nineteenth and twentieth centuries. The extensive literature on professionalization and on the process through which neophytes become professionals indicates that elite professional status is closely identified with male gender, and membership in the dominant economic, racial and ethnic group.¹⁷ In contrast, the professional status attained by Canadian nurses, as documented by MacPherson, Stuart and Boutilier in this volume, while genuine and important, was a muted, feminine variety of professionalism, which underscored the nurses' subordination as women and as workers, while at the same time affirming the benefits of their modernized training. Moreover, becoming a physician involves more than learning what there is to know about disease. Part of what the medical student learns is how to take on the role of physician. Michael Shapiro, who has written about his own experience of medical training at McGill beginning in 1969, has observed that young medical students, faced with the anxieties that accompany medical training, embrace the

role of "Doctor." "Medical students have to look for something to hang on to," Shapiro says. "And that something is provided: their new identity as 'doctor,' which becomes increasingly important as the medical years progress."¹⁸ As another perceptive observer put it, writing in 1979 about medical training in Britain: "The medical student, unlike students of the humanities, acquires an identity along with his education by his identification with the medical profession." Part of medical training involves the acquisition of a "professional mask."¹⁹

A Canadian study dealing with this subject published in 1982 draws the same parallel between the actors' craft and the task of learning to act like a physician.²⁰ The authors did their research in the context of McMaster University's medical school. In that school's program, students don white coats, wear badges, and mingle with patients from the very beginning of their training. The fact that they are taken for doctors long before they really know very much, makes the issue of role playing especially relevant.²¹ The authors emphasize that one crucial skill the neophyte physician must learn is that of detachment:

The lesson is not easy, given the emotionally charged situations inherent to medical practice plus the fact that many students seem genuinely committed to caring about people. Nevertheless, the professionalizing demand for detachment is quite clear.²²

The traits associated with this kind of masculine elite professional behaviour are *gendered*. Detachment, control, objectivity, the ability to assume authority and so on, are the very traits associated with the social construction of elite, white masculinity. In contrast, the traits that are—or at least were until very recently—associated with femininity include passivity, receptivity, the capacity to nurture and a readiness to follow rather than lead. In the period from 1945 until the late 1970s, not only were women medical students in North America in a small minority, and therefore vulnerable, becoming a physician meant assuming a role that was incongruent with conventional norms of femininity. Moreover, this was during a period when those norms were experiencing a resurgence: the 1940–1965 period, the years preceding feminism's "second wave," was throughout North America the anti-feminist era of the "Feminine Mystique." Thus, unlike the white, upper middle-class males who made up the great majority of North American medical students, or the majority of female health care workers who trained as nurses, women medical students were confronted with contradictory messages. To survive they usually ignored the incongru-

ities between what was expected of them as women and what was expected of them as aspiring physicians and repressed their awareness of the discrimination they faced in medical school itself and in the wider society.

At the University of Ottawa medical school, I asked one of the female physicians and the male physician with whom I talked about the presence of sexism in their medical training. Both agreed that it had been present. The woman had trained in the 1970s. She explained that during her medical school years she simply shut out her awareness of sexism. At the time, she recounts, "I just accepted it." However, she explained to me that in 1981, a friend gave her a copy of *For Her Own Good*, by Barbara Ehrenreich and Deirdre English.²³ Ehrenreich and English were among the most influential early feminist scholars of "the second wave" and their work on women and health care made a major contribution to feminist history and to the women's health movement. The book "really opened my eyes," my University of Ottawa respondent told me. The male respondent, who trained considerably earlier than the woman, recalls that during his training he "was a male chauvinist who resented the fifteen women students in my program." Like the woman physician, however, by the early 1980s he too had been influenced by the revival of feminism, as his use of the term "male chauvinist" indicates, and had become aware of the discrimination women faced in training and in practice.

During these middle decades, women medical students were ignored and confronted with contradictory messages about how they ought to behave and what identity they ought to assume. They were also routinely subjected to institutionalized discrimination and to what many observers today would immediately recognize as misogyny. A study published in 1973 provides a rare and instructive record of the experience of women medical students in North America two decades ago. The existence of the study itself and the circumstances of its publication (it was published by one of the earliest "second wave" feminist presses) bear witness to the influence of the resurgence of feminism. A woman physician using the pseudonym "Margaret A. Campbell"²⁴ collected data from the 107 degree-granting medical schools in the United States at that time and added to this information case study data gleaned from questionnaires filled out by 146 women students at 41 schools. Her respondents are noteworthy as a representative group of women during a transitional period. Under the influence of the revival of feminism they show a new awareness of their disadvantaged position as women

and a new ability to name the discrimination and the prejudice they faced.

Dr. Campbell's study documented pervasive institutional discrimination against women. For example, most schools provided inadequate "on call" rooms for women when they were doing clinical rotations at affiliated hospitals. As two respondents commented:

Being "forgotten" is most prominent in surgery. Women med students are required to dress in the nurses' dressing room and hence are often not informed by fellow male students and/or interns, residents of changes in Surgical scheduling. Also the women students on surgery are consistently deprived of the discussion of the actual operation after the surgery, which frequently occurs between students and surgeon in the "doctors' dressing room," and therefore the *men's* dressing room. We also encounter difficulty in the hospital in terms of finding a bed to sleep on overnight when we're on call—the nurses kick us out of their quarters, and the doctors and students out of the "men's" sleeping quarters.²⁵

Campbell's study also documented a wide range of overt non-institutional discrimination. Much of this was linked to the "men's club" atmosphere of the medical school. Her respondents reported frequent instances of unequivocally hostile remarks. For example, a student reported that the Chief of Obstetrics and Gynecology at her school said to her: "'A woman doesn't belong in the OR [operating room] except as a nurse.'"²⁶

The implications of these responses are more complex than the respondents themselves perhaps realized at the time. The women medical students quoted above focussed on the fact that as women medical students their existence was not fully recognized. In consequence they were barred from the "men's" dressing room, and thus denied access to part of their training. But they mention the antagonism of the nurses only in passing, and avoid any attempt to analyse the fact that the sexist hierarchy that declared that nurses are women and physicians men served to weaken any bond based on a shared experience as women between the nurses and the women physicians. For the same reasons, the respondent who reports that the Chief of Obstetrics and Gynecology thought she should be a nurse assumes—correctly—that this was meant as an insult. But she was not in a position to fully explore the circumstances that would have encouraged her to accept this identification of nursing with inferiority.²⁷ Faced with presumptions about gender and status that limited their opportunities to take full possession

of the status of physician, these female medical students distanced themselves from nurses. They appeared not to have understood the nurses' difficulties as women workers whose subordinate position in the medical hierarchy was reinforced by their gender. Shapiro, a sympathetic, non-sexist male observer noted such distancing on the part of the women medical students who were members of his cohort at McGill in the early 1970s. Commenting on the tensions between medical students and nursing staff he says: "Female students were, if anything, more anxious [than males] to assume the mantle of physician and, thereby, to clarify in the minds of patients, other health workers and themselves that they were a class apart from the nurses."²⁸

Another student in the Campbell survey reported that "[d]uring my first two weeks here, one student said he didn't think girls should be admitted to med. school as long as one male had to go to Europe."²⁹ That comment reflects the fact that male faculty and students in this era commonly subscribed to the myth that most women students would never actually practise medicine and were therefore taking a place from a more "deserving" or "serious" male candidate.³⁰

Campbell's respondents also reported many instances of sexist "humour." This appears to have been a universal problem in the early 1970s.³¹ Its most noticeable public form was the use of misogynist jokes and "pin-up" slides in lectures. Frequently the latter were taken from *Playboy* magazine. Here is a comment about some students who possessed considerable feminist awareness, and remarkable courage. It reports that they challenged a lecturer who had used such material:

A path. [pathology] prof. showed many nude pictures throughout his lecture, including a cartoon showing a physician (male) screwing his female patient with the caption "what to do while waiting for the doctor." When asked about the purpose of the non-academic and sexist display, he replied that since his lectures included many gruesome path slides, and since the majority of the class was male, he felt he needed the cheesecake pictures and accompanying "jokes" to make his path lectures "less gruesome." The women students asked him why "he . . . didn't also tell 'nigger jokes' since the majority of the class was white." He became quite belligerent and later called the Dept. of Path. Chairman to complain.³²

Campbell herself has some insightful comments to make about this tradition of humour. She observes that it stems partly from the very understandable fear and discomfort that physicians inevitably experience because they must confront the physical realities of disease and

death.³³ The rituals of humour, she suggests, allow the medical student to distance himself from these fears. However, she points out that such fears can be constructively dealt with, without victimizing women, and that "students of both sexes" need such help.

In 1973, Obstetrics and Gynecology instructors appear to have been the most frequent users of misogynist humour. Several factors may account for this fact. Male obstetricians and gynecologists must deal with women as physical and sexual beings. Sexist humour allows them to project their own fears about death, bodily decay and sexuality onto women. Their patients in the process become a classic example of the way in which a male-dominated society constructs woman as "other." As Campbell pointed out in 1973, the most important long-term victims of this hostile distancing were "the women who will be their patients."³⁴ In this context it is I think comforting to note that in Canada and the United States women are rapidly becoming a majority among obstetricians and gynecologists in training.³⁵

When it was published, Campbell's study was unusual, in that it was conducted and written with an insider's knowledge of the profession. Several feminist critiques of medicine of the same period written from an outsider's perspective were more widely known. For example, there was the sociological study of gynecology textbooks published by Diana Scully and Pauline Bart in 1973. This article, with its witty title: "A Funny Thing Happened on the Way to the Orifice: Women in Gynecology Textbooks,"³⁶ documented the sexism inherent in a category of text that most non-medical people never see. It was followed up by Kay Weiss's 1977 piece, "What medical students learn about women."³⁷ Weiss had a field day with one book, the fourth edition of Willson, Beecham and Carrington, *Obstetrics and Gynecology*, published in 1971 and widely used in North American medical schools, including the University of Ottawa.³⁸ The fourth edition of Willson, Beecham and Carrington is laden with sexist presuppositions, and misogynist prejudice. The authors, who evidently believed themselves to be progressive because they included psychoanalytical material and did not confine themselves to purely biological concerns, relied heavily on the anti-feminist psychoanalyst Helene Deutsch. The text was freely interspersed with comments like this one: "The traits that compose the core of the female personality are feminine narcissism, masochism and passivity."³⁹

As Weiss points out "all medical students and physicians are 'he' in *Obstetrics and Gynecology*" and moreover the text frequently suggests that the physician should assume an all-wise stance, and encourage a child-like trust in his patients. Both implicitly and explicitly the physi-

cian is encouraged to find out as much as he can about his patient's personality.

Because of its inclusion of material on "the feminine personality" the fourth edition of *Obstetrics and Gynecology* was more accessible to Weiss's critical analysis than most other texts, but it was not the only offender. Another textbook used at the University of Ottawa for obstetrics and gynecology during the 1960s and 1970s has a chapter on "Sex Education," in which the gynecologist is given the following advice on the premarital consultation:

The bride should be advised to allow her husband's sex drive to set their pace and she should attempt to gear hers satisfactorily to his. . . . In assuming this role of "follow the leader, however, she is cautioned not to make her sexual relations completely passive. Certain overt advances are attractive and provocative and active participation in the sex act is necessary for full fruition. She may be reminded that it is unsatisfactory to take a tone-deaf individual to a concert."⁴⁰

By the 1970s, physicians were not totally unresponsive to this feminist critique. The widely used Willson textbook was, for example, revised by Willson and Carrington in 1979.⁴¹ This revision reflects an awareness that feminist criticism was being levelled at their particular text, but the authors were confused about what the feminist critics wanted from them and their efforts to add feminist content in this sixth edition can best be described as an unsuccessful attempt to "add feminism and stir." The feminism appears as congealed lumps in a version of the same old sauce. The physician is no longer referred to as "he" and the authors do list works such as the pathbreaking Boston Women's Health Collective's *Our Bodies, Ourselves*, and Kate Millett's *Sexual Politics* in their footnotes, and there are occasional references to feminism in the text.⁴² However, an only slightly modified version of the older section on "The Feminine Core" remains and while there is less misogynist emphasis on women's narcissism and the need for female masochism, the sixth edition of this major textbook still contains much that is offensive from a feminist perspective. For example, in this edition as in earlier ones the physician is advised to evaluate the patient when she comes into the office in the following manner: "Character traits are expressed in her walk, her dress, her makeup, her responses to questions. . . . The observant physician can quickly make a judgment as to whether she is overcompliant, overdemanding, aggressive, passive, erotic, or infantile. . . ."⁴³ The authors still encourage the physician to ask intrusive questions about the sex lives of their patients, but never

about issues such as rape and incest that might relate to male sexual abuse of women.⁴⁴

Campbell's study of United States medical schools is more than twenty years old, but the Willson and Carrington sixth edition of *Obstetrics and Gynecology* is relatively recent. How much have medical schools in North America changed during the last decade in their treatment of women students? Do professors still tell sexist jokes? Has institutional discrimination decreased significantly? Do women feel more comfortable as medical students, as interns and residents and as faculty members in the 1990s than they did in the 1970s?

There are certainly some positive signs of change. If we take medical textbooks as a bellwether, for example, the obstetrics and gynecology text used at the University of Ottawa in the 1990–1991 academic year was Neville Hacker and J. George Moore's *Essentials of Obstetrics and Gynecology* (1986).⁴⁵ From a feminist perspective, this book represents significant progress. Its language is respectful of the patient. The child-like, hysterical woman of the earlier texts, in constant need of reassurance from her fatherly physician, is absent from its pages. The authors not only assume that the physician will be either female or male, but they encourage respect for the patient's privacy. For example, the physician is told that it is appropriate to enquire about the patient's sexual life, but that it is not appropriate to press the patient to discuss the issue. The chapter on human sexuality assumes that women have equal rights with men to sexual fulfilment, and there is a chapter on sexual assault, which is concerned with assisting victims of rape.

In 1990–1991, the University of Ottawa Health Science Bookstore also stocked a recent textbook on pediatric and adolescent gynecology.⁴⁶ It includes a chapter on sexual abuse that advises the physician about ways to deal with incest victims. It underscores that the older response, which was to assume that the child or adolescent was engaging in "wild fantasies" is not adequate. In the great majority of cases the children are "telling the truth," say the authors.⁴⁷

These and other signs, like the posters advertising events for International Women's Week in 1991 at the University of Ottawa's Faculty of Health Science⁴⁸ or the incredulous response of my second-year medical student respondent when I told her that in the 1970s professors had used *Playboy* slides in their lectures, indicate real change. But many problems still remain and gender discrimination is still an issue for women medical students and women practising physicians, just as it is for other women in our society.⁴⁹

First of all, there are areas where overt discrimination still exists. As one might expect, they are to be found in those specialties that are still largely male-dominated. Surgery appears to be the worst offender. Data from two recent American studies clearly indicate that some of the patterns of the early 1970s persist in surgery.⁵⁰ Students on clinical rotations still encounter sexist remarks and outright sexual harassment.⁵¹ Women are still sometimes excluded "from locker room discussions preceding and following surgical procedures" but fortunately this does not happen as frequently as it did in the past.⁵² One of my University of Ottawa respondents reported an incident that took place recently: during a clinical demonstration, the surgeon in charge asked the men students to come forward where they could see, and instructed the women students to stay in the back, "because they weren't going to go into surgery anyway."⁵³

In marked contrast to Campbell's findings in 1973, women students report that their fellow male students are largely supportive of them. Where overt sexism is encountered it appears to come largely from faculty.⁵⁴ While the *Playboy* slides may have disappeared from the lecture presentations, some older male physicians are still hostile to women medical students, and "subtle but persistent" discrimination continues.⁵⁵ It is because of the sexism of older faculty members that the gender imbalance in faculty numbers continues to damage women, even though the hiring processes themselves may now be equitable.⁵⁶

The 1990s and Beyond: Women in a Changing Medical Profession

It is noteworthy that the decisive shift in gender balance in medicine in Canada and throughout North America has occurred during a period when health care has been changing in a number of remarkable ways. From the rise of the health care consumer movement, which has transformed "patients" into assertive "health care consumers" to the current continent-wide "crisis" over health care costs, medicine is facing new challenges. At the beginning of the nineteenth century, North American medical practitioners were part of an occupational group with dubious social and economic status. By the middle of the twentieth century, they had become the most respected and most highly paid of all professional groups. Now, at the end of the twentieth century, although they are still powerful, still respected and still well paid, the authority of physicians both within the health care system and in the

wider society is being questioned. The physician is no longer undisputed “captain of the ship” of health care. Other professionals—including practitioners of “alternate therapies” and newly militant nurses⁵⁷—as well as patients and administrators of health plans are all questioning a decision-making power that a few decades ago was regarded as absolute.⁵⁸ As I write this (in May 1993), the Ontario provincial government, in an attempt to grapple with what it perceives to be a fiscal emergency, has announced that it will restrict the possibilities for practice of newly qualifying physicians. Of the estimated 350 doctors who are expected to enter family medicine this year, only 45 new family doctors will be allowed to set up practice in Ontario, and only in areas deemed by the Ministry of Health to be suffering from shortages of such physicians.⁵⁹

This attack on newly qualifying family physicians on the part of the Ontario government is occurring just when the gender balance in family medicine has shifted decisively in favour of women, and as the representation of individuals from racial and ethnic minorities has begun to increase. As the President of the Professional Association of Interns and Residents of Ontario—herself a woman—put it: “More than half of us affected by this proposal are women, and many affected are from minority communities.”⁶⁰

The Ontario government’s attack on young family physicians, the most vulnerable members of the profession, is an indication that a pattern that has been associated with the history of women and work in our own society and cross-culturally, is now a factor in medicine. Work tends to be “gendered,” and the work of women—whatever it may be—is perceived as less valuable than the work of men, simply because women do it. Women’s entry into North American medicine in significant numbers may be as much an indication of the declining status of medicine as it is of the improved position of women.

Ever since women began entering medicine, some observers have claimed that women physicians differ in fundamental ways from their male colleagues in their approach to medical practice. Female physicians today have been described by some observers as more caring and more humanistic than their male counterparts, as more attuned to the social and psychological needs of their patients and as less likely to resort to technological fixes.⁶¹ From the perspective of many critics of modern medicine, women physicians appear preferable to men, thus raising the hope that this new cohort of women will be able to transform the profession, just because they are women. But is there more than anecdotal evidence to support assertions either about the woman

physician's greater concern with caring or her more critical stance in relationship to the medical authoritarianism that has been an intrinsic part of the hierarchical nature of modern health care?

There are some measurable differences between female and male physicians. Women work in group practice with greater frequency than men, they work significantly fewer hours per week than male physicians, and they see fewer patients.⁶² Moreover, female physicians make less money than men, even when statisticians control for the above mentioned variables.⁶³ The most significant difference between young women and young men physicians in Canada today concerns choice of specialization. In Canada (and the United States), while young women physicians are indeed to be found in all areas of specialization, they are gravitating to family medicine, pediatrics, obstetrics and gynecology and psychiatry. They are not, for example, becoming surgeons.⁶⁴ As one perceptive commentator notes: "In thinking about how health professionals retain their niches . . . it is important to recognize one . . . feature of hierarchical behavior: it is rampant *within* medicine as well as with-out. . . . Within medicine, there is a pecking order of specialties, an order than has been far from invariant over time. . . ." ⁶⁵ In our own era, surgery has much more prestige than family medicine or obstetrics and gynecology.

The fact that female physicians spend more time with their patients than do males perhaps does reflect attitudinal differences, and it could be that women physicians choose specialties like pediatrics or family medicine rather than surgery because they enjoy dealing with people. However, there is also evidence to suggest that they select these fields both because they are discouraged from entering specialties such as surgery and because specialties such as family medicine or psychiatry make more manageable demands on a physician's time and are therefore easier to combine with the roles of wife and mother.

Two recent studies, one Canadian and one American, indicate that there is little difference between women and men physicians or medical students when one analyses their opinions concerning issues like preserving the clinical authority of the physician, or attitudes to medicare.⁶⁶ There is also plenty of evidence indicating that medical training "homogenizes" the attitudes of men and women physicians and encourages women to adapt to the masculine norms of the profession.⁶⁷

But even if it is true that women's socialization encourages them to be more empathic physicians than men, it is dangerous both for women and for the health care system to suggest that women's capacities as nurturers will humanize medicine and satisfy the demands of

contemporary critics. It is dangerous for women because such assumptions reflect traditional stereotypes about femininity. If it is assumed that women physicians because of their feminine nature can and should take on the task of humanizing medicine—a view implicit in statements like “women make better physicians than men because they have a greater capacity for caring”⁶⁸—then male physicians would be absolved of any obligation to change their ways. Male physicians need not become more caring; the women will do it for them, in the “soft” fields such as family medicine, pediatrics and obstetrics. Meanwhile, the men can get on with the more “rigorous” fields such as neurosurgery, oncology and biomedical engineering. If these patterns harden, men will continue to garner the most prestige within the profession, to make the most money, and to retain power.

In the 1980s and 1990s, as their numbers have increased, women physicians in North America are developing a heightened awareness of gender discrimination, whether or not they identify themselves as feminist. They are more able than they have been in the past to articulate their concerns about the ways in which they are affected by society’s continuing expectations of appropriate roles for women and men. Women physicians in both Canada and the United States are organizing themselves and discussing these issues with new interest. In both countries the women’s medical societies have been more open to feminist analysis than they had been previously, and this is reflected in their respective publications, the *Newsletter* of the Federation of Medical Women of Canada and the *Journal of the American Medical Women’s Association*. The Canadian organization has become during the last few years remarkably responsive to a feminist point of view, speaking out not only against sexism in the profession, but also for women as health care consumers. In its *Newsletter*, at conferences and in representations to federal and provincial levels of government it has taken a strong stand on such issues as the underfunding of medical research on women’s health needs, on the need for the profession to vigorously censure physicians who sexually abuse their patients, and on such wider social issues as violence against women.⁶⁹

One problem of concern to the organized medical women is that of the conflicts that arise when women physicians marry and have children during medical training. This happens most typically during internship and residency. The result is often described in the literature as “role strain,” that is, the conflict between what a woman is expected to achieve as a physician student, and what she is expected to do as a mother.⁷⁰ At the present time, when the majority of women physicians

in North America are young women still in their childbearing years this role conflict represents a serious and widespread problem. The discussions of the problem by physicians—whether women or men—assume for the most part that it is inevitable that women will shoulder the major responsibility for homemaking and child care in the families they establish. It is indeed the case that male partners of female physicians, whether they themselves are physicians or not, behave much like other young men in our society. While as a group they do more household and child-care tasks than their fathers did, they still do not participate equally with their female partners in this work.⁷¹

Although most women physicians in training and in practice do cope with the multiple demands on their time if they are combining their professional career with marriage and motherhood, it is clear that this is not an easy task. If they are in training, for example, they face stringent demands on their time: while there have been some changes in this area,⁷² internship and residency are extremely demanding. One of my female physician respondents, when asked about arrangements at the University of Ottawa for medical students, interns and residents commented that the school is definitely not "family friendly." But she also pointed out that there are real difficulties involved in making residency, internship and "on call" requirements more flexible. When I asked my more senior woman physician respondent why residency could not be made more flexible she replied that "medicine is not a correspondence course."⁷³

The literature indicates that women physicians frequently perceive the problems they encounter when they combine domestic with professional roles as personal dilemmas for which they must find personal solutions. For some, as we have seen, the solution is to choose to specialize in a field that will allow more rather than less flexibility. For example, to choose community medicine over surgery. While one could take the point of view that in making their selections of fields of specialization, women are simply making individual choices with no wider significance, the preference of individuals has more general implications. In the late twentieth century, the problems of combining family life and career are especially pressing for young professional workers, both male and female. The older pattern in which women sacrificed professional careers and assumed domestic responsibilities, thus allowing men to devote themselves nearly exclusively to professional life is becoming less and less common, but it is being replaced by one in which the burden imposed upon both sexes has become crushing. In North America at the present time, young professionals of all types are

simply expected to achieve too much in their personal and in their working lives during their twenties and thirties. The multiplicity of obligations imposed on young physicians is but one example of this contemporary dilemma, but it is a particularly telling one because of the tradition in medical training and in professional practice itself that encourages excessive work. As one observer puts it, medical students and physicians frequently "engage in compulsive work."⁷⁴ The negative effect of overwork on physicians, which is reflected for example in their higher than average rates of suicide and alcoholism, has been generally acknowledged only in recent decades.⁷⁵

Because women give birth, live longer than men and assume most of the responsibility for the health of children, they have more contact than men with the health care system as consumers. In Canada at the present time, "70% of visits to physicians are [by] women and children."⁷⁶

In recent years, women activists have been conscious of these numbers, and conscious of the extent to which the medical profession has not served women well. Indeed, women consumers have been in the forefront of those working for changes in medical practice. The clearest articulation of the demand that medicine be less mechanistic and authoritarian and more concerned with the whole person has come from the contemporary women's health movement. In the words of one writer on the subject:

One of the major goals of the women's health movement has been to make information about women's bodies and health accessible to all women in demedicalized, clear language. A medical expert is not required to tell us what is going on in our own bodies.⁷⁷

What is the connection between this new assertiveness on the part of women as consumers of health care and the rise in the numbers of women physicians? Are women physicians as a group responding in significantly different ways from their male colleagues to the demands of the women's health movement? Definitive answers to this complex question cannot be given but there are indications here in Canada and in the United States both of tensions between the women's health movement and women physicians, and of alliances between the two groups. On the question of the physician's relationship to women's health centres, for example, women consumer activists and women physicians sometimes have sharply differing points of view. For example, Nancy Worcester and Marianne H. Whatley, in a recent piece that examines the "co-optation" of the women's health movement by the medical

system suggest that women physicians play a major role in such co-optation. They observe that while women practitioners represent a step forward, hiring a woman physician and women staff members for a women's health centre will not guarantee that the feminist, consumer-oriented, non-authoritarian principles of the movement will be implemented. "Having women practitioners does not guarantee a particular philosophy," they point out, and they add that "the concept of consumer control is essential to the feminist demand for health care by women for women; medical control, even if by women, undermines this goal."⁷⁸ The very different perspective of some women physicians on this question is reflected in an article that appeared in the *Journal of the Medical Women of America* in 1988. The author discusses the fact that while feminist health centres prefer to hire women rather than men physicians, the organizers frequently are suspicious of *all* physicians; consequently, for the female physician, working in such a setting can be frustrating and unrewarding.⁷⁹

As these varying perspectives indicate, the issues posed by a feminist analysis of women and health care will not automatically be resolved simply because more of our physicians are women. In this regard, past and current controversy concerning maternity care is especially relevant. For decades, the demedicalizing of birthing has been a central concern of the women's health movement. One solution proposed by women's health advocates has been support for the prospective mother's right to choose an alternative practitioner as her birth attendant. That alternative practitioner is usually a woman who defines her occupation as "midwife." In Canada, as readers of the Connor and Dodd papers in this volume know, traditional midwives lost their right to practise before the twentieth century began. But in recent years, modern midwives and their supporters in the women's health movement have successfully organized, in spite of the opposition of physicians.⁸⁰ In Ontario, new legislation will allow trained midwives to assist in home births, as well as in hospitals and in proposed new birthing centres.⁸¹ Training programs are planned at three of Ontario's universities, and there is now a new Ontario College of Midwives.⁸²

It seems almost certain that this new development, when coupled with the rise in the numbers of women physicians entering obstetrics, will result in the reversal of the shift in gender balance in obstetrical care that took place in the eighteenth and nineteenth centuries.⁸³ Then, male birthing attendants gradually replaced the women who had traditionally done this work. Now, within decades it appears that women will once again dominate birthing. But this does not mean that the new

midwives will necessarily form an alliance with women physician obstetricians. There could be rivalry and competition between the two kinds of practitioners.⁸⁴ On the other hand, the new midwives, as their numbers grow, could find themselves subsumed as subordinate members of a health care system controlled by physicians. And will the expectant mother be allowed to choose between types of attendant and styles of birthing care, or will an underfunded health care system make these decisions for women, on the basis of cost to the system? These are just a few of the open questions regarding the future of maternity care that will not be resolved simply because the majority of practitioners in this field will be women.

Women health care workers have a multiplicity of identities and form a multiplicity of alliances. Women physicians have not in the past attempted to work together with nurses (or with midwives). Nurses, in turn, have not forged alliances with nurses' aids. Obvious barriers of status within the health care system and less obvious class, ethnic and racial differences between these groups have made it difficult for them to work together, either to enhance their status as women workers, or to represent the needs of the women who make up the majority of the recipients of their care.

Conclusion

One of the lessons to be learned from the contributors to this volume is that throughout its history, health care in Canada has affected women's lives in a variety of ways. As an occupational category, health care has been a site of struggle between a majority of female workers disadvantaged because of their sex and often because of their social class and sometimes because of their race or ethnicity, and a minority of male workers whose position as physicians has garnered them power, prestige and wealth. And we learn from the growing body of work on women and health care, of which this volume forms a part, the lamentable truth that women as patients have experienced not only curing and caring from physicians and from the health care system, but also denigration, neglect and abuse.

Recently, Dr. Frances Rosenberg, who was for several years the editor of the Federation of Medical Women of Canada (FMWC) *Newsletter*, reflecting on the changes in gender balance in the medical profession, suggested that women physicians could either use the power of their numbers to become "change agents" in the profession or they

could remain "second class citizens within medicine."⁸⁵ Rosenberg, like most of the activists within the FMWC, clearly hopes that women physicians will be agents of change, in a way that will benefit all women. Certainly the FMWC's remarkable openness to women's concerns is heartening, and perhaps the existence of a numerically strong female presence at the pinnacle of the health care pyramid will encourage change for the better for all women health care workers and for health care consumers. But it will not in itself bring about such change, nor should we expect it to do so. Resolving the moral, social and economic dilemmas confronting the Canadian health care system at the end of the twentieth century will require the collective effort of female and male practitioners across the complex spectrum of health care occupations and as well, the decision making of an informed, actively involved community of health care consumers.

Endnotes

* The quotation is taken from the title of an editorial by Dr. Frances Rosenberg, Editor, "No longer an invisible minority," *Federation of the Medical Women of Canada Newsletter*, October 1990, vol. IV, p. 5. This paper was first presented in the series "Gender and Medicine" offered by the Hannah Chair in the History of Medicine at the University of Ottawa in 1991. I would like to thank the following people for their help: Meryn Stuart, Dianne Dodd and Toby Gelfand, who organized the series; Myra Owen and her staff at the University of Ottawa's Health Sciences Library; the University of Ottawa archivists; my Carleton University colleague Fran Cherry, and E. Ryten, Director of the Office of Research and Information Services of the Association of Canadian Medical Colleges; and the faculty members and students at the University of Ottawa Faculty of Medicine who kindly answered my queries during the months of February and March 1991. These were two female physicians—one in the professoriate and one who was a faculty member within the last decade; one male full professor; and one second-year female medical student. Finally, I am grateful to Wendy Mitchinson for her careful reading of a version of this paper.

1. 79% is the figure for 1991. See Statistics Canada, *The Daily*, cat. 11-001E, 2 March 1993 (Ottawa: Statistics Canada, 1993). My thanks to the Women's Bureau, Labour Canada, for providing me with the source of this statistic. For a discussion of women workers in health care in the U.S., see P. A. Rosenthal, M.D. and Judith Eaton, M.D., "Women MDs in America: 100 Years of Progress and Backlash," *Journal of the American Medical Women's Association (JAMWA)* 37 (1982): 129-132. They say "women account for two thirds of the health care consumers and 87% of the health care workers," 129.

2. In Canada, as in the United States, progress in admissions at the end of the nineteenth century was followed by a decline in the first decades of the twentieth century. In 1955 in the United States, only 4.7% of medical students were women. See Rosenthal and Eaton, "Women MDs in America." For Canada see E. Ryten, "The changing demographics of physician supply in Canada: How did we get where we are and where are we going? Does it matter?" Unpublished paper, n.d. but 1990. I thank Ms. Ryten for giving me access to this and other papers cited here.

3. A. Paul Williams et al., "Women in Medicine: Practices, Patterns and Attitudes," *Journal of the Canadian Medical Association* 143, 1 (August 1990): 195. On the difference between Canadian and U.S. figures Williams et al. say: "A similar, though less marked, shift has occurred in the United States." For the United States, see Joan M. Altekruze and Suzanne W. McDermott, "Contemporary Concerns of Women in Medicine," in Sue V. Rosser, ed., *Feminism within the Science and Health Care Professions: Overcoming Resistance* (Oxford: Pergamon, 1988). In the U.S. in 1986–1987, women made up 37% of entering students.
4. Ryten, "The changing demographics of physician supply," 8. U.S. projections suggest that it will take approximately "forty years for women to make up 25% of the total physician population." Sharon Romm, "Woman Doctor in Search of a Job," *JAMWA* 37 (1982). See also J. A. Braslow and M. Heins, "Women in Medical Education: A Decade of Change," *New England Journal of Medicine (NEJM)* 304, 1129 (1981).
5. The Universities of Toronto, Western Ontario, and Ottawa, and Queen's and McMaster Universities all have schools of medicine.
6. *Canadian Medical Education Statistics* vol. 12, 1990, Table 17A, 19. There are some marked regional variations in the overall Canadian pattern. In 1989–1990 more than half the enrolment at the three Francophone schools in Quebec was female, whereas in Ontario female enrolment made up 39% of the total. At Laval University in Quebec City, women comprised 55.6% of the total enrolment.
7. Lila A. Wallis, M.D., "Academic Promotions: A Plan of Action," *JAMWA* 37 (1982).
8. "A profound lack of female physicians in academic leadership positions exists. In 1988 two (1.6%) of 127 deans, 11% of associate deans, 22% of assistant deans and 3% of chairpersons were women. Nine (13%) of these chairs were in pediatrics." "For the past 30 years, women have been more likely than men to enter academic medicine. However, they have not achieved the same success as men." Catherine DeAngelis, M.D., "Women in Medicine, Fantasies, Dreams, Myths and Realities," *American Journal of Diseases of Children (AJDC)* 145 (January 1991): 49–52.
9. Ryten, who has analysed this data, reminds us that "the cohort factor" is at work here. In her view, "just because the current output of Canadian medical schools is more than 40% female, by no means implies that the pool of qualified individuals from which medically qualified academics were recruited contained 40+% women." Ryten believes that at the present time, women are not meeting with discrimination in hirings at Canadian medical schools. Nonetheless, the fact that there are so few women in positions of power in academic medicine does contribute to continuing patterns of inequity. See the discussion of women in surgery below.
10. For example, see Penina Migdal Glazer and Miriam Slater, *Unequal Colleagues: The Entrance of Women into the Professions, 1890–1940* (New Brunswick, N.J.: Rutgers University Press, 1987).
11. Glazer and Slater, *Unequal Colleagues*, 75–76.
12. For this incident see Ray Strachey, "The Cause": *A Short History of the Women's Movement in Great Britain* (London: Bell, 1928), 179–180.
13. For this, see for example Martin Shapiro, *Getting Doctored: Critical Reflections on Becoming a Physician* (Kitchener, Ontario: Between the Lines, 1978). Shapiro, who was part of the entering medical school class at McGill in 1969, emphasizes in this excellent critical discussion of medical training, that his overwhelmingly male entering class of 135 students were from "economically privileged sectors of society" (p. 14), that there were no black

Canadians or black Americans in his class (p. 18), the only blacks being "a few Africans, all from wealthy families," and no native people. He also says that the interview process, in these years of student activism at McGill, were designed to weed out "radicals" from the medical school cohort (p. 19). The conservative, conformist, authoritarian atmosphere of medical school could be difficult for many males, of course; this is one of Shapiro's main points. But Shapiro himself emphasizes that women students faced active discrimination and denigration during these years: there was no way that they could fully conform, especially since the conservatism and conformism of the male students and staff included for the most part an acceptance of sexism and misogyny.

14. Dr. May Cohen goes on to recall that "our anatomy lab teams and our clinic groups consisted of women only—even though that meant much larger groups than the men's clinical groups." Cohen, since 1991 Associate Dean of Health Services in the Faculty of Health Sciences, McMaster University, graduated from the University of Toronto's medical school in 1955. In recent years, she has been active in promoting women's issues within the profession of medicine, and in speaking out on issues related to women and health. She has been active in the Federation of Medical Women of Canada (FMWC), serving as the organization's President in 1991–1992. The quotation is from her FMWC presidency acceptance speech, excerpts of which appear in the *FMWC Newsletter*, October 1991, vol. 4, p. 9. Regarding Cohen's reference to the 10% quota, affirmative action policies, especially in the United States, are sometimes said to involve "quotas," meaning that at least that many members of the targeted group must be included. The quotas of the 1950s, to which Cohen refers, were designed to limit the targeted group.

15. For Dr. Besnack, see the *Report of the Dean: Faculty of Medicine, 1970–1972*, which mentions her retirement after "close to 10 years," 19. Report is in the University of Ottawa Archives.

16. I read Calendars and Reports from the school's founding until the present in the University Archives. Some who were at the school do not agree: the one physician faculty member who attended the talk on which this paper is based, during the Hannah Chair's "Gender and Medicine" series in 1991, was a woman who had been at the school for many years. She insisted that there never was any gender bias at the school, but then she also insisted that in the twentieth century there never has been any bias against women in medicine anywhere.

17. On this question, as it relates to science and medicine, see Rosser, *Feminism within the Science and Health Care Professions*, pass., and also Glazer and Slater, *Unequal Colleagues*.

18. Shapiro, *Getting Doctored*, 27.

19. Glin Bennet, *Patients and Their Doctors: The Journey through Medical Care* (London: Baillière Tindall, 1979), 148.

20. Jack Haas and William Shaffir, "Taking on the Role of Doctor: A Dramaturgic Analysis of Professionalization" reprinted in David Coburn, C. D'Arcy, G. M. Torrance and P. K. New, *Health and Canadian Society: Sociological Perspectives*, 2nd ed. (Toronto: Fitzhenry and Whiteside, 1987), 399–421. The article first appeared in *Symbolic Interaction* 5, 2 (Fall 1982): 187–203

21. McMaster is not unique here; Shapiro's account of his McGill training makes it clear that there, too, during his training, medical students were referred to as "doctor" in their second year, when they entered the hospital setting. Shapiro, *Getting Doctored*, 59–67.

22. Haas and Shaffir, "Taking on the Role," 406–407. Note that while this article uses the pronouns "he" and "she" rather than the universal "he," and the authors are aware that

even in 1982 McMaster's medical school had a higher than average number of women students, the authors do not discuss gender as a factor.

23. Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 Years of the Experts' Advice to Women* (Garden City, N.Y.: Anchor, 1978).

24. Margaret A. Campbell, M.D., "Why Would a Girl Go into Medicine?": *Medical Education in the United States: A Guide for Women* (Old Westbury, N.Y.: The Feminist Press, 1973). On the inside cover we are informed that "Dr. Margaret A. Campbell is a pseudonym." This study received some recognition in the medical profession itself. For example see an article that appeared in the "Sounding Board" section of the *NEJM* in 1974: Mary C. Howell, M.D., Ph.D., "What medical schools teach about women," *NEJM* 291 (1974): 304–307. Howell, who, like Campbell, takes a feminist point of view, and believes that discrimination in medical schools was widespread, cites Campbell frequently.

25. Campbell, "Why Would a Girl Go into Medicine?," 110–111. Regarding women physicians in training and nurses' quarters, Cohen says of her experience as an intern, training at the University of Toronto medical school in the early 1950s, "As interns, we [women medical students] were forced to live in the nurses' quarters where no men were allowed to cross the threshold (even though I was already married). *FMWC Newsletter*, October 1991, vol. 4, 9.

26. Campbell, "Why Would a Girl Go into Medicine?," 25.

27. That the division between nurses and women physicians continues is reflected in this comment made by Dr. Frances Conley, a neurosurgeon who in 1991 resigned her professorship at Stanford University to protest the sexism of Stanford's medical school. (She has since returned to Stanford because some of her complaints have been addressed.) Conley is a feminist and an outstanding achiever in a field still overwhelmingly dominated by men, but in a speech she gave at the University of California at San Francisco she is reported as having made the following comment about nurses: "women have not responded to gender insensitivity very well. . . . Some operating room nurses with whom I have worked put up with blatantly sexist remarks because they do not want to jeopardize their 'special' relationships with the doctors; I term this type of women 'enablers' because they enable sexism to continue." Cynthia Corwin, "Conley foresees 'no room at top' for women in Academia," *Synapse* 36, 12 (14 November 1991): 5. *Synapse* is the student-run paper at UCSF.

28. Shapiro, *Getting Doctored*, 70.

29. Campbell, "Why Would a Girl Go into Medicine?," 27.

30. On the fact that this was not accurate, see Campbell, footnote 4, p. 102: "In 1952 and again in 1965 the modal numbers of hours of practice per week were 45 for women physicians, 50 for men physicians."

31. See Howell, op. cit.: "The men's-club atmosphere is heightened by the tradition of 'medical humor,' much of it at the expense of women. A major theme of this humor is male sexual prurience, and an underlying attitude is that any woman is an appropriate object for that prurience—any woman, including a patient, including a colleague," 306.

32. Campbell, "Why Would a Girl Go into Medicine?," 110.

33. Bennet makes the same point: "So often the medical students, and junior doctors too, react with a robust kind of detachment, so that grave or gruesome matters are the subjects of jokes" (p. 148).

34. Campbell, "Why Would a Girl Go into Medicine?," 42–43.

35. By 1992, one half of the obstetricians and gynecologists in training in Canada were women, according to an article in the *FMWC Newsletter*, October 1992, vol. 5, no. 3: 5. And that number will likely increase rapidly: "In 1980/1981, 28% of the post-M.D. trainees in obs/gyn were women; by 1984/1985, this figure had climbed to 41%; now [1989-1990] 81% of medical students who state they wish to become obstetricians/gynaecologists are women. If these figures mean anything at all, they signify that obstetrics and gynaecology will rapidly become a female dominated field of medical practice." Ryten, "The changing demographics of physician supply," 17. Others have noted this shift in obstetrics/gynaecology. For example, an observer writing about developments in the U.S. says: "The largest recent shift has come in obstetrics and gynecology, where the number of women doubled between 1980 and 1990." Valerie Ulstad, M.D., "How women are changing medicine," *JAMWA* 48, 3 (May-June 1993): 75-78.
36. Diana Scully and Pauline Bart, "A Funny Thing Happened on the Way to the Orifice: Women in Gynecology Textbooks," *American Journal of Sociology* 78 (1973): 1045-1049.
37. Kay Weiss, "What Medical Students Learn about Women," *Seizing Our Bodies: The Politics of Women's Health* (New York: Vintage, 1977).
38. J. R. Willson, M.D., C. T. Beecham, M.D. and E. R. Carrington, M.D., *Obstetrics and Gynecology*, 4th ed. (St. Louis: The C. V. Mosby Co., 1971). Weiss reports that it was used in 1977 in 60 U.S. medical schools. For the University of Ottawa, see Calendars in the University Archives. Texts are listed under subject specialties. This textbook appears in listings throughout the 1970s and into the 1980s.
39. This is quoted in Weiss, "What Medical Students Learn," 214.
40. Edmund Novak, Jerrgeanna Seeger Jones and Howard W. Jones, Jr., *Novak's Textbook of Gynecology*, 8th ed. (Baltimore: Williams and Wilkins, 1970), 663. Another text, also listed in the University of Ottawa calendars, and like Novak et al., still available in the Gynecology section of the University's Health Sciences Library, gives the following advice about the menopause: "The menopause exaggerates the woman's anxieties and fears. It increases her dissatisfaction with her socio-economic or domestic state and brings into sharper focus vague feelings of self-pity, apprehension and depression. Traits of pettiness, irritability and excitability which were controlled or dormant in former years make their appearance. They often appear as sudden outbursts of anger, weeping or depression which are out of proportion to the situation inciting them. Insomnia, boredom, fatigue and forgetfulness are frequently among the complaints which bring the menopausal woman to her physician." John William Huffman, *Gynecology and Obstetrics*, 11th ed. (Philadelphia: W. B. Saunders, 1962).
41. J. Robert Willson, M.D. and Elsie Reid Carrington, M.D., *Obstetrics and Gynecology*, 6th ed. St. Louis: The C. V. Mosby Co, 1979.
42. For example in the chapter on sexuality, the authors say: "The women's liberation movement has been an important influence in altering sexual roles in a most dramatic way . . . the new ideal places a woman's position as equal to that of the male. . . ." Willson and Carrington, *Obstetrics and Gynecology*, 98.
43. Willson and Carrington, *Obstetrics and Gynecology*, 51.
44. This sixth edition still contains the following racist and sexist statement about the psychological effects of pelvic surgery: "Many patients believe that the source of their sexual desires is located in this area. This is a common belief of black patients, who think that it is in the uterus; white patients think that the source of their sexual desires is in the ovaries," 59.

that it is in the uterus; white patients think that the source of their sexual desires is in the ovaries," 59.

45. Neville Hacker and J. George Moore, *Essentials of Obstetrics and Gynecology* (Philadelphia: Saunders, 1986). This text was not listed in the University Calendar, nor had it yet appeared in the Health Sciences Library catalogue, but it was the textbook ordered by the Health Science bookstore, and according to the bookseller, it was the required text.

46. S. Jean Herriot Emans and Donald Peter Goldstein, *Pediatric and Adolescent Gynecology*, 2nd ed. (Boston: Little, Brown Clinical Pediatric Series, 1982).

47. Emans and Goldstein, *Pediatric and Adolescent Gynecology*, 540.

48. During International Women's Week of March 1991, posters in Guindon Hall, the Health Science Building, for example, advertised study sessions on the subject "women abuse: it hurts." This project was sponsored by the student project for preventative medicine.

49. A sense of the way in which women physicians themselves view these problems can be gained from articles in *JAMWA* and the *FMWC Newsletter*. From the latter, here are comments from Mary Donlevy, the 1990–1991 president: "I have spoken to women residents who were being sexually harassed by their male professors and mentors; to fully qualified women specialists who do not practise their specialty because of sexual discrimination; to women residents who were told not to get pregnant during residency by the program director." Dr. Donlevy on the President's Page, *FMWC Newsletter*, October 1990, vol. IV: 9.

50. One study published in 1988 was based on interviews with male and female graduates of a "large midwestern medical school." Linda Grant, "The gender climate of medical school: Perspectives of women and men students," *JAMWA* 43 (1988): 109–119. Another was based on a "questionnaire survey of fully trained women surgeons . . . conducted between 1983 and 1986," Sylvia M. Ramos and Cheryl J. Feiner, "Women surgeons: a national survey," *JAMWA* 44 (1989): 21–25.

51. From a respondent in Grant's study, op. cit.: "I really was hassled a lot as a woman, had my ass pinched by a surgery resident, was picked on with trivial questions, was embarrassed, even brought to tears a few times. [The chief resident] just laughed and said there it was, proof that women didn't have the stamina and what it takes for surgery." Grant, "The Gender Climate," 110.

52. See Ramos and Feiner, "Women Surgeons," 24. In the Grant study, one student, for example, compared two different surgery rotations: in one, she was subjected to persistent sexism; in the next, however, "some of the [staff physicians] really encouraged women to enter surgery. The chief mentioned . . . a couple of times that surgery needed more women." Grant, "The Gender Climate," 110.

53. The American case of the neurosurgeon Dr. Frances Conley (see footnote 27) has given publicity to the issue of continuing discrimination against women, especially in surgery. When Conley spoke at the University of California at San Francisco medical school, she attracted a crowd of 500 people (about three-fourths women). In this talk, Conley, while generally optimistic about women's ability to fight sexism, talked of the pervasiveness of "gender insensitivity." See Corwin, "Conley foresees 'no room at top' for women."

54. Grant found that 34% of women said they had indeed experienced gender discrimination. However, "Faculty and staff physicians" are main source of "gender discrimination." Grant, "The Gender Climate," 118.

55. Grant, "The Gender Climate," 119.

56. On the equitability of Canadian hiring practices, see Ryten, "Women in Academic Medicine in Canada: Are Women Subject to Discrimination?" Unpublished paper: n.d. but c. 1989. But see in contrast Cohen: "Although the number of women in medicine has increased, gender harassment and gender discrimination are still important issues for women. Sexual harassment or gender discrimination is often subtle and difficult to label and may range all the way from sexual remarks, jokes or teasing to sexual assault. . . . Disapproval, overt or covert, of women who are pregnant, either residents or practicing physicians, is a form of gender discrimination which many in this room have experienced." Cohen's presidency acceptance speech, op. cit.

57. The articles on nursing in this volume can be seen in part as a reflection of a newly assertive nursing profession that is claiming both its own history and its right to define itself.

58. One good discussion of the question, in historical and philosophical context: Nancy M. P. King, Larry R. Churchill and Alan W. Cross, *The Physician as Captain of the Ship: A Critical Reappraisal*, Philosophy and Medicine series, vol. 29 (Dordrecht, Holland: D. Reidel Publishing Co., 1988). "Twenty years ago . . . the physician was 'captain of the ship. . . .' As a result of pressures from a number of diverse directions—including technological advances, the development of new health professionals, changes in health care financing and delivery, the recent emphasis on consumer choice and patients' rights—what our society expects physicians to do and to be is different now" (p. xi).

59. "The prospect of becoming Canada's first large group of unemployed doctors has shocked Ontario residents and interns. . . . [T]he Ontario government's dramatic and unexpected proposal last week [will] limit most new family doctors and pediatricians to 25 per cent of the normal billing rate for physicians, a rate so low it would in effect bar them from practice. Only 45 new family doctors in five counties in Southern Ontario where there are 'marginal shortages' would be exempt. That would leave more than 300 of the estimated 350 doctors who are expected to enter family medicine this year without work, a situation virtually unprecedented in Canada." "New doctors aghast at limits on practice," *Toronto Globe and Mail*, Tuesday, 4 May 1993: A6. A month later, the provincial government was forced to modify this policy: "Ontario improves offer to doctors: Billing by new MDs would be set at 75 per cent of OHIP fee," *Toronto Globe and Mail*, 5 June 1993: A3.

60. "New doctors aghast at limits on practice." Comment of Dr. Lisa Moore to the press.

61. See for example the discussion of the literature in Brigitte Maheux, Francine Dufort, François Beland, "Professional and sociopolitical attitudes of medical students: Gender differences reconsidered," *JAMWA* 43 (1988) and see also John M. Last, "Sexual inequity in medical care," *Journal of the Canadian Medical Association* 123 (8 November 1980): 834. And see also Valerie Ulstad, M.D., "How women are changing medicine," *JAMWA* 48, 3 (May-June 1993): 75-78.

62. For the fact that Canadian women physicians prefer group over solo practice—only 17.8% of female physicians were in solo practice as compared with 29.2% of male physicians—see Williams, "Women in Medicine," 197.

63. "The income differences reported . . . persisted even after we controlled for patient visits, hours worked, age and specialization. . . ." Williams, "Women in Medicine," 199.

64. For Canada, see Ryten, "The changing demographics of physician supply," 16, and for the U.S. see Altekruise and McDermott, "Contemporary Concerns," 72.

65. Russell C. Maulitz, "Physicians and Authority: A Historical Appraisal," in King, Churchill and Cross, *The Physician as Captain*, 6.
66. Williams et al., "Women in Medicine"; Maheux, Dufort, and Beland, "Professional and sociopolitical attitudes."
67. Maheux et al. suggest this (p. 75).
68. This statement was made by my male physician respondent.
69. Issues of the *Newsletter* from 1990 to the latest issue available, Winter 1992–1993, vol. 5, no. 4, reflect all the above-mentioned concerns and activities.
70. See for example Marcia Angell, "Juggling the personal and the professional life," *JAMWA* 37 (1982). As one might expect, doctors marry each other: "... over half of [medical] women are married to or will marry other doctors."
71. On this question see for example Joy Walker Bonar, M.S., James Allen Watson, Ph.D. and Lynne Stanford Koester, Ph.D., "Sex differences in career and family plans of medical students," *JAMWA* 37 (1982).
72. One of the two female physician respondents from the University of Ottawa commented that when she had a child during her residency some two decades ago, she was given virtually no time off. Now a resident is guaranteed a three-month pregnancy leave.
73. Not everyone agrees that the requirements need to remain so inflexible. See DeAngelis, "Women in Medicine" for a different point of view. And for the FMWC, "shared and part-time residency options" is a change to which they are currently committed. See the article by Dr. Jean Swenerton, the organization's President in 1992–1993 in the *FMWC Newsletter*, Winter 1992–1993, vol. 5, no. 4: 4.
74. Michael Shapiro, *Getting Doctored*, 31. Shapiro goes on, "The compulsion to work . . . represents also an attempt by the students to immerse themselves in and become part of something big and powerful. They readily submerge in a professional role and internalize the compulsion to work. The latter becomes integral, in fact, to their burgeoning professional identity" (p. 32).
75. For example, see the reference to "workaholic physicians" in a recent issue of the *FMWC Newsletter*: "While most workaholic physicians are men, the number of women who suffer from this problem is on the rise." January 1992, vol. 5, no. 1: 2.
76. *FMWC Newsletter*, January 1992, vol. 5, no. 1: 5. From an editorial by Dr. Chris Whittington.
77. Marianne H. Whatley, "Beyond Compliance: Towards a Feminist Health Education," in Rosser, *Feminism Within*.
78. Nancy Worcester and Marianne H. Whatley, "The Response of the Health Care System to the Women's Health Movement: The Selling of Women's Health Centers," in Rosser, *Feminism Within*, 121.
79. Carolyn Ambler Walter, "The dilemma of the female physician in the feminist health center," *JAMWA* 43 (1988).
80. Ontario is, as yet, the only province to have passed enabling legislation, but the issue is being discussed in Alberta, British Columbia and Quebec. For physicians' opposition see, for example, the pro-midwife editorial "Quebec is ready for midwives: Doctors should stop fighting this sensible step," *Montreal Gazette*, 14 March 1993, B2. And "Midwives complain that doctors refuse to give them support," *Montreal Gazette*, 28 January, 1993, A4. A Canadian Medical Association policy statement of May 1993, "Revisions to Recom-

recommendations of CMA's "Obstetrics 87' Report," makes no mention at all of midwives, but "recommends the continued support of the existing obstetrical care system in Canada," suggests measures to "encourage physicians with obstetric/gynaecological training to practice obstetrics" and "supports the continuing involvement of family physicians in all aspects of obstetrical care in Canada." My thanks to the CMA for providing me with this document.

81. According to a *Globe and Mail* story that appeared in March 1993, the legislation, the Regulated Health Professions Act, which includes midwifery, is expected to be proclaimed before the end of 1993. "Midwives to operate birthing centres," *Toronto Globe and Mail*, 30 March 1993, A1-A2.

82. For the training programs see "Ontario midwives get a big push: three B.A. programs will start in Fall for province," *Medical Post* 29, 2 January 12, 1993: 40. For the College of Midwives see "Midwives to operate birthing centres," *Toronto Globe and Mail*, 30 March 1993, A1-A2.

83. It should be noted, however, that not all modern midwives are female. The Dutch midwife who is assisting the Quebec Ministry of Health to establish guidelines for midwife training and standards is male. See "Only 12 of 120 hopefuls pass midwives' tests," *Montreal Gazette*, 12 March 1993, A5.

84. I have seen no indication that women physicians are taking a position different from that of their male colleagues on the midwife issue. The FMWC *Newsletter*, for example, although it discusses many women's health issues in a forthright manner, and often opposes the mainstream views of the profession, has not taken up this issue.

85. Editorial by Dr. Frances Rosenberg, ed., "No longer an invisible minority," FMWC *Newsletter*, October 1990, vol. IV: 5

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