

**‘TALKING ABOUT DOWN THERE’: THE DEVELOPMENT OF A PUBLIC  
DISCUSSION OF CERVICAL CANCER IN THE TWENTIETH CENTURY**

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### **Abstract**

This dissertation emerged from personal and political concerns and aims to fill a historiographical lacuna. This thesis is a study of how Canadian women learned about cervical cancer and its prevention in the twentieth century. In particular, this thesis seeks to understand how, when and in what forms did a public discussion of cervical cancer prevention develop in late twentieth century Canada. Cervical cancer is significant in terms of its place in disease history. When discovered in the pre-cancerous stage, cervical cancer is quite preventable. Since the 1960s, the medical community has been aware that Pap smears can be used to recognize pre-cancerous lesions and that deaths from cervical cancer were avoidable. Its uniqueness as a “preventable” cancer provides an example of the relationship between scientific knowledge, public health, and popular practice. The public dialogue about cervical cancer prevention, I argue, was complex. There were numerous groups that were part of this public discussion including medical doctors, the medical profession, medical educators, women’s health activists, women’s organizations, newspapers, women’s press, individual women and support groups, and the municipal, provincial and state agencies. This thesis demonstrates that while dialogue among these historical actors was rarely in conflict, tensions did emerge as medical practitioners, women’s health activists and public health officials debated how best to link biomedical knowledge with preventive health policies.

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## Introduction

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It was not until 1997 that I even questioned what was being done to my cervix during my yearly Pap smear. After the doctor yelled out to remind me of the importance of booking next year's appointment, I realized that I had no idea why I was even doing this. All I knew was that my cervix and my doctor had a yearly appointment, and I was along for the ride. I had no idea where to go or who to ask about the Pap smear. How many other women, I wondered, were just like me? Were there other women out there lying on cold examination tables, their feet in stirrups, not really understanding the procedure being performed and afraid to ask their doctors? How many women actually knew the medical reason why they were getting Pap smears? Did they understand that they might be at risk for cervical cancer? Was I at risk? Who was considered a high risk individual and how had medical professionals come to understand the risk factors for developing cervical cancer? Medical professionals have taken the role of experts over the bodies of women, co-opting management of women's health. For many years, women asked few questions about their bodies and health, at least in public discourse. If I did not learn about my Pap smear, I was complicit in this process, but searches in secondary materials gave few answers to my questions.

In 2011, my own mother did not know whether or not she even had a cervix to worry about. In the early 1980s my mother, along with staggering numbers of other Canadian women, had a hysterectomy. Afterwards, none of the doctors she encountered ever suggested she undergo a Pap smear. She was in a stable marriage, finished having children, and no longer had a uterus. But the question was - did she have a cervix? After

several weeks of encouraging, my mother finally had a pelvic exam (her first, she reminded me, in decades) revealing that she did not have a cervix – it had been removed as part of the hysterectomy. With her actual records of the surgery long gone, and the doctor who performed the surgery dead, there was no way to know why her cervix had been removed. Before this appointment, my mother, at the age of 57, did not have basic knowledge about the state of her reproductive organs. Although her level of risk for cervical cancer was decidedly low, so was her knowledge of the disease. How, I wondered, was this possible?

This dissertation emerged from these personal and political concerns and aims to fill a historiographical lacuna. This thesis is a study of how Canadian women learned about cervical cancer and its prevention in the twentieth century. In particular, this thesis seeks to understand how, when and in what forms did a public discussion of cervical cancer prevention develop in late twentieth century Canada. Cervical cancer is significant in terms of its place in disease history. When discovered in the pre-cancerous stage, cervical cancer is quite preventable. Since the 1960s, the medical community has been aware that Pap smears can be used to recognize pre-cancerous lesions and that deaths from cervical cancer were avoidable. Its uniqueness as a “preventable” cancer provides an example of the relationship between scientific knowledge, public health, and popular practice. The public dialogue about cervical cancer prevention, I argue, was complex. There were numerous groups that were part of this public discussion including medical doctors, the medical profession, medical educators, women’s health activists, women’s organizations, newspapers, women’s press, individual women and support

groups, and the municipal, provincial and state agencies. This thesis demonstrates that while dialogue among these historical actors was rarely in conflict, tensions did emerge as medical practitioners, women's health activists and public health officials debated how best to link biomedical knowledge with preventive health policies.

On a grander personal level, this thesis looks to be a catalyst for change. As a feminist, and applying feminist politics to my work, I want to further the crusade to educate the Canadian public about cervical cancer; ultimately, knowledge about cervical cancer will prevent needless deaths. My role, as a scholar, surely will be instrumental in promoting further discussions about cervical cancer and its prevention within my academic circle. It is clear to me that even today few women truly understand cervical cancer, its connections to HPV, and strategies to prevent this disease. Women continue to struggle to access information, support, and hope around cervical cancer. In 2000 Cathy Black and nine other women created a website, [eyesontheprize.org](http://eyesontheprize.org), in response to the lack of accessible information about women's reproductive cancers. Cathy Black was diagnosed with cervical cancer in December of 1998. She lived just outside of Toronto, was 38 years old at diagnosis, and was married and childless. While she battled through her treatments, struggling with startling side effects, she sought out emotional support. She met a small community of women via an on-line support group and quickly discovered that she was not alone in her feelings of disconnect and shame. Her website sought to provide more resources and support to women experiencing gynaecological cancer. While Cathy Black lost her battle with cervical cancer in 2001, she was successful in creating a safe space for women to not feel "alone and stigmatized by their

below-the-belt cancer.”<sup>1</sup> I have carried out research with the hope that I am also helping to increase knowledge about this type of gynaecological cancer, to encourage more public discussion of this disease and, like Cathy Black, to support women in both prevention and treatment.

This dissertation focuses on the years between the 1950s – when scientists and doctors were debated how to make the laboratory test for cervical cancer useful – and the 1980s – when medical understanding of HPV as the primary causal agent for cervical cancer was consolidated. These four decades were characterized by four significant historical trends. The first was the explosive growth of bio-medical knowledge. In the years after 1945, major advances in pharmacological research, proliferation of medical sub-specialities, and growth of large, technologically-driven institutions meant that more and more diseases could be cured, or at least managed, and more and more health problems came under the scrutiny of medicine. The lucrative post-war years allowed federal and provincial governments in Canada, as elsewhere, to invest heavily, for the first time ever, in hospital construction, medical research, and various social services.<sup>2</sup>

And after 1968 Canada’s signature health care policy – Medicare – ensured that all Canadians had access to biomedical services. Federal funds paid for hospital care and for provincial programs. Individual doctors continued to receive the traditional “fee for service” but now billed the provincial health department, rather than paying patients. General practitioners required fewer years of medical education and earned less for their

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<sup>1</sup> K. Jane George, Susan Donley, and Stephanie Black. “Lives Lived: Cathy Black.” *The Globe and Mail*, December 6, 2001.

<sup>2</sup> Feldberg, Gina et al (eds). *Women, Health, and Nation: Canada and the United States Since 1945*. (McGill-Queen’s University Press: Montreal and Kingston, 2003), 4.



services, while specialists undertook extensive post-graduate training thus rendering larger and more consistent incomes.

In the same years, however, public health began to decline in prestige.<sup>3</sup> Up until WWII, public health had proven its social prestige through its mass programs of inoculation, clean water, and quarantine. At the very basic level, public health is defined as the population's health. In the nineteenth century, the emergence of the germ theory of disease (microbes and viruses caused disease) had empowered public health officials to measure water quality, stem the transmission of contagious diseases, and vaccinate against others. In the twentieth century, though, it was pharmacological advances like penicillin and sulpha drugs which sparked the decline of major killers like tuberculosis. For the remainder of the twentieth century attention and investment shifted from public health to the triumphs of curative science and biomedicine. Cervical cancer screening programs had to find their way in this new landscape of curative and preventive medicine.

With biomedical advances came a new cultural authority for medical doctors, a cultural authority which drew growing criticism from feminist activists. In the late 1960s a vibrant Women's Health Movement in the United States, Canada, and Britain – and then subsequently across the globe<sup>4</sup> - sought to redefine women's health and to make women active participants in their own care. General practitioners were criticized for not only medicalizing otherwise processes like childbirth and menopause, but also for

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<sup>3</sup> Simon Szreter. "The Population health Approach in Historical Perspective." *American Journal of Public Health*, vol. 93/3 (2003): 421.

<sup>4</sup> Kathy Davis, *How Feminism Travels Across Borders: The Making of Our Bodies, Ourselves*. Durham and London: Duke University Press, 2007.

assuming the role of moral guardians of their patients, especially where issues of sexuality were concerned.

New techniques for identifying cervical cancer emerged in the midst of these social trends. The Pap smear (and the science needed to properly read the smears) was an excellent example of the triumphs of biomedicine. Screening not only flagged potential cervical disease in individual women, but if done *en mass* promised to provide data from which epidemiologists could track the disease and those most at risk. Unlike breast cancer, cervical cancer was not something women could personally feel or see on their own, they needed a health care professional and the lab system already in place to detect this cancer. But as a “women’s disease” which could be detected early, the question of who was going to be responsible for screening and how it was going to be promoted remained a subject for debate and disagreement.

### **Creation of a medical reading public**

Before the age of *Google* and readily available online medical information, my research revealed that women in Canada, particularly from the 1970s to the 1990s, had options for finding out information about cervical cancer. Barbara Clow, in her article “Who’s afraid of Susan Sontag?”, argues that even in the early 1900s “many people shrank from a frank discussion of the disease as well as knowledge of a devastating diagnosis, their reticence was not absolute, as implied by the term ‘silence.’”<sup>5</sup> The research for this thesis reveals that during the mid to late-twentieth century women in Canada successfully created a medical reading public via hubs such as *Chatelaine*,

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<sup>5</sup> Barbara Clow. “Who’s afraid of Susan Sontag? Or, The Myths and Metaphors of Cancer Reconsidered.” *Social History of Medicine* vol. 14 (2001): 297-98

newspapers, and even government-printed posters and pamphlets. In her work, *Early Detection: Women, Cancer, and Awareness Campaigns in the Twentieth-Century United States*, Kristin Gardner recognized a similar pattern in the US, as her work revealed that twentieth-century US women were very much “prepared to read, write, and talk about cancer.”<sup>6</sup> She found a rich history of cancer activism (participation in and promotion of cancer awareness programs) in the United States and my work fits into this emerging scholarship. As with Clow, Gardner recognized that while there may have been a ‘silence’ about cancer during the early twentieth century, by the very act of supporting cancer education programs and simply learning about the disease women were promoting cancer awareness.<sup>7</sup> While Gardner focuses exclusively on women’s activism, the research for this thesis reveals that women were not alone in promoting cervical cancer awareness in Canada.

Much of the discussion of cervical cancer and its prevention was led by medical professionals. Physicians were writing editorials in the *Canadian Medical Association Journal*, providing informative pieces in *Chatelaine* and newspapers such as the *Globe and Mail* and the *Toronto Star*, and collaborating with provincial public health agencies in the production of promotional health materials. The articles written by physicians were general in nature (focusing mostly on the different stages of cervical cancer, on who was most at risk, and how beneficial screening was to prevention), and the majority of such

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<sup>6</sup> Kristin Gardner. *Early Detection: Women, Cancer, and Awareness Campaigns in the Twentieth-Century United States*. (Chapel Hill: The University of North Carolina Press, 2006), 3.

<sup>7</sup> Ibid.

articles suggested that women should seek further consultation with their physicians for screening and monitoring.

By the 1970s, women's health activists were pushing the medical community to focus more on the health needs particular to women, and were challenging the paternalistic tone of some medical advice. Gaining knowledge about cervical cancer and ways to prevent it was empowering for many women and allowed them to actively participate in the maintenance of their gynaecological health. The health activists of the 1970s, including Canadian women such as Linda Light, Nancy Kleiber and Melanie Conn, argued that medical doctors (particularly gynaecologists) did not necessarily have women's needs as their primary concern or focus – advocacy was more about professional advancement and perfectionism. Authors and activists penned articles like Michele Landesberg's "Gynecology Guide," which offered women the information that they needed to navigate the kind of health care they required.<sup>8</sup> The result was a growing public dialogue in Canada that allowed women to seek information beyond the confines of the doctor's office. As this dissertation demonstrates, physicians and women's health activists agreed that Pap smears were essential; disagreement arose, however, between these groups and amongst physicians themselves, about how to reach the greatest number of women.

### **Experiencing the Pap Smear:**

It has to be noted that the Pap smear is an invasive procedure. For a healthy woman, this is a disincentive to participation in screening programmes. All too often the

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<sup>8</sup> Ibid., 66.

woman's body is disconnected from the self and the procedure is unpleasant; women can feel that they are acted upon, rather than seeking control over their bodies and health. The female medical body, according to Emily Martin, became viewed as a machine as early as the eighteenth century in French hospitals where the womb was viewed as producing and "expelling a fetus." The womb was additionally medicalized with the development of obstetrics and obstetrical tools to help extract the fetus. As Martin clearly states, "the woman's body is the machine and the doctor is the mechanic or technician who 'fixes' it."<sup>9</sup> This reference to obstetrical tools can be paralleled to the tools needed to screen for cervical cancer. Proper equipment, such as an examination table with stirrups (to place the woman in the infamous Sims position), a speculum, and the scraping tool to obtain the smear, are all needed for a physician to screen for cervical cancer. Often the woman is covered with a drape and cannot see what the physician is doing. Not only are women unable to see the actual procedure, their cervixes are being invaded by foreign objects, opened up, and scraped for specimens. These tools reinforce the separation of the body from the self and the idea of the female body as machine to be fixed. Martin argues "ordinary women do not seem aware of the underlying fragmentation implied in the ways they speak and the assumptions they make about their selves and bodies." For example, even though women tend to resist procedures such as caesarean sections and anaesthesia during labour, "they seem unable to resist the underlying assumptions behind those procedures: the self and body are separate."<sup>10</sup>

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<sup>9</sup> Emily Martin. *The Woman and the Body: A Cultural Analysis of Reproduction*. (Boston: Beacon Press, 1987), 54.

<sup>10</sup> *Ibid.*, 89.

Similarly, some women may avoid screening for cancer because of the invasive nature of the procedure.

It may also simply be difficult to convince women to undergo screening when they feel well. Cervical cancer screening is a form of secondary prevention in that it is “an intervention at an early or pre-symptomatic stage.” The Pap test does not necessarily detect cancer cells; it detects cervical cell abnormalities that could eventually become cancerous.<sup>11</sup> Some doctors and health activists assumed that women can gain control over their own bodies if they present themselves (or their bodies) for screening on a regular basis.<sup>12</sup> However, given the invasive nature of the procedure, it is unrealistic to think that all women see Pap smears as a way of reclaiming control over their bodies. As Linda McKie asserts in “The Art of Surveillance or reasonable prevention? The Case of Cervical Screening,” “this screening service is both creating and reinforcing surveillance of women’s sexual lives and health. Thus, it must be asked is this service providing reasonable prevention for cervical cancer or is it a further means of policing women’s sexuality?”<sup>13</sup> The potential anxieties and stresses from such an invasive procedure are often ignored. As some researchers have pointed out, the list of potential risks is long: the potential for inadequate sterilization of equipment, the stress of waiting for results, concern regarding the social stigma associated with a positive diagnosis, potential

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<sup>11</sup> Linda McKie. “The art of surveillance or reasonable prevention? The case of cervical screening.” *Sociology of Health and Illness* vol. 17/4 (1995); 443.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid., 441.

inaccuracy of reading of smears, and the distress that if not treated these abnormalities may or may not eventually become cancer.<sup>14</sup>

There is also potential that the societal pressure for women to participate in screening causes an increase in “risk consciousness.”<sup>15</sup> As active and consenting participants in screening, women become increasingly aware of the risk of cancer. Using Foucault, Alexandra Howson argues that this new “regulated body” contributes to women redefining themselves as “controlling self,” “risky self,” or “health promoting self.” Once a woman becomes defined through personal responsibility to care for herself, this responsibility becomes “equated with virtue”. If women refuse to define themselves as potentially at risk and to participate in screening, they are labelled as immoral.<sup>16</sup> By default, women are expected to participate in screening opportunities because if they choose not to participate they are seen to be disregarding risk and failing to fulfill their “duty to maintain health and well-being.”<sup>17</sup> Because screening opportunities are more limited for poor women, women in remote locations, women who do not speak English, and those with other social disadvantages, such judgments are dangerous. In addition, as Barbara Clow asserts, “if we accept that women have the right and power to make healthcare choices, we run the risk of blaming them for their ill health or, in the case of thalidomide, for the suffering of their children. But if we hold doctors responsible for the tragedy or accuse drug manufacturers and government officials of impropriety, we run the risk of disenfranchising women and providing a rationale for the revival of

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<sup>14</sup> Ibid., 444.

<sup>15</sup> Alexandra Howson. “Surveillance, knowledge and risk: the embodied experience of cervical screening.” *Health* vol.15/4 (1997): 196.

<sup>16</sup> Ibid., 196-7.

<sup>17</sup> Ibid., 199.

paternalism.”<sup>18</sup> How can education about risk be promoted without either blaming women for engaging in risky behavior (either sexually risky behavior, or behavior that fails to take responsibility for personal health) or disempowering women by placing responsibility solely with the medical profession? This thesis seeks to understand these tensions from an historical perspective. It also explores the limitations of screening when performed only in the offices of physicians and the pressures that mounted, from doctors and from women, for more comprehensive, government-funded, screening and recall programs.

There are significant differences between a government-funded cervical cancer screening program and getting a Pap smear at your family physician’s office. While the actual process of collecting specimens via a Pap smear is usually done in the physician’s office, whether you are participating in a program or not, it is ultimately about how the results are handled. If a woman is part of a larger, funded organized screening program, her results will be part of a larger central database, have proper and timely recall systems in place and measured levels of risk. Physicians have contested, and some still do contest, the idea that a program can more efficiently handle large numbers of smear results than it is possible for individual physician to do. The physicians in opposition to mass screening programs feel that they can effectively decide when to screen their patients on an individual basis, and can recommend further investigation if a positive smear is received. But as many organized, government-funded programs argue, public

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<sup>18</sup> Barbara Clow. “An Illness of Nine Months’ Duration”: Pregnancy and Thalidomide Use in Canada and the United States.” In Georgina Feldberg, et al. *Women Health and Nation: Canada and the United States Since 1945*. (Montreal and Kingston: McGill-Queen’s University Press, 2003): 59.



education, management of a large database and an effective recall system are vital to maintaining a decline in morbidity and mortality rates from cervical cancer. This thesis explores the interplay between physicians and women in the public debate about the desired response to cervical cancer and in the establishment of varied provincial screening programs.

### **History and Women's Health**

It is impossible to talk about the history of cervical cancer without first understanding a much larger historiography of women's health. Wendy Mitchinson has contributed enormously to this growing historiography and her book, *The Nature of their bodies: Women and their Doctors in Victorian Canada*, was the first book to study Canadian women's interaction with the Canadian medical establishment in this period. She was the first to remind us how valuable it is to "investigate medical care in the past," as it not only helps to define perceptions of health and disease, but also tells us much about the society at the time. She places late nineteenth century women as patients at the centre of her study and argues that the decision to seek medical attention is complex. People only seek medical treatment if they can afford it, or when they recognize that a problem is serious enough to require help, and if treatment for the particular problem is available. These variables force medical historians to push beyond simply defining a disease within a particular time period, but to further study its social constructions and "the way that care [was] provided in that intervention."<sup>19</sup> As many medical historians have revealed, however, attempting to place the patient at the centre of study does not

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<sup>19</sup> Wendy Mitchinson. *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*. (University of Toronto Press: Toronto, 1991),4.

eliminate the power imbalances that permeated treatment. Power dynamics existed between patient and doctors (and still do). These hierarchies were more extreme when male doctors dealt with female patients as Mitchinson stresses. It is vital to recognize this dichotomy early in any study on women and health in order to capture the entire story. Women's health activists in the 1970s contested this disempowerment; ironically, however, they shared many goals with physicians themselves with regard to optimal screening practices for cervical cancer.

Since cervical cancer is a disease particular to a woman's reproductive organs, Mitchinson's book, *The Nature of their Bodies*, provides a theoretical foundation in which to examine the social constructions of this disease. Her book examines the "mysteries" of puberty, menstruation, menopause, sexuality, birth control, and eventually obstetrics in the Victorian period. While this dissertation focuses on a period much later than the Victorian period, it is necessary to understand the history behind each of these aspects of women's reproduction. A woman's sexuality has seemingly always been a concern when talking about the epidemiology of cervical cancer. As her chapter, "Sexuality and Women," argues, sexuality is more than just physiological changes one may feel, it is also culturally defined.<sup>20</sup> By the end of the nineteenth century many women were assured by their doctors that any sexual desire or activity outside of marriage would surely lead to disease.<sup>21</sup> Cervical cancer, as a disease of the sexual organs, was constructed as a form of punishment for abnormal sexual behaviours, creating a context in which female diseases were stigmatized and in which discussion of

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<sup>20</sup> Mitchinson, *Nature of Their Bodies*, 99.

<sup>21</sup> *Ibid.*, 100.

such diseases was muted and shameful. Texts in the nineteenth century even went as far as labelling “unbridled female sexuality” as a *cause* of cervical cancer.<sup>22</sup> These connections are still prevalent in current discussions of the disease. Karen Nolte, a German historian of medicine, argues that “cervical cancer and the women suffering from it continue to be burdened with imputation of sexual promiscuity.” Even current studies on the human papillomavirus continue to highlight promiscuity as a cause of infection.<sup>23</sup> This connection is now dismissed both in the medical literature and in popular literature. In 1988, Petr Skrabanek<sup>24</sup> commented in an article published in the *Journal of Clinical Epidemiology* that “the link between women’s sexual activity and cervical carcinoma is an expression of sexist, pejorative attitudes, implicitly embedded in epidemiological studies”. More comically, he argued “it seems that promiscuity, if it means anything, is having more sex than the investigator.”<sup>25</sup>

In 1994, in commemoration of its final issue, a Canadian women’s health magazine *Healthsharing*, published a book revisiting some of its most popular articles. *On Women Healthsharing* is organized into sections that focus on issues most pertinent to women’s health. Some of these issues include: the health care system in Canada; health and the workplace; reproductive health and choice; menopause; medical, cultural, and social violence; disease; and community health activism. It is in section eight,

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<sup>22</sup> Karen Nolte. “Carcinoma Uteri and ‘Sexual Debauchery’ – Morality, Cancer and Gender in the Nineteenth Century.” *Social History of Medicine* vol. 21/1 (2008): 41.

<sup>23</sup> Ibid.

<sup>24</sup> Petr Skrabanek was a well-known doctor, professor of medicine, and open critic of epidemiological studies who claimed that diseases were preventable. After an extensive list of published works and a successful career, Dr. Skrabanek died in 1994.

<sup>25</sup> Petr Skrabanek. “Cervical Cancer in Nuns and Prostitutes. A Plea for Scientific Continence.” *Journal of Clinical Epidemiology* vol. 41 (1988): 579.

“Identifying and Challenging Notions of Disease,” that Jan Darby’s chapter on cervical cancer is included. Darby, a then graduate student at York University, argues that “the current [medical] model, which portrays women as predominately sexual beings, and labels our behaviour with moral terms such as ‘promiscuity,’ is based on misogynist assumptions about women, our bodies and our sexuality.”<sup>26</sup> While her work recognizes the current medical understandings of cervical cancer, her chapter focuses more on critically analyzing the problem with a focus on women’s sexual behaviour as a key risk factor in its development. She believes that the medical community needs to “broaden their approach to the causation of cervical cancer,” to include the “complex social and environmental influences in women’s lives.”<sup>27</sup> Her main worry was that with the medical community’s obsession on focussing on sexual behaviour as the main pre-cursor to developing cervical cancer, they run the risk of suggesting that “women bring this disease upon themselves by violating social norms of sexual conduct,” thus creating a “badge of shame.”<sup>28</sup> While her chapter is short, it is indicative of a feminist/sociological analysis of cervical cancer in the 1990s.

Two substantial studies on women and health in Canada have been published in the last decade: one an edited collection and the other a comprehensive and multi-disciplinary work. In 2012, medical historian Cheryl Krasnick Warsh wrote *Prescribed Norms: Women and Health in Canada and the United States since 1800* and in 2003 a collaborative effort by Gina Feldberg, Kathryn McPherson, Alison Li, and Molly Ladd-

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<sup>26</sup> Jan Darby. “Sex and Punishment: The Politics of Cervical Cancer,” in Enakshi Dua et al., *On Women Healthsharing*. (Toronto: Women’s Press, 1994), 261.

<sup>27</sup> Ibid.

<sup>28</sup> Ibid., 260.

Taylor, the collection *Women, Health, and Nation: Canada and the United States Since 1945*, was published. *Women Health and Nation: Canada and the United States Since 1945* is a book that successfully touches on key historical topics in women's health such as childbirth, abortion, activism, healthcare workers, and the medicalization of women's bodies. The analytical categories, race, class, gender, and ethnicity are highlighted in this book.

Krasnick Warsh's book, *Prescribed Norms*, is multi-disciplinary and focuses on three key aspects of women's health, rituals (menstruation and menopause), technologies (childbirth), and women's participation in health care as practitioners. Her epilogue highlights a central lesson with regard to the history of women's health: "women have confronted their reproductive experiences with the weight of centuries of socio-cultural attitudes and expectations."<sup>29</sup> Her book concludes that "the stories of women's health, as indeed life itself, are complicated, messy, and even chaotic. Perhaps it is time to embrace the chaos instead of prescribing what the norms of a woman's life should be."<sup>30</sup> While these books do not focus on cervical cancer, they do contribute to a narrative of the Canadian-specific women's health movement and what makes it distinct from the American experience, knowledge which provides a necessary backdrop for the study of Canadian cervical cancer activism and screening. These recent works also remind us of the ways in which diseases, their construction, and prevention, are mediated through differences of class, race and ethnicity.

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<sup>29</sup>Cheryl Krasnick Warsh. *Prescribed Norms: Women and Health in Canada and the United States Since 1800*. (Toronto: University of Toronto Press, 2010), 271.

<sup>30</sup> *Ibid.*, 273.

## Disease and Cancer History

This dissertation will additionally contribute to a growing international historiography on cervical cancer. One of the earliest scholarly works on the history of cervical cancer and its prevention is an unpublished PhD dissertation by Eftychia Vayena from the University of Minnesota. Vayena's dissertation, "Cancer detectors: An international history of the pap test and cervical cancer screening, 1928-1970," focuses on interpretations, promotion, and the utilization of the Pap test as a cancer detection tool in the United States, Britain, and Greece. Vayena provides a comprehensive study of the discovery of the Pap test and its implementation and funding via respected bodies such as the National Cancer Institute in the U.S., and the National Health Service in Britain.

Vayena briefly discusses the role women played in the dissemination of knowledge of the Pap test and its role in cancer prevention, particularly in the United States. She argues that women's participation in the promotion of the Pap test peaked in the 1970s as much of their efforts in the 1960s "did not appear as a conscious effort to distinguish their health from men's health or to claim their right to health care."<sup>31</sup> She also points out that while their efforts were mixed with personal motives, women's promotion of the Pap test did not stand alone; the American Cancer Society's agenda to fight cancer, regardless of gender, was the primary contributor to the successes of the Pap test.<sup>32</sup> This discussion appears in the dissertation immediately before an entire chapter on the development of cervical cancer screening in the United States. She provides

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<sup>31</sup> Eftychia Vaeyna. "Cancer detectors: An international history of the pap test and cervical cancer screening, 1928—1970." (PhD Dissertation, University of Minnesota, 1999), 157.

<sup>32</sup> *Ibid.*, 157-158.

additional analysis and discussions of the evolution of the Pap test and its utilization in Britain and Greece.

Canada was not part of Vayena's "international" study, though there are references to Canada throughout her dissertation. As my dissertation demonstrates, Canadian doctors were carrying out their own medical studies on cervical cancer and the efficacy of population screening and partaking in cancer conferences all over the world.<sup>33</sup> Vayena's study was not focused on the public discourse that was evolving in her countries of choice and was more on the evolution and utilization of the Pap test as a screening device. While she did not use newspapers and other public discourse in the same way that my work does, she did allude to the importance of public dialogues about cancer prevention in helping to promote the validity of the Pap test.

In the last few years two major works on the history of cervical cancer, focussing on diagnosis, treatment and prevention, have been published in the United States and the United Kingdom: Kristin Gardner's *Early Detection: Women, Cancer, and Awareness Campaigns in the Twentieth-Century United States*, and Ilana Löwy's *The History of Cervical Cancer*. Gardner's book, while more generally focused on public discussions of women's cancers, spends a considerable amount of time discussing public campaigns for screening and prevention, particularly cervical cancer screening. First and foremost, however, Gardner's work highlights the work of the American Association of University Women, the Women's Field Army of the American Society for the Control of Cancer, the

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<sup>33</sup> For example, see page 243 where Vayena mentions studies being done in the United States and Canada. She also referenced articles from the *Canadian Medical Association Journal* which included studies done by Canadian researcher Ernest Ayre.

General Federation of Women's Clubs, and the American Cancer Society in the distribution of cancer information – particularly about the breast, ovaries, uterus, and cervix. Her work successfully explores “women’s participation in cancer control, as educators, organizers, and activists throughout the twentieth century.”<sup>34</sup> She eloquently highlights the focus on early detection throughout these programmes and how this message furthered claims that curing cancer (particularly of the breast and cervix) was largely a responsibility of women. Women took on this crusade quite confidently throughout much of the twentieth century and proved that cancer control meant more than early detection. They created “space where the merits of early detection rhetoric can be reconsidered in the twenty-first century.”<sup>35</sup> Gardner argues that women, throughout much of the twentieth-century, learned about cancer from other women.<sup>36</sup>

In one of her recently published pieces in the collection *Gender, Health and Popular Culture: Historical Perspectives*, Gardner focuses on cervical cancer and awareness efforts about this disease in the United States in the twentieth century. She argues that since as early as 1913, women have consistently been “encouraged to consult physicians at the first sign of irregular vaginal discharge, which is an early warning sign for cervical cancer.”<sup>37</sup> She asserts that studying the history of cervical cancer, in her case in the United States, is important because it “illustrates the change and continuity evident

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<sup>34</sup> Gardner, 7.

<sup>35</sup> Ibid.

<sup>36</sup> Ibid., 8.

<sup>37</sup> Kristin Gardner, “Controlling Cervical Cancer from Screening to Vaccinations: An American Perspective,” in Cheryl Krasnick-Warsh (ed), *Gender, Health and Popular Culture: Historical Perspectives*. (Waterloo: Wilfred Laurier University Press, 2011), 109.



in public awareness about women and cancer.”<sup>38</sup> My dissertation also illustrates that women have worked closely with medical professionals to emphasize the importance of early detection via the Pap smear.

As part of the same collection, I contributed a piece focused on Canada. My chapter, “The Challenge of Developing and Publicizing Cervical Cancer Screening Programs: A Canadian Perspective,” focuses on early Canadian responses to cervical cancer screening, particularly in Ontario and British Columbia. This chapter argues that women used film and print as “integral places...to seek knowledge about this disease” and that some provincial governments were slow to invest in organized/funded screening programs.<sup>39</sup> This chapter further demonstrates that while it was clear that the “Canadian government was on board with the international movement to ‘conquer’ cancer,” little was being done specifically to deal with rising cervical cancer rates.<sup>40</sup> This dissertation builds on this earlier work to explore growing public awareness of this disease in Canada.

Capturing an international perspective on the history of cervical cancer, Ilana Löwy’s recent book, *A Woman’s Disease: The History of Cervical Cancer*, illustrates the changing public presence of this disease over time with her chronicling of public personalities of Ada Lovelace, Eva Péron, and Jade Goody. Löwy uses these three women’s stories to make “visible radical changes in the understanding, prevention, and

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<sup>38</sup> Ibid.

<sup>39</sup> Mandy Hadenko. “The Challenge of Developing and Publicizing Cervical Cancer Screening Programs: A Canadian Perspective,” in Cheryl Krasnick-Warsh (ed), *Gender, Health and Popular Culture: Historical Perspectives*. (Waterloo: Wilfred Laurier University Press, 2011), 127.

<sup>40</sup> Ibid., 128.

treatment of cervical cancer in 150 years.”<sup>41</sup> While the exact disease Ada Lovelace suffered from is unclear, according to her experience and descriptions of symptoms, it was more than likely some form of cancer of the uterine cervix. Her experience is particularly unique as, compared to the other two women highlighted in Löwy’s book, she lived and died in the nineteenth century. Physicians prior to the twentieth century, with a limited understanding of cervical cancer, had little ammunition against an often aggressive disease. In Lovelace’s case, even upon the discovery of an “extensive and deep-seated sore” (cervical tumour), her doctor continually assured her that she simply had a “health sore” and continued his treatment of quinine, nitrate of silver, rest, and no creative writing.<sup>42</sup> The other two women, First Lady Eva Péron and Jade Goody, were from the early and late twentieth-century and had experiences remarkably different from Lovelace. While Lady Péron kept her disease intensely private from the public and even her husband, Jade Goody was highly public about not only her diagnosis, but also about her treatment and late stage suffering. These two women represented contemporary understandings of the disease and its prevention and treatment and public response to its presence. As Löwy demonstrates consistently throughout her book, the stories of these women were “at the same time very different and quite similar.” For example, while there was more than half a century between Eva Péron’s experience and treatment and Goody’s more recent cancer therapies, they were not terribly different. Surgery, followed by radiation therapy and chemotherapy, were experienced by both Peron and Goody. As

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<sup>41</sup> Ilana Löwy. *A Woman’s Disease: The History of Cervical Cancer*. (New York: Oxford University Press, 2011), 1.

<sup>42</sup> *Ibid.*, 3-4.

Löwy points out, however, the key difference was that “commentators believed that Jade Goody brought on her fate herself.” As a result of cervical cancer being presented in the twenty-first century as a preventable disease, Goody was positioned as not having responded quickly enough to her early abnormal smear results. She was thus seen as responsible for her quick and painful death.<sup>43</sup>

Löwy’s book on the history of cervical cancer was preceded by a more general history of preventive approaches to cancer. Her book, *Preventive Strikes: Women, Precancer, and Prophylactic Surgery*, was rooted in her observations of women receiving counselling at a leading French cancer treatment center. She was particularly bewildered by the fact that women who possessed a mutation in the BRCA gene were recommended to undergo the prophylactic removal of their (healthy) ovaries. She was immediately curious about the history of preventive surgery as a form of cancer treatment, and therefore focused on three key cancer bodies (the American Cancer Society, the British Empire Cancer Campaign, and the Ligue Française Contre le Cancer) and their particular education campaigns for “precancerous” or “pre-malignant” conditions.<sup>44</sup> Focussing on two cancers, breast and cervical, she tracked how each of these countries (England, the USA, and France) diagnosed and treated these diseases throughout the twentieth century. She further attempted to track the history of, and to also bridge the gap between, a patient being healthy to ill (or as she calls it – becoming a “healthy ill”), from a precancerous state to a potentially cancerous one.<sup>45</sup> Löwy demonstrates “the history of preventive

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<sup>43</sup> Ibid., 14.

<sup>44</sup> Ilana Löwy. *Preventive Strikes: Women, Precancer, and Prophylactic Surgery*. (Baltimore: Johns Hopkins University Press, 2010), 1-2.

<sup>45</sup> Ibid., 4.

treatment for cancer is the history of concepts and practices that made a diagnosis of precancerous conditions possible.”<sup>46</sup> Her study of the history of pre-cancer treatment successfully “illuminates the ways doctors deal with diagnostic uncertainty and manage cancer risk.”<sup>47</sup> This research provides a similar illumination – it reflects what doctors believed to be the most productive form of cancer prevention according to a woman’s defined and embodied risks during the mid to late-twentieth century. Doctors in Canada, with much confidence, wrote articles and columns in public spaces telling women what *they* needed to do to prevent cancer – whether it was maintaining a healthy sex life or consulting a doctor for regular Pap smears and advice about abnormalities.

Unlike Löwy, this dissertation studies the complex intersections of gender and health and the ways in which Canadians talked about cervical cancer. Within the scope of this study, cancer is defined as a disease, even in its “pre” cancer stage medically defined as carcinoma *in situ*, or Stage 0. This is a stage when cells are showing abnormalities or change and may develop into cancerous cells. There has been much debate, particularly during the 1960s about whether or not carcinoma in situ (CIS) progressed to cancer if left untreated. In the post-war period the International Congress of Obstetricians and Gynecologists passed a resolution adding a new categorization of cervical cancer, Stage 0, to include CIS.<sup>48</sup> The debate continued, as some studies surfaced that pointed out that a high number of cases of CIS tracked over a long period of time did

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<sup>46</sup> Ibid., 5.

<sup>47</sup> Ibid., 13.

<sup>48</sup> Linda Bryder. *Women’s Bodies and Medical Science: An Inquiry into Cervical Cancer*. (Basingstoke and New York: Palgrave MacMillan, 2010), 8-9.

not actually develop into cancer.<sup>49</sup> However, for this dissertation's focus, recognizing the role CIS plays in highlighting the importance of cervical cancer screening programs is important and will be assumed under the umbrella term of 'cancer'. While this study does not necessarily focus on the debate surrounding the actual categorization of cervical cancer, it is recognized that this debate exists.

Barbara Clow's work, *Negotiating Disease: Power and Care, 1900-1950* reveals that women learned about cancer from a variety of sources in the twentieth century. Clow's work is focused on the earlier decades of the twentieth century and includes professional and political, in addition to popular, reactions to cancer in Ontario. She provides an essential foundation with regard to how to interpret the growing "health culture" in Canada. Interpretations of health, illness, and healing, by either doctors or patients, is complex and Clow looks to compare and contrast how medical and lay opinions interacted with one another.<sup>50</sup> She also recognizes that while her book may be a history of cancer in many ways, she also writes about power. Recognizing the authority "wielded by medical practitioners" in the twentieth century, she points out that the power dynamic was not that simple. Citing Paul Starr (author of *The Social Transformation of American Medicine*), Clow additionally argues that while practitioners in the twentieth century may have gained a considerable amount of "cultural" authority, "the power to define health, illness, and healing," they lacked in "social" authority, "the ability to compel patients or the public to accept their advice."<sup>51</sup> This notion resonates loudly

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<sup>49</sup> *Ibid.*, 10.

<sup>50</sup> Barbara Clow. *Negotiating Disease: Power and Cancer Care, 1900-1950*. (Montreal: McGill-Queen's University Press, 2001), xii.

<sup>51</sup> *Ibid.*, xiii.

within the research conducted for this dissertation. I was able to track how much information was made available to Canadian women in various forms, but it was much more difficult to measure how much advice women actually heeded. They may have read about how important a Pap smear was in an article in the *Globe and Mail*, but did they actually book appointments with their physicians? Physicians and pharmaceutical companies in Canada may have had a stronghold on what information was being printed in most public spaces, even in the films being produced and viewed, but they had less power over how women used this information. Doctors could define diseases and recommend prevention and treatment, but they could not determine the “health care choices of patients: information gleaned from family, friends, neighbours, and even the media.”<sup>52</sup>

There are some unique, more cultural, studies of cancer, but most of them are American or British in nature. For example, Jackie Stacey’s book focusing on the cultural study of cancer entitled, *Teratologies: A Cultural Study of Cancer*, was a revolutionary study of her interaction with a cancer diagnosis and treatment in the late 1990s. Her study dissects the precise health culture that created silence about a disease that is known to have increasing prevalence. She argues “cancer has a ubiquitous presence in everyday culture, yet the person with cancer is nevertheless confronted by a striking silence that reminds them they have entered stigmatized territory.”<sup>53</sup> She compares the avoidance of the “C word” to the avoidance of the “L word” – referring to cancer and lesbian. Her complex argument is that “denial, avoidance, and displacement,”

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<sup>52</sup> Ibid., xiii.

<sup>53</sup> Jackie Stacey. *Teratologies: A Cultural Study of Cancer*. (New York and London: Routledge, 1997), 70.

or what Stacey refers to as “cultural disavowals,” further produce a culture that is overwhelmed with information about cancer but simultaneously one that is unable to even say the word.<sup>54</sup> Cervical cancer is particularly complex and subject to avoidance and disavowal because the cervix, and women’s reproductive organs generally, are deemed private, and the disease is still linked in the public mind with ‘inappropriate’ sexuality and promiscuity. While this dissertation is not directly looking to provide a semiotic analysis of *cervical cancer*, language is critical to the formation of public discussions of the disease.

Other cultural studies on cancer include James T. Patterson’s book, *The Dread Disease*, and Robert Proctor’s book, *Cancer Wars*. Patterson’s book focuses on the cancerphobia that initially blossomed in the nineteenth century, and tracks this phobia well into the twentieth century. He also explores the influence of science and the government on encouraging public fear of cancer. He is well-versed in poverty struggles and government flaws in the twentieth century, and much of his book on cancer and modern American culture focuses on topics such as research, government funding and propaganda, religion, popular responses, and fear-mongering. While he argues that cancer did not initiate the same fears of epidemics and level of panic as did diseases such as tuberculosis, doctors continually struggled to find successful treatments that were visually satisfying to the American public.<sup>55</sup>

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<sup>54</sup> Ibid., 70-71.

<sup>55</sup> James T. Patterson. *The Dread Disease: Cancer and Modern American Culture*. (Cambridge and London: Harvard University Press, 1987), 33.

Similar to Patterson's work, Robert Proctor's *Cancer Wars: How Politics Shapes What We Know and Don't Know about Cancer* focuses on the political history of cancer, particularly on the scientific and public debates about its causes.<sup>56</sup> He argues that his work is inherently *political* because "the question of what causes cancer – and how and to what extent – remains a politically charged one."<sup>57</sup> A unique and certainly entertaining writer, Proctor most importantly reminds researchers to be wary of who is writing public information. He asks key questions such as "how might knowledge be different, and how should it be different? What are the virtues of looking at ultimate rather than proximate causes, for example, or of seeking prevention rather than cure? Who does science and who gets science done to them?"<sup>58</sup> He argues that these questions are inherently and "self-consciously political and ethical; they take us beyond the merry-go-round of realism versus relativism that plagues so much of recent science studies."<sup>59</sup> He faces, head on, the social responsibility of science in his study and pushes researchers such as myself to further evaluate who is writing public health information and what personal and social motives may exist for such writing. Understanding these connections is essential in evaluating the responses of both physicians and women's activist groups to cervical cancer morbidity and mortality rates.

### **Larger movements – The Women's Health Movement and Breast Cancer**

In the context of the burgeoning Second Wave Feminist Movement, the Women's Health Movement took hold in North America with the first print edition of *Our Bodies*,

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<sup>56</sup> Robert M. Proctor. *Cancer Wars: How Politics Shapes What we Know and Don't Know about Cancer*. (New York: Basic Books, 1995), 6.

<sup>57</sup> Ibid.

<sup>58</sup> Ibid., 8-9.

<sup>59</sup> Ibid., 9.



*Ourselves* in 1971. This book, written by a group of women in Boston, would for the first time in women's health history question women's access to equal health care options and encourage personal knowledge about women's bodies. *Our Bodies, Ourselves* started a revolution in the type of information made available to women. As Kathy Davis demonstrates in her book, *How Feminism Travels Across Borders: The Making of Our Bodies, Ourselves*, by the late 1970s *OBOS* had appeared in most Western European countries, as well as Japan and Taiwan. Within a decade, it had moved south and east and was translated into several different languages including Hebrew, Arabic, Russian, and Telegu.<sup>60</sup> While Davis' book was primarily "an analysis of the book [*OBOS*] as a transnational feminist epistemological project," she also successfully reinforces the notion that *Our Bodies, Ourselves* represented a pivotal point in women's health history.

As Davis' work demonstrates for other countries, there is no doubt that Canadian women read *Our Bodies, Ourselves*. The book devotes an entire section to the importance of cervical health and self-examination. With a focus on self-education and encouraging women to take part in their health care, this book was a foundational piece in starting to create a public dialogue about cervical cancer prevention. It was only a few years later, in 1978, that the Vancouver Women's Health Collective published a similar book, *Caring for Ourselves: An Alternative Structure for Health Care*. After offering a basic history of the Collective, *Caring for Ourselves* offered various sections on childbirth, sexual health, and preventive health tips. There is also an extensive section on

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<sup>60</sup> Kathy Davis. *How Feminism Travels Across Borders: The Making of Our Bodies, Ourselves*. (Durham and London: Duke University Press, 2007): 5.

breast health and self-examination, which is a topic that often appeared in women's health guides throughout much of the twentieth century.

As the Women's Health Movement took hold in Canada throughout the 1960s, 1970s, and 1980s, three objectives became clear: "the health care delivery system, the development and analysis of the social determinants of health, and a commitment to increase the participation of women in all aspects of health care."<sup>61</sup> Women across the country started to gather to discuss these objections, form partnerships with other interest groups, and to even plan to provide adequate health services themselves.<sup>62</sup> One of the most fascinating and unique parts of the Canadian-only experience was the production of the play *Side-effects*. This play was about the "popular education campaign about women and pharmaceuticals" that traveled from coast to coast in the early 1980s. Other Canadian aspects to the Women's Health Movement were the establishment of the Montreal Health Press, environmental action groups, breast cancer action groups, DAWN, feminist counselling services, and even study groups based on traditional healing techniques.<sup>63</sup> These new organizations and services is that they were "characterized by innovation and social action." It was always clear that women's health was directly influenced by poverty, class, and even experiences of abuse and racism.<sup>64</sup> By providing programs that were sensitive to all these aspects, it was believed that women could be provided with the health care they deserved. But, despite its clear objectives, the experience of health activists was not the same in each province.

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<sup>61</sup> Madeline Boscoe, et al. "The Women's Health movement in Canada: Looking Back and Moving Forward." *Canadian Woman Studies* col. 24/1 (2004): 8.

<sup>62</sup> *Ibid.*, 7.

<sup>63</sup> *Ibid.*, 8-9.

<sup>64</sup> *Ibid.*, 9.

One of the unique aspects of the Women's Health Movement in Canada is how this movement mobilized in the province of Quebec. Jacinthe Michaud is the key individual responsible for researching and writing about the French-Canadian experience of the Women's Health Movement. In her 1995 PhD dissertation, "Angel Makers or Trouble Makers? The Health Centres Movement in Quebec and the Conditions of Formation of a Counter-Hegemony of Health," Michaud argued that the Health Centres Movement in Quebec was distinctive because it involved women health activists infiltrating provincial and regional health boards to promote change, something not experienced in any other province in Canada. In Quebec, because feminist health activists had a long history of working with women, they believed, without a doubt, that "health was central to women's oppression,"<sup>65</sup> and that their unique positions within the political arena as "visible collective actors,"<sup>66</sup> allowed them to institute change both at the ground level and at the policy level.

As she also argued in a later published article in *Studies in Political Economy*, studying regional boards and women's activists' participation in these boards is important because, beyond simply managing regional health services, they were places where "different visions of the world and different ideological and political definitions of health interact[ed] and evolve[d]."<sup>67</sup> Her research revealed that feminist health activists in Quebec engaged directly with the medical establishment "in order to change attitudes

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<sup>65</sup> Jacinthe Michaud. "Angel Makers or Trouble Makers? The Health Centres Movement in Quebec and the Conditions of Formation of a Counter-Hegemony on Health." *PhD Dissertation*. (Toronto: University of Toronto, 1995): 66.

<sup>66</sup> *Ibid.*, 5.

<sup>67</sup> Jacinthe Michaud. "The Restructuring of the Health Care System in Québec: Its Impact on the Women's Health Movement." *Studies in Political Economy* vol. 61 (2000): 42.

towards women and transform the traditional representation of women's bodies by scientific medicine."<sup>68</sup> While most of the centres Michaud studied in Quebec focused on providing abortion services and counselling and not necessarily screening for cervical cancer, her work highlights the larger Women's Health Movement that occurred during the timeframe of this dissertation.

During the Women's Health Movement, health activists were keenly aware of the importance of breast cancer awareness. In many cancer publications, the prevention of cervical cancer is discussed alongside the prevention of breast cancer. But there is one key difference between the two when it comes to prevention – you can examine your breasts and potentially *feel* an abnormality, however, a woman can not *feel* her cervix and detect any abnormalities in the same way. The prevention of cervical cancer requires a smear test done by a medical practitioner. Breast cancer prevention and awareness campaigns often exist alongside cervical cancer prevention campaigns – in *Chatelaine*, some medical journals, films, newspaper articles, and sometimes in posters and pamphlets. Even the basic pelvic exam, or annual physical, has been and still is, performed in conjunction with a breast exam.

The history of breast cancer and its prevention has a much longer, detailed and different history than cervical cancer. Many historians of medicine have written a larger collection of work on understandings of breast cancer and the development of breast cancer prevention campaigns in North America. Rose Kushner's *Alternatives*, Audre Lorde's *The Cancer Journals*, and Sharon Batt's, *Patient No More: The Politics of Breast*

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<sup>68</sup> Ibid., 43.

*Cancer*, are all examples of a rich literature on breast cancer. Most histories of breast cancer, including the ones just listed, focus on prevention, understanding, and the experience of breast cancer. Few studies on breast cancer focus on the public dialogue regarding the disease. This history of breast cancer and the development of prevention campaigns have developed very differently from cervical cancer. Breast cancer has a much longer history of surgical treatment (with radical mastectomy by Halsted) and visual diagnosis. Breast cancer, however, does not have long-standing discursive connections to sex, gender, and morality. Perhaps because of this difference, survivor stories and illness journals with regard to cervical cancer have yet to be produced.

One of the more famous works on the history of breast cancer (in the United States) was written by a medical doctor, Barron H. Lerner. Based on his memories of his own mother being diagnosed with breast cancer in 1977, Lerner attempted to demystify the varying ways in which women respond to similar diagnoses. Speaking as a social historian, Lerner sought to understand how the radical mastectomy triumphed by evaluating and understanding the larger social system in which it was introduced. He asks key research questions such as “to what degree did the professionalization of surgery – for which Halsted was largely responsible – reinforce the notion of a ‘surgical solution’ to a dreaded disease such as breast cancer? To what extent did Americans’ growing faith in scientific medicine in the early twentieth century influence the spread of radical mastectomy?”<sup>69</sup> He also attempts to place *women* as a central focus within his study, as he argues that “given the association of the breast, and therefore mastectomy, with

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<sup>69</sup> Barron H. Lerner. *The Breast Cancer Wars: Hope, Fear, and the Pursuit of a Cure in Twentieth-Century America*. (New York: Oxford University Press, 2001), 7.

sexuality, intimacy, and motherhood,” it is essential to recognize experiences of female patients as part of the history.<sup>70</sup> Similarly, this thesis seeks to recognize the experiences of women, not as patients *per se*, but as advocates of change and sources of knowledge, and as the subjects of public education campaigns. Hearing the voices of women requires that the historian go beyond the traditional sources of medical history.

### **Sources and methods**

I sought to unearth the voices of women and those of doctors and the medical establishment, necessitating recourse to a wide range of disparate source materials. Several archives were visited throughout the life of this thesis. The Library and Archives of Canada and the Wellcome Institute Archives in London were the largest archives searched for information about cervical cancer. Other archives such as the Ontario Archives, Nova Scotia Archives, British Columbia Archives, and various local archives such as Admiral Digby Archives and Yarmouth Archives in Nova Scotia were also visited. What these archives revealed were unique stories of approaches to cervical cancer screening and debates about its importance. I encountered one significant disappointment when I attempted to search the University of Toronto Medical School archives. I had hoped to search their archives to gain a better understanding of curriculum development, especially in regards to their gynaecology courses, to see if information about cervical cancer and Pap smears was required reading and knowledge. Although I found several files that might have been useful, they were all restricted, most likely because they included exams with names on them, or meeting minutes with names

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<sup>70</sup> Ibid., 9.

of board members. I had the same hopes when I visited Dalhousie University Medical School archives, but there were not any files that directly dealt with curriculum development or curriculum requirements for the gynaecology courses offered. Denied access to curriculum, I was able nonetheless to spend some time at the Gerstein Medical Library at University of Toronto getting a sense of gynaecological textbooks and was able to mark change over a few decades with regard to the information provided to medical students through their texts.

I also searched *Chatelaine*, *Healthsharing*, *Homemaker's Magazine*, *Kinesis*, *Makara*, *The Toronto Star*, *The Globe and Mail*, *The Vancouver Sun*, *The Halifax Herald*, and three university newspapers, *The Varsity*, *Excalibur*, and *The Ubyssy* for discussions of cervical cancer. These sources revealed the critical role newspapers and women-centred periodicals played in distributing knowledge about cervical cancer and encouraging a public discussion of this disease throughout the twentieth century in Canada. Variations in the extent to which these papers explored cervical cancer, and the tone of commentary, are examined. Other medical periodicals were included in this thesis, such as the *Lancet*, *The Journal of Obstetrics and Gynecology*, *Cancer*, *The Canadian Medical Association Journal*, the *New England Medical Association Journal*, and various other academic journals that published articles on cervical cancer. These journals allowed me to track the changing medical understandings of cervical cancer between the 1950s and the 1990s. In her study of medical periodicals, Wendy Mitchinson argues that the “value of this literature is that it was the principal forum for physicians in Canada to communicate with one another and to raise issues about what

concerned them. It was written by and for physicians.” While medical journalists and doctors tended to write about what was wrong with a particular definition or medical conclusion and the unusual case was often highlighted over the normal case, these were public forums “even if the public was other physicians.”<sup>71</sup> As my chapter on *Chatelaine* will demonstrate, these well-read physicians were using their knowledge to write articles, as experts, in popular, non-medical periodicals such as *Chatelaine* and *Healthsharing* providing some transparency as to how physicians were applying this knowledge in their interactions with individual patients.

All magazines were only available on microfilm or hard copy. Every issue, of every year between 1950 and 1990 was consulted. All major editorial stories were searched, along with letters to the editor and health columns for references to cervical cancer, its prevention and diagnosis. The newspapers that were online, such as the *Toronto Star* and the *Globe and Mail* were searched using their online search engine. Terms such as cervical cancer, women’s health, women’s cancer, and cancer were used to find all articles, letters to the editor, and health columns that referenced cervical cancer. *The Vancouver Sun* and the *Halifax Chronicle Herald* are housed at York University on microfilm and some sampling was used to examine these daily newspapers. All three university newspapers were exhaustively read throughout all the years my dissertation focuses on.

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<sup>71</sup> Wendy Mitchinson. *Giving Birth in Canada: 1900-1950*. (Toronto: University of Toronto Press, 2002), 16.



An interesting collection of films still exists at Library and Archives Canada, and I was fortunate enough, nearing the end of this dissertation, to view them.<sup>72</sup> Not only were these films fascinating to watch, but they were vital to understanding how sources such as films were breaking down boundaries of literacy and income. While only a few films focussed directly on cervical cancer, its medical understanding and prevention, other more general discussions of cancer were vital to understanding public dialogue that was emerging through the twentieth century. It impossible to track how many times these films were shown, or where they were shown, but community centres and schools were probably the most common sites for showings. One of the films, *Today's People*, which focused on how valuable it is to volunteer with your local branch of the Canadian Cancer Society, explicitly named the community centre as an excellent location to get the local population out to an educational session on cancer.<sup>73</sup> It should be noted that it is recognized that there is a rich literature on the theory of the cinematic gaze in medical culture. This debate goes back as far as the invention of x-rays in the early twentieth century. Some of the key examiners of these critical film studies include Lisa Cartwright, Marita Sturken, Barbara Duden, and Anne Friedberg. This dissertation does not engage in this literature, as these films were viewed simply for the information they were conveying (or not conveying).

In the final chapter of this dissertation I use government documents and communication between physicians and governments to focus on three particular

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<sup>72</sup> Canadian Cancer Society Fonds are housed at the Library and Archives Canada, and local branches' files at their respective provincial archive collections.

<sup>73</sup> Canadian Cancer Society Fonds, *Today's People*, unknown date, *Library and Archives Canada*, accession number R9308-0-6E, video, consultation copy, VLTSLF# 8306-0005.

provinces, British Columbia, Nova Scotia and Ontario and their cervical cancer screening program development. These three snapshots of Canada's developing public discourse about cervical cancer reveal national, regional, and local responses to the same disease. As Löwy argues in her book, *Preventive Strikes*, while similarities in case studies are often recognized immediately in academic work, "differences indicate that professional practices are historically and geographically situated and, therefore, open to questioning and change."<sup>74</sup>

### **Chapter Outline**

This dissertation begins with a chapter on the development of the understanding of cervical cancer as a disease. These changing understandings place cervical cancer within a social context and help us to understand how current understandings of the role HPV plays in cancer development were established. The epidemiology of this disease further complicates these understandings, as definitions of risk, target groups, and causation can either encourage, or discourage, screening programs. Chapter one not only tracks the changing medical understandings of cervical cancer and the resulting epidemiology but also discusses the growing medical discourse of the prevention vs. curative nature of cancer. Professional conferences were taking place that focused primarily on cancer, allowing medical professionals to share their understandings and to brainstorm plans to decrease mortality and morbidity rates. By the 1960s medical practitioners were aware that, with screening via the Pap smear, cervical cancer was an entirely preventable disease, and this knowledge drove efforts to expand screening.

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<sup>74</sup> Löwy, *Preventive Strikes*, 14.

Chapter Two, “Working Together: *Chatelaine* and Health Activists talking about Cervical Cancer,” focuses on one feminist publication and its influence on the growing public dialogue about cervical cancer. After reading through other feminist periodicals, such as *Healthsharing*, *Kinesis*, *Makara*, and even a non-feminist woman’s magazine, *Homemaker’s Magazine*, *Chatelaine* continued to prove to be the single-most important magazine in Canada to distribute knowledge about cervical cancer in the mid-twentieth century. Highlighting the period from the 1940s to the 1990s, this chapter demonstrates that *Chatelaine* played an integral role in educating Canadian women about cervical cancer. Its feminist roots, and the growing Women’s Health Movement and the resulting feminist/health literature, pushed the editors to provide health information to women in more accessible language in addition to encouraging women to take active roles in their own health care. Interestingly, however, many of the articles published in *Chatelaine* were written by medical professionals and urged self-awareness through consultation with a doctor.

As the next chapter, “Making Cervical Cancer Public – Films, Posters, and Newspapers,” argues, Canadian women did not necessarily have to rely on women-specific periodicals for information on cervical cancer. Nationally funded films, posters and pamphlets, circulated via the Canadian Cancer Society, and many different types of newspapers were also rich sources of health information during much of the twentieth century. While many of these sources of information tended to focus on the triumphs of science and the all-knowing physician, they were nonetheless rich sources of information.

The visual sources were also able to move beyond boundaries of low-income and literacy, as they were often shown in schools and community centres.

As will be demonstrated in the final chapter, “Regional Differences: Cervical Cancer Screening in British Columbia, Ontario, and Nova Scotia in the Post-WWII era,” Canadian provinces responded differently, both in terms of policy development and by decade, in providing screening options. Because health care is a provincial responsibility, experiences vary province to province, region to region. These three provinces were chosen originally as regional representations, but as my research continued I realized that regions are not always defined solely by their provincial boundaries. A key province to utilize the Pap smear in Canada was British Columbia. BC was the first province in Canada to develop a provincially organized cervical cytology service based on one large central laboratory. In 1949, the government of British Columbia developed a program that began as a diagnostic laboratory. This program expanded to full population screening in the 1950s with additional support from the CCS.<sup>75</sup> The history of screening in British Columbia is largely an urban story as the Vancouver Women’s Health Collective reached mostly women within the city limits. In contrast, the Ontario story, while also arguably largely urban after the Second World War, reflects a government that responded late and inefficiently to various outcries for an organized screening program. Ontario has a long history of strength in offering cancer treatments to its population but has been scrutinized for its lack of attention paid to prevention. The cancer clinic opened in Toronto in 1948 was a glimmer of hope that well-person examination was the way of

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<sup>75</sup> “The Walton Report”. *Canadian Medical Association Journal* vol. 114 (1976): 12.

the future for the province, but little came to fruition for cervical cancer screening until the late twenty-first century. The Nova Scotia story is a rural story of local Women's Institutes and an organized Well Women Clinic system collectively attempting to change mortality and morbidity rates. The programs in these three provinces developed as a result of one or several reasons - policy implementation, professional response, or pressure via grassroots organizations.

The history of the public dialogue regarding cervical cancer in Canada in the twentieth century is a story that needs to be told. This history highlights the importance of women's health research. The National Network on Environments and Women's Health stated in 1998 "...women's health research needs to focus on advocacy for all women and on generating health policies, services and treatments that adequately address most, if not all, women."<sup>76</sup> Understandings of women's health have changed drastically throughout the twentieth century. It is clear to me that even in the 21<sup>st</sup> century understandings of cancer prevention and cervical cancer are critically inadequate. By tracing Canada's evolving public dialogue about this disease, and its responses at the popular and policy level, we can avoid the mistakes of the past and create programs that will eradicate a disease that is still needlessly killing Canadian women each year. History illustrates that we will only achieve full screening for all women if screening is non-judgmental, readily accessible and, most importantly, if all women understand why the Pap smear can be life-saving.

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<sup>76</sup> McDonough, Peggy, et al. "Feminist Research Methodology and Women's Health: A Review of the Literature." *National Network on Environments and Women's Health*, York University, 1998.

## Chapter 1 – Medical Knowledge of Cervical Cancer – 19<sup>th</sup> and 20<sup>th</sup> centuries

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Over the course of the twentieth century, significant advancements occurred in medical understandings of the etiology and epidemiology of cervical cancer. Understandings of the disease and its causes ranged from trauma from vaginal childbirth at the turn of the century to infection via the human-papilloma virus (HPV) in the 1980s. This chapter tracks international understandings of cervical cancer and places Canada and Canadian medical researchers and practitioners within this international dialogue. Canadian physicians and researchers contributed to medical discussions of cervical cancer and participated in debates about its causes and etiology. Moreover, as it became clear that cervical cancer was preventable, Canadian physicians debated the best ways by which to reduce cervical cancer morbidity and mortality. They hosted conferences on cancer and set up task forces to evaluate screening opportunities throughout the provinces. While not all of the medical conferences discussed here focussed on cervical cancer *per se*, they demonstrated that medical doctors and researchers were interested in the possibility of controlling a disease that was both rampant and medically preventable. What were these doctors trying to accomplish with these conferences? What did general practitioners want in terms of population screening for cervical cancer? In the 1960s there was much upheaval within the medical profession in terms of an emerging national

health insurance plan and physicians fearing the loss of autonomy within their own payment schedules.<sup>1</sup>

This threat of external control was very real for many Canadian physicians and maintaining basic testing such as the Pap smear within their offices may have been a move to protect individual incomes. There seemed to be continuing reluctance to trust a mass screening project, even after the Walton Report – illustrating the value of mass screening - was released in 1976. Be it questionable statistics or questionable classification, or private payment, some doctors were more confident in maintaining preventive screening strategies within their own offices. But, as statistics continued to demonstrate throughout the later twentieth century, restricting screening opportunities to within the confines of the general practitioner's office was not creating adequate decline in mortality rates from cervical cancer. These issues are vital to understanding the social realities of cervical cancer prevention and treatment in the past. Moreover, many of the historical social constructions of this disease illustrated in this chapter – a concern in particular with women's sexual behaviour and responsibility to engage in preventive care - are still problems in more current discussions of cervical cancer.

### **Understanding the Causes of Cervical Cancer:**

In 1842 Veronese surgeons and amateur epidemiologists, Rigoni-Stern, published a report of the 150,000 death certificates from the Veronese district (1760-1839) concluding that “cancer in nuns was about five times more common than in other women, mainly because of an excess of breast cancer in nuns.” While he made no clear

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<sup>1</sup> David Naylor. *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966*. (Kingston and Montreal: McGill-Queen's University Press, 1986), 174.

comments on the lack of cervical cancer in the nun population, it has been deduced from other researchers that he was implying such a conclusion.<sup>2</sup> The concern about the connections between sexuality and cervical cancer risk continues into the present.

Much of the medical literature with regard to cervical cancer from the late 19<sup>th</sup> century and particularly early 20<sup>th</sup> century focussed on “injuries incidental to labour.” As will become clear throughout this chapter, this was a theme of concern to the medical community into the 21<sup>st</sup> century. Not only was the number of births a concern, but also abnormal labour via the introduction of instruments (mainly forceps) to assist the birth, multiple abortions, miscarriage, unhygienic living conditions and class were all highlighted in the early literature.<sup>3</sup> There were hints of a concern about infection causing cervical cancer, but this was a notion that was not fully developed until well into the 20<sup>th</sup> century as the discussion of herpes type-2 and cervical cancer risk later in the chapter addresses.<sup>4</sup>

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<sup>2</sup> Petr Skrabanek. “Cervical Cancer in Nuns and Prostitutes: A Plea for Scientific Continence.” *Journal of Clinical Epidemiology* vol. 41/6 (1988): 577.

<sup>3</sup> For further study, please refer to the following sources: John Pattison, *Remarks on Some Diseases of the Breast and Womb with what to avoid and what to do.* (London: 1861); George H. Napheys, *The Physical Life of Woman: Advice to the Maiden, Wife and Mother* (Toronto: 1871); Lawson Tait, *Diseases of Women* (New York: William Wood and Co., 1879); Arthur Edis, *Diseases of Women including their Pathology, Causation, Symptoms, Diagnosis, and Treatment* (London: 1881); Thomas Aldis Emmet, *The Principles and Practices of Gynaecology* (London: 1885); Alexander J.C. Skene, *Treatise on the Diseases of Women, for the Use of Students and Practitioners* (London: 1889); Herbert Snow, *The Proclivity of Women to Cancerous Diseases and to Certain Benign Tumours* (London: 1891); J. Bland Sutton, and Arthur E. Giles, *The Diseases of women: A Handbook for Students and Practitioners* (Philadelphia: W.B. Saunders, 1897); Thomas Cullen, *Cancer of the Uterus: Its Pathology, Symptomology, Diagnosis, and Treatment.* (New York: Appleton, 1900); Arthur H.N. Lewers, *Cancer of the Uterus: A Clinical Monograph on its Diagnosis and Treatment* (London: 1902); Frederick John McCann, *Cancer of the Womb: Its Symptoms, Diagnosis, Prognosis, and Treatment* (London: 1907).

<sup>4</sup> Please see the following sources for early discussions of the connections between infection/bacteria and cervical cancer: Charles Egerton Jennings, *Cancer and Its Complications* (London: 1889); Frederick John McCann, *Cancer of the Womb: Its Symptoms, Diagnosis, Prognosis, and Treatment* (London: 1907).



Sophisticated understanding of the etiology of cervical cancer followed from the development of the Pap smear which allowed physicians to track changes in cell morphology. The Pap smear advanced understanding of the disease and allowed for accurate diagnosis of cervical cancer, and George Papanicolaou was a revolutionary individual in the quest to prevent this disease. The Pap test has its origins in science of the 1920s. Although George Papanicolaou was primarily a researcher in zoology, some say that his discovery “in its significance in our fight against cancer stands unsurpassed in our century.”<sup>5</sup> He believed that smaller female animals had to have some sort of reproductive cycle. In order to prove this, Papanicolaou purchased a small nasal speculum and, after daily observation, found that guinea pigs did have a regular menstrual period. In addition to his daily observations, he also took small vaginal smears in order to trace microscopic cell changes throughout the cycle. His examinations of his first slides of vaginal smears produced “an impressive wealth of diverse cell forms and a sequence of distinctive cytologic patterns.”<sup>6</sup> With this discovery, Papanicolaou was offered an appointment as professor of Zoology by the Prime Minister of Greece in the early 1920s. But, due to a variety of political matters, the offer disintegrated and Papanicolaou settled comfortably in the United States.<sup>7</sup> After numerous experiments with other rodents and some higher mammals such as opossums and monkeys, he turned to human subjects.

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<sup>5</sup> Leopold G Koss. “George N. Papanicolaou.” *Acta Cytologica* vol. 7 (1963): 145 quoted in, Carmichael, D. Erskine. *The Pap Smear: Life of George N. Papanicolaou*. (Springfield: Charles C. Thomas, 1973): xiii.

<sup>6</sup> D. Erskine Carmichael. *The Pap Smear: Life of George N. Papanicolaou*. (Springfield: Charles C. Thomas, 1973): 48.

<sup>7</sup> *Ibid.*, 52-53.

In order to understand the effectiveness of his discovery, Papanicolaou had to find human subjects on whom to experiment. Papanicolaou's first human subject was his wife. He continued to study her for 21 years. In addition to his wife, between the years of 1920 and 1925, he acquired several other subjects, mostly laboratory staff, and for two to three months, he obtained daily smears from these women.<sup>8</sup> He also took several smears from pregnant women to analyse in order to submit his first article concerning vaginal smears entitled "Human Pregnancy Diagnosis by Vaginal Smear" in 1928.<sup>9</sup> Despite the fact that he had been working on the morphological changes in vaginal smears in order to reveal changes in the uterus and ovaries since 1925, his presentation and paper revealed some hesitation with regard to the smear's efficacy. In order to present a new method of cancer diagnosis, Papanicolaou was well aware that extensive clinical trials and more proof were needed.<sup>10</sup> In 1928 George Papanicolaou was refining his research on vaginal smears as a diagnostic (and later a preventive) tool. George Papanicolaou announced the discovery of the vaginal smear (Pap test) when medical officials were struggling to find a tool to fight rising cervical cancer rates. Initially the Pap test was introduced by Papanicolaou as a diagnostic tool. He argued that it was more reliable than the process of taking a biopsy. The vaginal smear was met with serious reservations by surgeons and pathologists as they felt it was a threat to their established practice of biopsy and their power over several medical specialties, such as cancer

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<sup>8</sup> Ibid., 55.

<sup>9</sup> Ibid, 56.

<sup>10</sup> Vayena, "Cancer Detectors," 32.

diagnosis and research.<sup>11</sup> Since it was initially introduced as a diagnostic tool, it was some time before it was used in the physician's office as a preventive procedure.

Its name would indicate that George Papanicolaou was the primary discoverer, but there was another individual who played a pivotal role in the development of the smear test. Aurel Babes also published on cervical smears and their specific technique. As George Weid states in his article discussing the discovery of the Pap test, "...in the field of diagnostic cytology there are few major 'firsts,' since essentially the entire field is an evolutionary one to which many researchers have contributed significant details which might have seemed too small to warrant tracing by medical historians."<sup>12</sup> In 1928, George Papanicolaou and Aurel Babes both published on the same topic, cervical smears, within months of each other, although neither mentioned the other's work. Papanicolaou presented his findings at a conference in January 1928, and Babes published an article that did not appear until April of the same year. Because both used different routes and ways of presenting their findings, it is extremely hard to assess who actually made the initial discovery.<sup>13</sup> Most literature written on the Pap test attributes its discovery to Papanicolaou, hence the name of the technique. Babes was continually referred to as a fundamental part of its discovery, but was never formally labelled as a discoverer.

Throughout the 1930s, Papanicolaou continued his research with vaginal smears but abandoned the idea of cancer diagnosis for a period. He continued research on the use of vaginal smears, but with a focus mostly on the endocrinology of the estrous cycle

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<sup>11</sup> Eftychia Vayena. "Cancer Detectors: An International History of the Pap Test and Cervical Cancer Screening, 1928-1970." *PhD. University of Minnesota* (1999): 34-35.

<sup>12</sup> George Wied. "Pap-Test or Babes Method?" *Acta Cytologica* vol. 8 (1964): 173.

<sup>13</sup> Vayena. "Cancer Detectors," 18.

in female humans. He revived the idea of cancer diagnosis once he was teamed with Herbert Traut, an expert in gynaecological pathology.<sup>14</sup> When the team of Papanicolaou and Traut became official in October of 1939, they were quick to set up a research agenda. The agenda had three basic foci: “1) to develop the method [of diagnosis] and establish its validity, 2) to train others to use it, and 3) then to educate the profession and the public as to what it had to offer.”<sup>15</sup> Papanicolaou did not publish another article with reference to cytologic cancer diagnosis until 1941.<sup>16</sup>

Not long after Papanicolaou’s ground-breaking work with the smear technique, the medical community started to focus more explicitly on the precursors to cervical cancer. From the 1930s well into the 1950s, childbearing and the inevitable trauma and inflammation of the cervix were considered the primary causes of cervical cancer. Many of the key medical journals printed articles on cervical cancer that focussed on parity as a risk factor. For example, in 1932, while focussing on the rare occurrence of cervical cancer in 3 cases of nulliparous women, Louis Phaneuf argued that “cancer seldom develops on a healthy cervix.” The author believed that the healthy cervix became no longer healthy after “lacerations of childbirth and the infections of the endocervix.”<sup>17</sup> A researcher in Toronto, W.A. Scott, claimed that in the years 1930 to 1933 there was only one diagnosis of cervical cancer in a nulliparous woman in all of the public wards of the

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<sup>14</sup> Ibid., 35-36.

<sup>15</sup> Ibid., 37.

<sup>16</sup> The article published in 1941 was entitled, “The Diagnostic Value of Vaginal Smears in Carcinoma of the Uterus.” *Wied.*, “Pap-Test or Babes Method?” 173.

<sup>17</sup> Louis E. Phaneuf. “Cancer of the Cervix in Nulliparous Women,” *New England Journal of Medicine* vol. 206/16 (1932): 840.

Toronto General Hospital, and this woman had previously had an abortion.<sup>18</sup> The articles on cervical cancer that were printed in medical journals in the 1940s were similar in focus to those in the 1930s. In the *Canadian Medical Association Journal* alone there were several articles that were either discussing the Pap smear or the treatment options and successes with regard to cervical cancer.<sup>19</sup> For the most part, the primary concern for developing cancer was still parity and trauma to the cervix.

At this point in the medical profession's general understandings of the precursor to cervical cancer, religious practices also became part of the concern for cancer risk. A number of authors claimed that Jewish women, whose husbands were circumcised at birth, were generally free from this disease.<sup>20</sup> The role sexual intercourse and circumcision played in cancer risk were also discussed in popular literature "handbooks" on becoming a woman. For example, W. Gifford Jones'<sup>21</sup> book, published as late as 1969, *On Being a Woman: The Modern Woman's Guide to Gynecology*, refers to the rarity of cervical cancer among Jewish women, particularly recognizing their adherence

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<sup>18</sup> W.A. Scott. "Cervical Cancer," *The Canadian Medical Association Journal* vol. 29 (1933): 290.

<sup>19</sup> Please see, "Control of Cancer: Editorial." *CMAJ*, vol. 54 (1946): 57-58; J. Ernest Ayre and Evelyn Dakin. "Cervical Cytology Tests in Cancer Diagnosis: Glycerine Technique for Mailing," *CMAJ*, vol. 54 (1946): 489-491; W.G. Cospie. "The Early Recognition of Uterine Cancer," *CMAJ* vol. 55/3 (1946): 237-240; John D. Hamilton. "The Vaginal Smear Technique for Diagnosis of Cancer in the Female Genital Tract," *CMAJ* vol. 59 (1948): 42-47; Edwin M. Robertson. "Cell Smears in the Diagnosis of Carcinoma." *CMAJ* vol. 59 (1948): 148-151; A. Maxwell Evans. "The Treatment of Carcinoma of the Cervix Uteri," *CMAJ* vol. 59 (1948): 458-462.

<sup>20</sup> Paul A. Younge. "Cancer of the Cervix: A Preventable Disease." *Obstetrics and Gynecology* vol. 10 (1957): 470. Other authors claiming the same rarity among Jewish women include: Irwin Weiner et al., "Carcinoma of the Cervix in Jewish Women." *American Journal of Obstetrics and Gynecology* vol. 61/11 (1951): 418-422; E.L. Kennaway, "The Racial and Social Incidence of Cancer of the Uterus." *British Journal of Cancer* vol. 2 (1948): 178-212; Maurice Sorsby, *Cancer and Race: A Study of the Incidence of Cancer*. (London: John Bale, Sons and Danielson Ltd., 1931); Jerome V. Treusch et al., "Infrequency of Carcinoma of the Uterine Cervix Among Jewish Women." *American Journal of Obstetrics and Gynecology* vol. 52 (1942): 162.

<sup>21</sup> Dr. W. Gifford-Jones was a famous Canadian doctor and medical journalist that had a column in the *Toronto Sun* for decades.

to specific religious practices that avoid uncircumcised penises and intercourse during particularly susceptible periods for the cervix. One hypothesis proposed that penile cleanliness played a role in lowering cervical cancer incidence rates. The medical reasoning was that with the removal of the foreskin, the occurrence of smegma, which was often retained under the uncircumcised foreskin and was considered to be a weak carcinogen, was thus avoided. Therefore, ritual circumcision and the resulting additional penile cleanliness were considered to be protective measures in preventing cervical cancer.<sup>22</sup> One researcher argued that the statistics were proof enough. It was found in Amsterdam in 1919-1920 that cervical cancer was occurring in 10 out of every 100,000 non-Jewish women, compared with only four (or less) in every 100,000 Jewish women.<sup>23</sup> These statistics demonstrated that cervical cancer occurred in Jewish women at half the rate of non-Jewish women. Such a ratio could additionally be demonstrated in Fijians who also practiced circumcision. One study concluded that from 1925-32 only three cases of cervical cancer were found in a hospital in Fiji. Among other populations of women whose cultures did not practice circumcision, it was found that there was more than an eight times higher incidence rate of cervical cancer.<sup>24</sup>

The Jewish immunity was often explained by married Jewish women's adherence to strict religious practices of constant cleansing and prohibition of sexual congress during times of menstruation.<sup>25</sup> Maurice Sorsby, an Ear Nose and Throat specialist and researcher at the London Jewish Hospital, suggested that with careful consideration of the

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<sup>22</sup> ? *Canadian Medical Association Journal* vol. 90 (1964): 1132.

<sup>23</sup> Sampson Handley. "The Prevention of Cancer." *The Lancet* (May, 1936): 987.

<sup>24</sup> *Ibid.*, 990.

<sup>25</sup> Hiram N. Vineberg. "The Relative Infrequency of Cancer of the Uterus in Women of the Hebrew Race." *Journal of the Mount Sinai Hospital* vol. 10 (1943): 37.

Jewish woman's adherence to strict cleanliness and avoidance of coitus during or for some time after menstruation, and a limited number of pregnancies, one might be able to decrease the risk of developing cancer. He stated "it is clear that married life in some form or other is the usual soil from which uterine cancer springs. Therefore, it is easy to see that a well-regulated sexual life might be a favourable factor in the avoidance of this disease."<sup>26</sup> Jewish women were generally considered to be "cleaner in body than the masses of non-Jewish women."<sup>27</sup> They were taught to believe that any sort of discharge which soils the genitals and causes an increase in infections is theologically "unclean."<sup>28</sup> Their immunity was also attributed to their generally poor living conditions and simpler lifestyle, consisting of little recreation and interaction with other people.<sup>29</sup> The same explanation was used for the low incidence rates of cervical cancer among Fijian women. There was an automatic protection of the cervix from "mixed bacterial infections of the cervix during coition."<sup>30</sup> Gifford-Jones concluded that for every Jewish woman who developed cervical cancer, nine non-Jewish women developed the disease.<sup>31</sup> It was uncircumcised penile foreskin that was believed to cause unnecessary irritation to the fragile cervical walls. This sort of irritation could also be mimicked by the use of

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<sup>26</sup> Maurice Sorsby. *Cancer and Race: A Study of the Incidence of Cancer Among Jews*. (London: John Bale, Sons and Danielson Ltd., 1931): 86.

<sup>27</sup> *Ibid.*, 87.

<sup>28</sup> *Ibid.*, 88-89.

<sup>29</sup> *Ibid.*, xiv.

<sup>30</sup> Handley, "The Prevention of Cancer," 990.

<sup>31</sup> W. Gifford-Jones. *On Being A Woman: The Modern Woman's Guide to Gynecology*. (Toronto; McClelland and Stewart Limited, 1969): 178.

tampons.<sup>32</sup> It was believed that any foreign object in the vagina was sure to cause harm by irritation and the possibility of carrying infection.<sup>33</sup>

Canadian doctors also asserted that religious practices contributed to the development of cervical cancer. On the opposite end of the spectrum to Jewish women, Native women had unusually high rates of cervical cancer, as reported in Canada in the late 1940s. In a report entitled “Cancer Among Canadian Indians,” published in 1954, cancer was the number two cause of death next to tuberculosis in 1949.<sup>34</sup> In the five years of data collection, women made up approximately 62% of deaths from cancer recorded. Cancer of the cervix was the cause of death in 40% of those cases. In comparison to breast cancer, cervical cancer was more than three times more likely to occur as the primary cause of death.<sup>35</sup> This article did not offer any concrete explanation for these statistics, other than it was found that cancer of the cervix tended to occur earlier in life in native women than it did among white women.<sup>36</sup> The authors speculated that this could be because of “the high birth rate and limited post-natal care”<sup>37</sup> common amongst native women in Canada.

However, despite the emergence of religion and ethnicity as concerns, earlier connections between parity, trauma and cervical cancer were echoed in the 1950s. In an article printed in 1955 in the *American Journal of Obstetrics and Gynecology*, researchers studied two groups comparing their cervical cancer risk: a group of nuns and

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<sup>32</sup> Elizabeth Parker. *The Seven Ages of Woman*. (Baltimore: The John Hopkins Press, 1960): 64.

<sup>33</sup> Ibid.

<sup>34</sup> O.H. Warwick and A.J. Phillips. “Cancer Among Canadian Indians.” *The British Journal of Cancer* vol. VIII (1954): 225.

<sup>35</sup> Ibid., 226.

<sup>36</sup> Ibid., 228.

<sup>37</sup> Ibid., 229.



a group of women who had several children. The language in the 1955 article was slightly different from earlier articles in the 1930s, as it referred to the group of women who had several children as “married,” thus assuming that unmarried women were not having children or, for that matter, having sex.<sup>38</sup> Another 1950s example was P. Stock’s article discussing the problem of increased fertility rates during the post-war era as a precursor to cervical cancer. Social class and hygiene were also part of his discussion because there was an assumption that lower-class families had more children in less hygienic environments. Age at marriage was also a brief part of his discussion because the earlier a woman married the more children to whom she would be able to give birth.<sup>39</sup>

Similar to medical journals during the mid-twentieth century, medical texts in the 1950s and 1960s continued to focus on multiple births as a risk factor in the development of cervical cancer. In the text, *A Practical Handbook of Midwifery and Gynecology: For Students and Practitioners*, of the three key risk factors multiparæ was a paramount concern. The two other key risk factors were age and predisposed chronic inflammatory eversion and erosion.<sup>40</sup> These chronic inflammatory conditions were usually attributed to damage to the cervix that occurs during childbirth. One medical textbook, *Applied Gynecologic Pathology*, clearly stated in the introduction to a chapter dedicated to malignant lesions of the cervix, “it is easy to understand why patients who have had

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<sup>38</sup> Janet Towne. “Carcinoma of the Cervix in Nulliparous and Celibate Women,” *American Journal of Obstetrics and Gynecology* vol. 69 (1955): 607.

<sup>39</sup> P. Stocks. “Cancer of the Uterine Cervix and Social Conditions.” *British Journal of Cancer* vol.9 (1955): 488. This is also the post-war period that is famous for the baby-boom generation. It has been argued that the new social pressures for earlier marriage and more children dramatically changed Canadian demography unlike any other generation in history. For further detail see, Douglas Owrain. *Born at the Right Time: A History of the Baby Boom Generation*. (Toronto: University of Toronto Press, 1996).

<sup>40</sup> W.F.T. Haultain, Clifford Kennedy, and J.L. Henderson. *A Practical Handbook of Midwifery and Gynecology: For Students and Practitioners*. (Edinburgh and London: E. & S. Livingstone Ltd, 1957), 304-305.

vaginal deliveries would have a higher incidence of this disease [cervical cancer] than individuals who have never had such a disturbance to the uterus.”<sup>41</sup> While most gynaecological textbooks focused on examination techniques and treatment options, often the key risk factors such as multiparæ were mentioned.<sup>42</sup> Thomas Greens’ text, *Gynecology: Essentials of Clinical Practice*, spent a considerable amount of time discussing sexual activity and childbearing as main predisposing factors to cervical cancer. This section even briefly mentioned the connections between low rates of cervical cancer and Jewish women and how this fact must be related to the male sexual partner being circumcised.<sup>43</sup> Even nursing textbooks from the 1960s mentioned risk factors for cervical cancer such as early marriage and giving birth to several children. For example, in *Gynecologic Nursing*, published in 1965, while discussing prescribed care for a patient with a gynaecological malignancy, it was clearly stated that a “woman who has married early and has borne children is the primary candidate for cancer of the cervix.”<sup>44</sup>

While parity remained a primary concern for several decades, there were also early connections made between cervical cancer and syphilis. In 1931, Dr. George H. Belote, an associate professor of Dermatology and Syphilology at the University of Michigan’s medical school, published an article that argued that of the positive bloods

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<sup>41</sup> J. Edward Hall. *Applied Gynecologic Pathology*. (New York: Appleton-Century-Crofts, 1963), 72.

<sup>42</sup> For other examples see, Robert A. Kimbrough (ed). *Gynecology*. (Philadelphia: J.B. Lippincott, 1965), Eric Easson. *Cancer of the Uterine Cervix*. (London: W.B. Saunders Company Ltd, 1973), Mary DeWitt Pettit (ed). *Gynecologic Diagnosis and Treatment*. (New York: McGraw-Hill Book Company Inc., 1962) Stephen Thomas Cullen, *Cancer of the Uterus: Its Pathology, Symptomology, Diagnosis, and Treatment*. (New York: D. Appleton, 1960), and Hugh McLaren, *The Prevention of Cervical Cancer*. (London: English Universities Press, 1963).

<sup>43</sup> Thomas Green. *Gynecology: Essentials of Clinical Practice*. (Boston: Little, Brown and Co., 1965), 290.

<sup>44</sup> Genevieve M. Fitzpatrick. *Gynecologic Nursing*. (New York: The MacMillan Company, 1965), 27.

(tested for syphilis) collected in his study, 15.1% were also positive for carcinoma of the cervix uteri. This, at the time, was “3 times the average for all hospital admissions and 2 times the average for all carcinomatous female patients.”<sup>45</sup> This conclusion came as a big surprise to Dr. Belote as he suggested that “perhaps that this organ [was] the seat of syphilitic lesions more commonly than we know, and if searched for, they might more frequently be found.”<sup>46</sup> Other studies were done in the 1940s that furthered Belote’s findings. Drs. Morton L. Levin, Louis C. Kress and Hyman Goldstein (all from the Division of Cancer Control in New York) found that in their study subjects “women with cancer of the uterine cervix, syphilis was found approximately three times as frequently as in women with cancer of other sites.”<sup>47</sup> Borrowing from current understandings of the causes of cervical cancer, the authors reminded readers that it might not necessarily be the syphilis infection itself, but rather the greater frequency of coitus “which may be presumed in syphilitic women” as the cause for the carcinoma. They further recognized that while “experimental proof is lacking, the possibility cannot be dismissed that tissue changes resulting from syphilitic infection may, under favouring circumstances, initiate the process of carcinogenesis.”<sup>48</sup> Another article was printed in the same year, “Influence of Syphilis in Cancer of the Cervix,” written by W.G.D. Harding, who also argued that while there was a lack of objective data to support the claim, there seemed to be “a general concern of the role syphilis may play in cancer of the cervix.”<sup>49</sup> By 1953, a full-

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<sup>45</sup> George H. Belote, “The Association of Cancer and Syphilis as Determined by Positive Serology.” *American Journal of Syphilis* vol. 15 (1931): 373.

<sup>46</sup> *Ibid.*, 375.

<sup>47</sup> M.L. Levin et al., “Syphilis and Cancer.” *New York State Journal of Medicine* vol. 42 (1942): 1739.

<sup>48</sup> *Ibid.*, 1743.

<sup>49</sup> W. G.D. Harding. “Influence of Syphilis in Cancer of the Cervix.” *Cancer Research* vol. 2 (1942): 59.

scale study was published in Copenhagen, *Uterine Cancer and Syphilis*, further reinforcing these earlier claims and leading the medical community in the direction of being more concerned about the role viruses might play in cancer development. The key researcher, Jorgen Rojel, concluded that “syphilis [was] about 3 times as common among women with carcinoma of the cervix uteri as among women without cervical carcinoma.<sup>50</sup> These early viral theories of causation lay the foundation for a more complex understanding of viruses as risk factors for developing cervical cancer that came a decade later.

These early and relatively rudimentary understandings of virus and cervical cancer were coupled with the medical community becoming additionally concerned with sexual activity itself as a precursor to the development of cervical cancer. At the Fifth Annual Meeting of the Society of Obstetricians and Gynecologists, held in Jasper Park, Alberta in 1949, Canadian Gynecologist (Laval University) Fabian Gagnon claimed that he had found epidemiological evidence that concluded that cervical cancer was more common among prostitutes, thus directly correlating the disease with so-called excessive amounts of sexual activity.

Without considering earlier theories of virus and contagion in the development of cervical cancer, Gagnon believed that continuous sexual activity with several partners increased a woman’s risk of developing chronic conditions of the cervix and thus of developing cervical cancer. Gagnon was clinging to claims from earlier in the century that it was primarily the irritations by foreign objects that predisposed the cervix to a

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<sup>50</sup> Jorgen Rojel. *Uterine Cancer and Syphilis*. (Copenhagen: NYT Nordisk Forlag Annold Busck, 1953), 43.

condition more susceptible to cervical cancer. He concluded that the cure of cervicitis would “bring about the disappearance of cancer of the cervix.” He stated that “in well over 4,000 cases of cervicitis, treated systematically during the last 17 years, both at the hospital and in private practice, I have not yet come across a single carcinoma of the cervix.”<sup>51</sup>

As a result of the medical researchers’ shift in focus to the amount of sexual activity as a risk factor for developing cervical cancer, many epidemiological studies in the 1960s and 1970s treated cervical cancer as a venereal disease. Researchers believed that the “observed relationships of cervical cancer to coital practice, circumcision, syphilis, prostitution, and low socioeconomic class led a number of investigators to suggest the possibility of a venereally transmitted viral etiology for this neoplasm.”<sup>52</sup> In the late 1960s the herpesvirus type 2 (specific to genital infection only) was isolated from human cancer cells found in the cervix and, although not initially conclusive, the findings strengthened the evidence of viruses causing cervical cancer.<sup>53</sup> Researchers at the Emory School of Medicine at the Sutav Stern Symposium on Perspectives in Virology in 1970 stated that “our findings so far demonstrate that the pattern of genital herpetic infection fits very well that established for cervical cancer, including the greater prevalence of both entities in lower socio-economic groups, their apparent venereal mode of transmission, their higher incidence in sexually promiscuous women and in those with early coital

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<sup>51</sup> Fabian Gagnon, “Contribution to the Study of the Etiology and Prevention of Cancer of the Cervix of the Uterus.” *American Journal of Obstetrics and Gynecology* vol. 60/3 (1950): 521.

<sup>52</sup> Irving I. Kessler. “Human Cervical Cancer as a Venereal Disease.” *Cancer Research* vol. 36 (1976): 786.

<sup>53</sup> “Herpes Virus, Cancer of the Cervix, may be linked, U.S. doctor finds.” *Globe and Mail*, November 18, 1971.

experience and contact with uncircumcised males.”<sup>54</sup> The second edition to Thomas Green’s, *Gynecology: Essentials of Clinical Practice*, published in 1965, discussed the role type-2 herpesvirus simplex in connection to the development of cervical cancer.<sup>55</sup> While it was later recommended that women known to have had genital herpes “should be followed closely in order to detect as soon as possible any evidence of the development of cervical dysplasia or carcinoma,” there was no mention of how to discuss this topic with the patient herself.<sup>56</sup>

Researchers also believed that the developmental patterns of cervical cancer suggested that the introduction of a virus would assume “different biologic properties, including carcinogenicity” in an otherwise healthy cervix.<sup>57</sup> Several diseases could be considered to be venereal in nature. These include spirochetal and bacterial diseases and a number of viral protozoal, fungal and parasitic conditions; the herpes simplex virus is part of the latter.<sup>58</sup> The herpesvirus hominis type 2 (HVH2) has been thought to be responsible for all genital infections and has been rarely demonstrated in other sites. The only exception in location for the herpetic infection is in newborn infants who have been exposed to a genital infection maternally.<sup>59</sup> Herpesvirus hominis, as a result of laboratory studies in both Europe and the United States, has been divided into two antigenic types:

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<sup>54</sup> Library and Archives Canada (LAC), RG29, Department of National Health and Welfare, File #311-C1-8, Gustav Stern Virology Symposium. “Cervical Cancer, Herpes Virus are Linked.” *Medical Tribune*. March 5, 1970, 1.

<sup>55</sup> Thomas Green. *Gynecology: Essentials of Clinical Practice*, 2<sup>nd</sup> ed. (Boston: Little, Brown and Co., 1965), 303.

<sup>56</sup> *Ibid.*, 304.

<sup>57</sup> William Josey et al. “Genital Infection with Type 2 Herpesvirus Hominis.” *American Journal of Obstetrics and Gynecology* vol. 101 (1968): 718.

<sup>58</sup> Kessler, “Human Cervical Cancer,” 783.

<sup>59</sup> Scott Jordan et al. “Ethnic Distribution of Cytologically Diagnosed Herpes Simplex Genital Infections in a Cervical Screening Program.” *Acta Cytologica* vol. 16/4 (1972): 363.

herpesvirus hominis type 1 (HVH1) and herpesvirus hominis type 2 (HVH2). HVH2 is characteristically different from HVH1 in that it is specific to genital tract infections in both females and males. The majority of cases of HVH2 are a result of venereal transmission.<sup>60</sup> For well over a decade, during the latter part of the twentieth century, researchers focused on the potential role of HVH2 in the development of cervical cancer. HVH2 has been found to be a venereal disease affecting individuals in their early adulthood and adolescence. It is also rare in children and nuns and is common among prostitutes. These are, as discussed earlier, all attributes similar to cervical cancer. Numerically, “these observations indicated that there are more than enough cases of genital herpetic infection to account for every case of cervical anaplasia.”<sup>61</sup> André Nahmais, a medical researcher in the 1970s, believed that while many epidemiological studies were hindered by various laboratory, histopathological, and statistical problems, each study allowed researchers to further understand risk factors for cervical cancer.<sup>62</sup> In addition to recognizing the methodological faults of these studies, it is also essential to realize that researchers who recognized the potential role of HVH2 were only steps away from understanding the role other viruses played in the risk for this disease.

In the 1960s and 1970s, textbooks were being published that focused solely on cancer of the cervix uteri. In 1967 doctors Malcolm Coppleson, Bevan Reid, and Ellis Pixley published a textbook, *Preclinical Carcinoma of the Cervix Uteri: Its Nature, Origin, and Management*, that discussed the precursors to the disease and its treatment.

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<sup>60</sup> Josey et al. “Genital Infection,” 718-719.

<sup>61</sup> André J. Nahmais et al. “Epidemiological Studies Relating to Genital Herpetic Infection to Cervical Carcinoma.” *Cancer Research* vol. 34 (1974): 1112.

<sup>62</sup> *Ibid.*, 1111.

There was no discussion of doctor/patient interaction, education of the patient, or possible preventive strategies. Similar to most textbooks during this period, the focus was on diagnosis and treatment. In 1973, Eric Easson published a textbook dedicated to cervical cancer that spent a considerable amount of time (in comparison to other textbooks at the time) discussing the concept of cancer control and the prevention of cervical cancer. Based out of England, this textbook is indicative that there was early recognition that professional education of general practitioners and nurses alike was vital to educating the general public about the preventive strategies possible for cervical cancer.<sup>63</sup> Another textbook published in the 1970s, David Schottenfeld's, *Cancer Epidemiology and Prevention*, spends an entire chapter discussing cervical cancer. He argued that periodic screening is difficult and inefficient, yet publicity to encourage women to take part in screening often produces "anxieties among women and [may] overburden the existing medical care system with demands for attention."<sup>64</sup> Other than seeing a dilemma in giving women too much information and as a result overburdening the health care system, Schottenfeld's text provided little advice to physicians about how to approach their patients in regards to cervical cancer. From the 1970s to the early 1990s there was a surge in the numbers of textbooks being published that dealt with the psychosomatic symptoms and gynecology.<sup>65</sup>

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<sup>63</sup> Eric Easson. *Cancer of the Uterine Cervix*. (London: W.B. Saunders Company Ltd., 1973), 3.

<sup>64</sup> David Schottenfeld. *Cancer Epidemiology and Prevention: Current Concepts*. (Springfield: Charles C. Thomas, 1975), 278.

<sup>65</sup> See, Dennerstein, Lorraine and Eylard van Hall. *Psychosomatic Gynecology: A total approach to women's health problems*. (Lancs, England, The Parthenon Publishing Group Limited: 1986); Leysen, B. et al. *Research in Psychosomatic Obstetrics and Gynecology*. (Leven, ACCO: 1986); Wolman, Benjamin B. (ed). *Psychological Aspects of Gynecology and Obstetrics*. (New Jersey, Medical Economics Company, 1978); O'Hara, Michael W. Et al (ed). *Psychological Aspects of Women's Reproductive Health*.



While several medical studies were published regarding the connection between HVH2 and cervical cancer, none of them provided terribly convincing proof. Most researchers were quick to recognize the limitations within their own studies and discussed options for further research. For example, in an article published in the journal *Cancer Research* in 1973 entitled, “An Analysis of Seroepidemiological Studies of Herpesvirus Type 2 and Carcinoma of the Cervix,” the authors began by explaining the two significant limitations to their study’s conclusions:

There are two aspects of the seroepidemiological studies of the herpesvirus type 2 and cervical cancer that imposed limitations upon the interpretation of the data. One aspect is the antibody assay systems; the degree of accuracy with which the present assay systems detect past infections with the herpesvirus type 2 is not known. The 2<sup>nd</sup> problem is the difficulty in controlling for the attributes of sexual behaviour that appear to affect the risk of cervical cancer.<sup>66</sup>

Other problems related to obtaining “uniform histopathological criteria” included the inability to define appropriate controls and “determining the best methods for analyzing data.” The first study to demonstrate an increased rate of cervical carcinoma in women with cytologically positive herpetic infection was Nahmias, Haib, and Josey’s article, “Epidemiological Studies Relating to Genital Herpetic Infection to Cervical Carcinoma,”

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(New York, Springer Publishing Company, 1995); Hirsch, Herman (ed). *The 4<sup>th</sup> International Congress of Psychosomatic Obstetrics and Gynecology*, Tel Aviv, October 27, 1974: The Family. (London: Karger, 1975); Morris, Norman (ed). *The 3<sup>rd</sup> International congress of Psychosomatic Ob and Gyn*, London, March 29-April 2, 1971: *Psychosomatic Medicine in Ob and Gyn*. (London: Karger, 1972); Notman, Malkah et al (eds). *The Woman Patient: Medical and Psychological Interfaces*. (New York: Plenum Press, 1978); Broome, Annabel et al (eds). *Psychology and gynaecological Problems*. (London: Tavistock Publications, 1984); David Youngs and Anke Ehrhardt. *Psychosomatic ob and gyn*. (New York: Appleton-century-crofts, 1980.

<sup>66</sup> Willaim E. Rawls, et al. “An Analysis of Seroepidemiological Studies of Herpesvirus Type 2 and Carcinoma of the Cervix.” *Cancer Research* vol. 33 (1973): 1477.

published in 1974 in Atlanta, Georgia.<sup>67</sup> However, this study was also guilty of the same methodological problems others had experienced.

Anomalous for the medical community in the early 1970s was the role diethylstilbestrol (DES) played in the development in a rare form of cervical cancer, clear cell adenocarcinoma. A double-blind study was done in Chicago in 1951 attempting to realize the effectiveness of DES in the “protection of pregnancy.” For a couple of decades the study participants and their offspring were followed closely. It was realized in the data collected up to 1977 that the female offspring of the women who had been given DES were “at an increased risk for a variety of benign abnormalities of the genital tract. Also, and more frighteningly, these daughters were at an increased risk of developing rare forms of vaginal and cervical cancer.”<sup>68</sup> There was also initial concern that women who had been given DES were at an increased risk of developing breast cancer.<sup>69</sup> Dr. R.A.H. Kinch, representing the Special Advisory Committee on Reproductive Physiology out of Montreal General Hospital, wrote that it was noteworthy that all physicians “ensure that follow-up [was] adequate and early diagnosis [was] made in women who may have been exposed to diethylstilbestrol or other estrogens during pregnancy.”<sup>70</sup> Also, drug manufacturers were advised to change their indicators appropriately. A virus, too many children, or a chronic vaginal condition could not be used to explain this form of cervical cancer. The medical community could not blame the woman for this cancer, in terms of her lifestyle choices; they could only blame

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<sup>67</sup> Nahmias, et al. “Epidemiological Studies,” 1111-1117.

<sup>68</sup> R.A.H.Kinch. “Diethylstilbestrol: risk of malignant disease and congenital malformations.” *CMAJ* vo. 120 (1979): 1483.

<sup>69</sup> *Ibid.*

<sup>70</sup> *Ibid.*, 1484.

themselves and their lack of understanding of this synthetic hormone. It was noted in a 1982 *CMAJ* article that “while available evidence indicates that the magnitude of the DES problem in Canada [was] low,” it was still part of the growing understanding of cervical cancer at the time.<sup>71</sup> This synthetic estrogen was first used for a variety of medical conditions, namely pregnancy complications, from the 1940s to 1971. In 1971 the Food and Drug Administration in the US required “product labeling to state that DES was contraindicated for use in the prevention of miscarriages.”<sup>72</sup> It has been estimated that between 500,000 and three million women were given DES while pregnant.<sup>73</sup> The estimate has even appeared as high as four and six million women when including both mothers and the children.<sup>74</sup> The clear cell adenocarcinoma can only occur in the daughters who were exposed to DES intrauterinely. Up to 90% of DES daughters were also known to have adenosis<sup>75</sup> and other cervical conditions including erosion, ectropion, or eversion.<sup>76</sup> In November of 1971 the Department of National Health and Welfare announced that there was a clear association between the use of DES during pregnancy and the development of carcinoma of the vagina in the exposed offspring. This announcement was based solely on data out of the United States. By 1979 all Canadian physicians were advised by the health protection branch’s special advisory committee on

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<sup>71</sup> Robert A.H. Kinch. “Diethylstilbestrol in pregnancy: an update.” *CMAJ* vol. 127 (1982): 812.

<sup>72</sup> Roberta J. Apfel and Susan M. Fisher. *To Do No Harm: DES and the Dilemmas of Modern Medicine*. (New Haven and London: Yale University Press, 1984), 1.

<sup>73</sup> Cynthia Kaitman Orenberg. *DES: The Complete Story*. (New York: St. Martin’s Press, 1981), 36.

<sup>74</sup> *Ibid.*

<sup>75</sup> “Adenosis is the name for the condition in which the cells that normally line the cervix are found on the walls and surfaces of the vagina.” *Ibid.*, 49.

<sup>76</sup> *Ibid.*, 49.

reproductive physiology that there were clear risks of “congenital malformations and malignant disease in the offspring of women exposed to DES during pregnancy.”<sup>77</sup>

Going back to the viral theory (HVHS-2) discussed before the DES story interrupted medical understandings of cervical cancer, the next main breakthrough was the human papillomavirus. It was not until the 1980s that medical researchers successfully linked human papillomavirus (HPV) and cervical cancer development and the viral theory began to look more practical.<sup>78</sup> Throughout the 1980s a few articles were appearing in medical journals, but most of them were reluctant to confidently connect HPVs with the development of cervical cancer. As one researcher stated in 1987 while reviewing current literature on the connection, “gynaecologists and venereologists are keen to know whether there is sufficient evidence to deduce that human papillomaviruses are the sexually transmitted carcinogen we have been seeking for so many years”. It would be several more years before the medical community would openly confirm this theory.<sup>79</sup> A Canadian study published in 1990 revealed the connection between HPV infection and cervical neoplasm, which is the precursor stage to invasive cancer. While the study was critical of the variables between both the study group and its coinciding control group, they confidently stated in their results that “the biologic and clinical evidence supporting a role for genital HPV in cervical neoplasia [was] impressive.”<sup>80</sup>

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<sup>77</sup> Ibid.

<sup>78</sup> Susanne K. Kjaer, et al. “Human Papillomavirus – The most Significant Risk Determinant for Cervical Intraepithelial Neoplasia.” *International Journal of Cancer* vol. 65 (1996): 601.

<sup>79</sup> “Human Papillomaviruses and Cervical Cancer: A Fresh Look at the Evidence.” *The Lancet* March 28, (1987): 725.

<sup>80</sup> Deoraj Caussy, et al. “Human papillomavirus and cervical intraepithelial neoplasia in women who subsequently had invasive cancer.” *CMAJ* vol. 142 (4) (1990): 316.

By the mid-1990s, researchers demonstrated that “these viruses are able to integrate themselves into the human genome, and by a variety of mechanisms including viral protein production and binding of human suppressor p53 and retinoblastoma proteins, lead to unregulated cell growth, accumulation of chromosomal mutations, and finally to malignant transformation.”<sup>81</sup> There are over seventy different strains of HPV that have been identified both as cutaneous and mucosal types.<sup>82</sup> Specific types of the HPV, however, are associated with cancer development. Data, mostly experimental, suggest that type 16, 18, 31, 33, and 35 all have been identified in penile, vulvar, and cervical cancer specimens, indicating that both male and female humans can be affected by HPV.<sup>83</sup> Finally, a consensus panel convened by the World Health Organization International Agency for Research on Cancer in 1995 concluded that there was enough “compelling evidence, from both the biological and epidemiological standpoints, to consider certain papillomaviruses as carcinogenic in humans.”<sup>84</sup> By 2000, medical articles were confidently stating that “HPV is thought to be the primary cause of cervical intraepithelial neoplasia and cervical cancer.”<sup>85</sup> At this point the science was finally conclusive as to the causes of cervical cancer. The question was now figuring out whose responsibility it was to prevent this disease and how prevention could be accomplished.

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<sup>81</sup> Alice Lytwyn and John W. Sellors. “Sexually Transmitted HPVs: Current Concept and Control Issues.” *The Canadian Journal of Human Sexuality* vol. 6/2 (1997): 2.

<sup>82</sup> Cutaneous HPV infection refers to the infection of the skin and mucosal HPV refers to the infection of a mucous membrane.

<sup>83</sup> E. M. DeVilliers et al. “Human Papillomavirus Infections in Women With and Without Abnormal Cervical Cytology.” *The Lancet* (September 26, 1987): 703.

<sup>84</sup> Luisa Lina Villa. “Human Papillomaviruses and Cervical Cancer.” *Advances in Cancer Research* vol. 71 (1997): 321.

<sup>85</sup> John W. Sellors, et al. “Prevalence and Predictors of Human Papillomavirus Infection in Women in Ontario, Canada.” *Canadian Medical Association Journal* vol. 163/5 (2000): 503.

An example of this transition in focus is in a textbook published in 1983. In its chapter “Malignant Cervical Lesions,” J. Robert Wilson and colleague’s book *Obstetrics and Gynecology*, a small section was dedicated to whose responsibility it was to ensure the early diagnosis of cervical cancer. The authors argued that initially the responsibility rested on communities and public health services in order to make “screening facilities more readily available and acceptable.” Additional responsibility was put on the shoulders of the physician, who had to provide the actual service to his or her patients. And finally, of course, the responsibility was on patients themselves “who must learn to assume more responsibility for their own health.”<sup>86</sup> This insistence on patient accountability has never been more emphasized than in our current context.

Based upon the current medical understanding of the connection between HPV and cervical cancer, provinces such as Ontario have been discussing the use of Gardasil, a vaccine for HPV marketed in Canada by Merck Frosst. The primary goal of this vaccine is to eliminate HPV from the cervical cancer equation, in addition to preventing the spread of genital warts. There is an obvious risk that this vaccine will develop into the primary mode of cervical cancer prevention. However, while this vaccine is useful, Pap smears are still necessary. Many of the early Gardasil campaign strategies in North American were fuelled by highly risky agendas. Promising to have a direct impact on an “individual’s experience of risk,” the vaccine has been constructed and marketed as one that could also bring “relief from feelings of randomness, shame, and stigma.”<sup>87</sup> While

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<sup>86</sup> J. Robert Willson et al. *Obstetrics and Gynecology*. (St. Louis: The C.V. Mosby Co., 1983), 637.

<sup>87</sup> Robert Aronowitz. “Gardasil: Vaccine against Cancer and a Drug to Reduce Risk,” in Keith Wailoo et al (eds), *Three Shots at Prevention: The HPV Vaccine and the Politics of Medicine’s Simple Solutions*. (Baltimore: The Johns Hopkins University Press, 2010), 26.

an extensive study of Canadian marketing strategies has not yet been completed, the American experience and exposure to Gardasil is not dissimilar to Canada's. Gardasil was approved for sale in 56 countries, including Canada, in 2006.<sup>88</sup> In September of 2007, Nova Scotia, Ontario, PEI, Newfoundland and Labrador public health officials began administering Gardasil to select groups of girls in grades 6, 7, and 8.<sup>89</sup> These immunization programs attract intense public debate. Politicians and religious leaders have all weighed in on the debate, arguing about the impact of Gardasil on sexuality and morality. Some researchers believe that Canada's National Advisory Committee on Immunization's recommendation to vaccinate is premature due to lack of extensive scientific knowledge of the vaccine. Another key debate is whether or not the HPV vaccine should be covered by the Canadian health care system. There is fear that if the Canadian government finances and mandates this vaccine, young girls will feel a newfound sexual freedom for a lifetime (even when the long term effectiveness of Gardasil is unknown).<sup>90</sup>

While the medical understandings of this disease are crucial, it is also important to place the science of cervical cancer within the context of the larger medical community. Historically, cancer has been a disease that has been a priority for the medical community. The key concern for the medical community, for the most part, has always been the diagnosis and treatment of cancer. Clearly it is necessary to diagnose and treat cervical cancer promptly and effectively; however, the history of cervical cancer is a

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<sup>88</sup> Pauline Comeau. "Debate Begins Over Public Funding for HPV vaccine." *CMAJ* vol. 176/7 (2007): 913.

<sup>89</sup> Laura Eggerston. "Adverse Events reported for HPV vaccine." *CMAJ* vol. 177/10 (2007): 1169.

<sup>90</sup> Comeau, 913.

unique one. Once it was understood that cervical cancer could be diagnosed in the very early stages of development, even at the *pre-cancerous* stages, a new language of prevention emerged in both cancer conferences in Canada and various medical journal editorials. Medical textbooks, especially gynecology textbooks, demonstrated a pattern in both the growing understanding the science of cervical cancer and concern about its prevention. The next section in this chapter charts early cancer conferences in Canada starting as early as the 1920s, the open-forum discussions in the *Canadian Medical Association Journal's* editorial section, and how Canadian medical doctors and researchers contributed to discussions regarding not the etiology, but the treatment and prevention of cervical cancer. While this dissertation highlights the post-WWII period, it is important to note earlier professional discussions of cancer in the medical community. These pre-war concerns carried over into the post-war period and once war concerns were less of a priority, governments and medical professionals alike turned their focus on the war on cancer. What did practicing physicians want – authority over screening in their own private offices, or a more organized population screening program managed externally? How valid was the Pap smear? How should doctors be educating their patients about cervical cancer?

#### **Canadian Medical Discussions of Cancer Treatment and Prevention:**

By the 1920s, the international medical community was responding to the cancer 'epidemic' via conferences and symposiums. Cancer was starting to be discussed in terms of bacteriology. This was a reflection of the medical community's recent success in curing TB. Borrowing from this success, it was believed that if they (the medical



community) spoke about cancer in terms of it being curable, similar to TB, it would render the disease “less mysterious and suggested it would be as easy to conquer as an infectious disease.”<sup>91</sup> A key symposium, in 1926, marked the international agreement that “human society needed to mount a response to cancer.”<sup>92</sup> Delegates from around the world, including Canada, arrived in Lake Mohonk, New York to organize a “war against cancer.”<sup>93</sup> Key points of discussion were issues surrounding public education and treatment facilities with adequate equipment and staff.<sup>94</sup> This symposium in New York was only the beginning. Key addresses at the Toronto Academy of Medicine in 1929 and a lead editorial in 1930 in *Canadian Journal of Medicine and Surgery* represented a call for a “national effort to combat cancer.”<sup>95</sup> Additional responses to the symposium in 1926 were various provincial cancer programs, starting in Saskatchewan in 1929, that were created across Canada.<sup>96</sup>

In 1947, a Cancer Conference was held in Ottawa, sponsored by the NCIC and the CCS. The conference’s main topic of discussion was “Cancer Control in Canada.” It was understood by many of the conference attendees that “for the person that has cancer today the greatest hope lies in early accurate diagnosis and treatment by an expert.”<sup>97</sup> Overall, it was clear that cancer prevention and cervical cancer were not a focus at the cancer conference, even with the Pap smear being well known throughout the medical

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<sup>91</sup> Charles Hayter. “Cancer: “The Worst Scourge of Civilized Mankind.”” *Canadian Bulletin of Medical History* vol. 20/2 (2003): 260.

<sup>92</sup> Ibid.

<sup>93</sup> Ibid.

<sup>94</sup> Ibid., 260-261.

<sup>95</sup> Ibid., 261.

<sup>96</sup> Ibid.

<sup>97</sup> LAC, RG 29, Department of National Health and Welfare, vol. 1183 file # 311-C1-37, “Cancer Conference - Ottawa” (1947).

community. There were five main topics for discussion at the conference: lay education, professional education (including fellowships), diagnosis and treatment, clinical research, and fundamental research. The first three of these topics are of particular interest as they would potentially pertain to cervical cancer screening. Discussions at the conference stressed that, according to the constitutional division of legislative authority, “the health of the citizen is a provincial responsibility, with certain exceptions...it seems proper, therefore, to regard the provision of diagnostic and treatment services as a provincial responsibility to be organized on a provincial basis.”<sup>98</sup>

The *Canadian Medical Association Journal* has been a consistent source of medical information over the years for Canadian medical students and physicians alike. Not only did this journal focus on current medical breakthroughs, it was also a place for open discussions between physicians on particular practices and approaches to health care delivery. A survey of this journal from 1945 to 1990 reveals that there was quite an extensive discussion of new medical understandings of cervical cancer, in addition to evaluations of existing screening programs, particularly the early organized screening that occurred in British Columbia. As the early parts of this chapter have demonstrated, the *CMAJ* was a large part of the greater international discussion of the etiology of cervical cancer. Despite this extensive exposure to the emerging understandings of the causes and treatment of cervical cancer, there was little discussion in the *CMAJ* of how to approach the topic of cervical cancer with female patients and how to promote public education about the prevention of cervical cancer.

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<sup>98</sup> Ibid.

Beyond general medical information about cervical cancer, I attempted to gather an understanding of what exactly medical students and practitioners were being told about how to approach screening within general health care facilities. The *CMAJ*, in particular, published many articles with regard to the role of the Pap test and its validity in practice. Since the Pap smear was not wholly embraced in Canada as a “cancer detector” until the 1960s, it is notable to see an article published in 1946 discussing the validity of the Pap smear. Ernest Ayre and Evelyn Dakin stated that while the “vaginal and cervical cytology smear [was] a relatively recent development in uterine cancer diagnosis,” it [was] “rapidly becoming established as a reliable and simple method of making a presumptive diagnosis of malignancy arising from the uterus.”<sup>99</sup> While the remainder of the article detailed how to obtain the smear, via scraping the cervix, and how to successfully prepare the smear for mailing to a lab, there was no discussion about how to approach the patient or educate the patient with regard to the Pap smear and its importance.

There was concern, however, in the same year the Ayre’s article was printed (1946) that too many physicians were brushing off female patients complaining of abnormal vaginal discharge. W.G. Cosbie argued in the *CMAJ* in 1946 that survival rates were noticeably better when the patient was treated within three months of the onset of symptoms.<sup>100</sup> The other point he raised was that too many physicians were simply sending their female patients home with “douches, pills and reassurance,” and not the

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<sup>99</sup> J. Ernest Ayre and Evelyn Dakin. “Cervical Cytology Tests in Cancer Diagnosis: Glycerine Technique for Mailing.” *CMAJ* vol. 54 (1946): 489.

<sup>100</sup> W.G. Cosbie. “The Early Recognition of Uterine Cancer.” *CMAJ* vol. 55 (1946): 238.

proper referral of the patient for treatment.<sup>101</sup> Cosbie was concerned that physicians did not “thoughtfully” consider the complaints of the female patient.<sup>102</sup> There was also a concern in the 1940s that physicians simply lacked the proper equipment to perform Pap tests, even if they were enthusiastic about them.<sup>103</sup> It is important to note that in the 1940s cervical cancer was the second most common form of cancer in women.<sup>104</sup>

It was not just Papanicolaou who was making a mark on developing understandings of the prevention of cervical cancer; a Canadian female doctor, Dr. Marion Hilliard, also contributed much to the prevention of this disease. In early 1950 Dr. Marion Hilliard, a renowned obgyn at the Women’s College Hospital in Toronto, published an article in the *CMAJ* that claimed that she had found a more efficient and practical method for the detection of cervical cancer (keep in mind that these detection methods were not used to detect *pre-cancerous* conditions), based on the foundation of what Papanicolaou and others in the field had found earlier. She argued that it was not practical to think that all physicians had easy access to a trained cytologist and the necessary laboratory to read a Pap smear, and she had found a method that could be used by gynecologists and general practitioners alike.<sup>105</sup> The new method involved using a new collection technique – one that scraped serial secretions and did not involve any pain associated with biopsies. She argued that the cervical scraping method was more

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<sup>101</sup> *Ibid.*, 239.

<sup>102</sup> *Ibid.*

<sup>103</sup> Edwin Robertson wrote an article, “Cell Smears in the Diagnosis of Carcinoma,” that only select doctors were given equipment, part of an examination of the accuracy and popularity of the test, and even then the doctors were not properly educated in how to prepare the smear for proper reading. *CMAJ* vol. 59 (1948): 148-151.

<sup>104</sup> Maxwell Evans. “The treatment of carcinoma of the cervix uteri.” *CMAJ* vol. 59 (1948): 458.

<sup>105</sup> Marion Hilliard. “Cervical Scrapings Test.” *CMAJ* vol. 62 (1950): 235.

accurate because even the “best placed biopsies” often missed questionable cells.<sup>106</sup>

While she detailed how to use her new method, she did not discuss how the practitioner should discuss the process with female patients or educate them about cervical cancer in general. It was clear that in 1950 it did not seem reasonable to use government public health funds to encourage the adult female population to “present themselves for vaginal smear examination at regular intervals” when there were clear issues with the technique of obtaining the smears and insufficient trained cytologists to accurately read the smears.<sup>107</sup>

There were various articles throughout the 1950s mentioning the pap/vaginal smear as not necessarily an accurate test for diagnosis. Even when authors referred to the Pap test as accurate, they often followed the statement with “radical treatment is justified only if confirmatory evidence [beyond the smear] is obtained.”<sup>108</sup> Another author in the same year stated that it was “evident that even in skilled hands occasionally false positive reports will be made.”<sup>109</sup> Dr. Desmond Magner argued that in 1950 “it does not seem that such procedures can be recommended because of the unavailability of a sufficiency of trained personnel, the high cost, and the relatively low yield of symptomless cases of cancer to be expected.”<sup>110</sup>

As mentioned earlier, screening for cervical cancer via the Pap test became more common during the 1960s as a test for pre-cancerous conditions. At a symposium focused solely on cervical cancer in 1965 “the value in cytology in the management of

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<sup>106</sup> Ibid.

<sup>107</sup> Desmond Magner. “Exfoliative cytology diagnosis.” *CMAJ* vol. 63 (1950): 108.

<sup>108</sup> Deward Ferris. “Carcinoma of the Uterus.” *CMAJ* col. 62 (1950): 161.

<sup>109</sup> Desmond Magner, “Exfoliative cytology diagnosis,” 104.

<sup>110</sup> Ibid., 109.

carcinoma of the cervix [was] recognized.”<sup>111</sup> The result of this widespread acceptance of the Pap smear by general physicians was a series of articles on the successes of the British Columbia screening program. The first of the series simply argued that because the use of cytology to detect cervical cancer in its pre-cancerous stages was so simple, a large-scale screening program was deemed practical. Fidler *et al.*, argued that the population screening program in BC had been successful in dropping the incidence of invasive carcinoma by 30.6% over a period of 6 years.<sup>112</sup> The second article in the series focused on the organization, staffing, and training of the staff of the laboratories processing the smear slides. Also, the article discussed the importance of various “cancer forums” that had been held around the province at large meeting halls or theatres, in addition to public showings of “Time and Two Women,” a film that dealt with the “value of exfoliative cytology in genital tract disease.”<sup>113</sup> The final article in the series focused on the treatment of preclinical carcinoma of the uterine cervix and detailed the various recommended diagnostic steps. There was no discussion of public education or education within the walls of the physician’s office.<sup>114</sup>

At the same time the international medical community was making the connections between HVH2 infections and cervical cancer, another cancer conference was held in 1967 in Montreal, sponsored by the National Cancer Institute of Canada, with

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<sup>111</sup> Ivan Smith, E.N. MacKay, and A.H. Sellers, “A symposium on cancer of the cervix uteri.” *CMAJ* vol. 84 (1961): 351.

<sup>112</sup> H.K. Fidler et al. “The Cytology Program in British Columbia: I. An evaluation of the effectiveness of cytology in the diagnosis of cancer and its application to the detection of carcinoma of the cervix.” *CMAJ* vol. 86 (1962): 784.

<sup>113</sup> H.K. Fidler et al., “The Cytology Program in British Columbia: II. The operation of the cytology laboratory.” *CMAJ* vol. 86 (1963): 829.

<sup>114</sup> F.E. Bryans et al., “The Cytology Program in British Columbia: III. Management of Preclinical carcinoma of the cervix.” *CMAJ* vol. 90 (1964): 62-70.

the purpose of discussing the prevention and control of cancer. In comparison with conferences in the past, the meeting was under the direction of doctors from British Columbia and Ontario, the majority from British Columbia. This conference focussed more on cervical cancer screening options and the impact of mass screening on incidence and mortality rates. British Columbia was the first province to develop a central cervical cytology lab and screening program available to the entire population of the province. Their representation at such conferences was instrumental in convincing other provinces of the need for organized screening programs. In general, it was believed that “the meeting had been worthwhile in that it had achieved its purpose of stimulating frank and informal discussion of certain aspects of the problem of cancer. It was hoped that the conference might stimulate interest in this area on the part of younger members of the medical staff of teaching hospitals.”<sup>115</sup> Finally, an open discussion about the importance of cervical cancer screening occurred. This was important for a few reasons: to help bring about change in other provinces besides BC; to demonstrate that change was very much an option; and to force evaluation of the other provinces and their poor response.

During this conference, Dr. D.A. Boyes<sup>116</sup>, from British Columbia, reported on the impact that a mass screening program had on cervical cancer rates. He reported that “the fall in morbidity from invasive cervical carcinoma in the Province [British Columbia] was shown to be about 50% when two thirds of the female population 20

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<sup>115</sup> LAC, RG 29, file # 311-C1-8, “The Role of Mass Surveys in The Detection of Cancer.”

<sup>116</sup> Dr. David Boyes was the former head of the BC Cancer Agency from 1960-1987. He was, along with Dr. H.K. Fidler responsible for the first organized program in the world to screen for cervical cancer. He also initiated training programs and public education programs focusing on cervical cancer. A group of gynaecologists and oncologists started the “D.A. Boyes Society” that meets annually to discuss various oncology topics. <http://www.obgyn.ubc.ca/CME/daboyes.html> (accessed on March 30, 2011)

years and over had been examined.”<sup>117</sup> Mortality rates from cervical cancer had shown little change in the rest of the country – a result, Dr. Boyes believed, of a lack of organized screening programs in other provinces. Dr. Boyes also discussed the benefits of having a central laboratory as opposed to several private labs, as “the large volume of specimens also keeps down the cost per specimen.”<sup>118</sup>

The idea of self-sampling Pap smears was also discussed. Dr. Anderson from the Ottawa Civic Hospital announced that the “accuracy of the resulting screening was lower than for cervical scrapes.”<sup>119</sup> Although the technique was questionable, it was agreed at the conference that it might have potential success in communities where medical personnel were not available to take specimens during a pelvic examination. Despite this discussion, it was eventually concluded that self-sampling had no place in an area where appropriate medical personnel were available.<sup>120</sup> Self-sampling also had been proposed a few years prior to this conference by Dr. M.B. Dymond, Minister of Health in Ontario in 1964. Dymond discussed the option of self-sampling as opposed to the costly Pap smear being done in the physician’s office. He believed that it was an excellent way to save money for the provincial government, even though the procedure was often questioned because of the numbers of false-negatives. In a 1964 memorandum to Dymond, Deputy Minister Dr. W.G. Brown concluded that any shift in the direction of a do-it-yourself

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<sup>117</sup> LAC, “The Role of Mass Surveys in the Detection of Cancer.”

<sup>118</sup> Ibid.

<sup>119</sup> Ibid.

<sup>120</sup> Ibid.



examination program would be a mistake and would hinder the progress of an organized provincial program screening program.<sup>121</sup>

In order to gain a better understanding of the health issue of cervical cancer, provincial governments all over Canada sought to establish task forces with reporting responsibility to the Minister of Health in each province. In 1973, at the Conference of Provincial Ministers of Health in Charlottetown, Prince Edward Island, many provinces did in fact establish task forces. For example, the Quebec minister proposed the establishment of several expert task forces to study the screening and therapeutic programs that would be useful in battling cervical cancer across the country. Each task force had specific instructions, and in their report in June of 1976, the Walton Report, the following recommendations were made:

1. Health authorities should encourage and support screening programs for cancer of the cervix;
2. women should be informed of their degree of risk of developing cancer;
3. a schedule of screening should be designed according to degree of risk;
4. quality control in laboratories should be encouraged; and
5. registries should be maintained for follow-up, and designed to permit inter-registry comparison.<sup>122</sup>

Other recommendations included regulated provincial registries to record data and carry out recalls both at regular and long-term intervals, and to ensure that all physicians and recording databases use a uniform terminology.<sup>123</sup> In a personal reflection on the task force, R.J. Walton revealed that the members of the task force, unanimously, believed that Canadian cervical cancer screening programs were only going to become more

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<sup>121</sup> Archives of Ontario(AO), RG 10, file # 1-1-3.40, "Cancer Research - Pap Smear, 1964."

<sup>122</sup> LAC, RG 29, vol. 1180 file # 311-C1-21, National Cancer Institute of Canada. "Briefing Notes for the Minister - Cervical Cancer Screening."

<sup>123</sup> R.J. Walton et al. "Cervical Cancer Screening Programs: V. Conclusions and recommendations." *CMAJ*, vol. 114 (1976): 1033.

effective if there was a reduction in the frequency of screening women who did not necessarily need to be screened, and further deployment of resources to concentrate on women most at risk. He also noted that even with recommendations on the frequency of smears “will be implemented only if the health professionals and, even more important, the public at large are persuaded that this is a reasonable thing to do.”<sup>124</sup> Although it would be many years before these recommendations would be put into place in Canada, they demonstrated that there was a general sense that women needed to be more informed about their own health care and that quality, in both collection and evaluation of smears, was simply not yet at an optimal level.

In the early 1970s there were many professional evaluations and discussions of cervical cancer. Concurrently with the establishment of the task forces in 1973, a prominent editorial debate exploded in the *Canadian Medical Association Journal*. A fairly extensive editorial was written in the *CMAJ* in 1974. This editorial responded directly to those medical professionals who still challenged the usefulness of cervical cytology in early detection and treatment and causing a marked reduction in incidence and mortality from invasive carcinoma.<sup>125</sup> Dr. Ann J. Worth<sup>126</sup> argued further in this editorial that this consistent disappointment in the charted successes of population screening was “a result of premature attempts to assess the programs before sufficient time had elapsed for rates to respond.” She argued “short-term studies leave little doubt that a marked reduction in the incidence of invasive carcinoma can be achieved. Such

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<sup>124</sup> R.J. Walton. “The task force on cervical cancer screening programs.” *CMAJ* vol. 114 (1976): 981.

<sup>125</sup> A.J. Worth. “Cervical Cytology Screening.” *CMAJ* vol. 110 (1974): 129.

<sup>126</sup> Dr. Ann J. Worth was a researcher at the British Columbia Cancer Institute when she wrote this editorial.

studies, however, do not produce mortality data.” She believed that proper mortality data required “extensive follow-up systems” as well as “estimates of migration and of the age of distribution within the populations under study.”<sup>127</sup> This inaccuracy, Dr. Worth argued, made it impossible to compare mortality rates between different areas, therefore making it impossible to recognize areas of a program that need improvement. She also spent a considerable amount of time in this editorial being critical of the classification system in Canada. While “unspecified uterus” cancer deaths were on the decline, this general terminology caused many earlier statistics to be understated in comparison to a more detailed classification of different types of uterine cancer deaths.<sup>128</sup> So what did Dr. Worth really want in terms of a screening program? She wanted to move beyond unsuccessful “media propaganda” and put more stress on “personal contacts,” as they had proved to be more effective. She wanted an increase in the “utilization of community health resources, family planning clinics, and ‘in hospital’ screening, possibly supported by selective screening of high-risk groups.”<sup>129</sup> She ended her editorial by stating that it was the general medical practitioner who was most suitable to offer the necessary care in terms of cervical cancer screening.<sup>130</sup>

In response to Dr. Worth’s editorial, two other doctors weighed in on the debate about the validity of population screening vs. general practice screening. Lending his support to Dr. Worth and the value of cervical cytology screening, Dr. Andrus J. Voitk from the Department of Surgery at the University of Manitoba stated that while he was

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<sup>127</sup> Ibid.

<sup>128</sup> Ibid.

<sup>129</sup> Ibid.

<sup>130</sup> Ibid.

running his own private practice (before he closed it to focus solely on surgery) he routinely screened his female patients as part of a complete assessment. He believed that “the routine use of a Pap smear was undoubtedly the single most useful screening test in [his] practice.”<sup>131</sup> Another physician, Dr. Frank White of the Department of Epidemiology and Health at McGill University was quite critical of Dr. Worth’s inadequate interpretation of why “no unequivocal decline in mortality has been reported.” He also was highly critical of Dr. Worth’s statement that the majority of dysplasias and in situ eventually progress to invasive carcinoma. Dr. White further complicated this statement arguing that until it was clear “what proportion” of these dysplasias and in situ actually progress to invasive carcinomas and “how these compare with the proportion of invasive carcinoma which may occur spontaneously in a previously normal cervix,” the “predictive value of an ‘abnormal’ smear will remain undetermined.”<sup>132</sup> He ended his article arguing that the “controversy surrounding the validity of this procedure and the adequacy of its application as a publically sponsored program should not be so easily laid to rest.”<sup>133</sup> Clearly Dr. White was reluctant to support population screening, even with the Walton Report on the horizon. In a final editorial based on Dr. Worth’s original response, Dr. Worth herself weighed in one last time on the debate. While many clinical studies were far from precise in both their collection and interpretation of medical data, Worth argued, one should “refrain from reaching a decision about clinical usefulness until data have been presented that will satisfy every critic.”<sup>134</sup> The most salient factor,

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<sup>131</sup> Andrus J. Voitek. “Cervical Cytology Screening: editorial.” *CMAJ* vol. 110 (1974):893.

<sup>132</sup> Frank White. “Cervical Cytology Screening: editorial.” *CMAJ* vol. 110 (1974): 894.

<sup>133</sup> *Ibid.*

<sup>134</sup> Dr. Ann J. Worth. “Cervical Cytology Screening: editorial.” *CMAJ* vol. 110 (1974): 894.

Dr. Worth further argued, was the need to truly understand the natural history of cervical cancer. Despite these criticisms, Dr. Worth remained firm in her belief that “until the time that a test of more predictive value is developed, thoughtful incorporation of cytology into clinical practice has much to offer.”<sup>135</sup> So, as these editorials indicate, as late as the 1970s, physicians still considered population screening very much debateable as a successful approach to eradicating cervical cancer mortality.

After the Walton Report in 1976 the *CMAJ* published many articles discussing cervical cancer, screening programs, and the results and recommendations of the task force.<sup>136</sup> One of the key aspects of the concluding article to the series dedicated to the task forces results was the recommendation that “appropriate means should be employed: (a) to inform women of their degree of risk of developing carcinoma of the cervix, and (b) to persuade all women at risk to participate in the screening program.”<sup>137</sup> This particular article was the first time any clear recommendations were made to physicians about how to handle their female patients in regards to their risk of developing cervical cancer and to encourage them to undertake screening, presumably by educating them about their risk. In a congratulatory editorial, a pathologist from Manitoba openly

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<sup>135</sup> *Ibid.*

<sup>136</sup> The key issues are vol. 114 and 115 (1976). The following articles are of interest: G.H. Anderson, “Editorial: Cervical Cancer Screening Programs: a pathologist’s viewpoint.” *CMAJ* vol. 114 (1976): 981a-982; “Cervical Cancer Screening Programs. III. Components of a practical screening program for carcinoma of the cervix.” *CMAJ* vol. 114 (1976): 1027-1031; “Cervical Cancer screening programs. IV. Relations between screening programs for carcinoma of the cervix and other screening and preventive programs in Canada.” *CMAJ* vol. 114 (1976): 1031-1033; “Cervical Cancer screening programs. I. Epidemiology and natural history of carcinoma of the cervix.” *CMAJ* vol. 114 (1976): 1003-1012; “Cervical cancer screening programs. II. Screening for carcinoma of the cervix.” *CMAJ* vol. 114 (1976): 1013-1026; “Cervical cancer screening programs. V. Conclusions and recommendations for the task force.” *CMAJ* vol. 114 (1976): 1033; J.D. Brown, “Cervical cancer screening programs.” *CMAJ* vol. 115 (1976): 1078b; and D.W. Penner, “Cervical Cancer Screening Programs.” *CMAJ* vol. 115 (1976): 725-729.

<sup>137</sup> Cervical cancer screening programs. V. Conclusions and recommendations for the task force.” *CMAJ* vol. 114 (1976): 1033

thanked the task force for all their hard work in evaluating the current status of cervical cancer screening. In addition to their congratulations, they also offered some solid recommendations and solutions to improve cervical cancer screening opportunities. While Dr. Penner was critical of the portion of the report that discussed quality control, he was clearly appreciative of the successes of the task force.<sup>138</sup>

There was evidence, however, that shortly after its release some physicians took offence to the task force's reports. For example, in the same year Dr. J.D. Brown wrote an editorial professing his disgust with the "complete lack of understanding by the academic medical community regarding the practice of medicine at the grass-roots level." He was offended that the report insinuated that physicians working in clinics were not using the Pap smear, when all along Dr. Brown had "successfully used the Pap smear as a carrot to convince women to come in for annual check-ups."<sup>139</sup> It was obvious from Dr. Brown's arguments that some physicians were using the Pap smear as a tool to encourage well check-ups and to educate their female patients about genital tract health. The task force for cervical cancer screening in Canada, however, had worked under the premise that physicians were not consistently and efficiently using the Pap smear. Dr. Brown also pointed out that the task force reports mentioned that high-risk women should be undergoing cytology screening via several different types of clinics, but "fail[ed] to mention that all women should have a family physician who [was] equally capable of making these examinations."<sup>140</sup> Whether the response to the task force reports were

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<sup>138</sup> D.W. Penner, "Cervical Cancer Screening Programs." *CMAJ* vol. 115 (1976): 725.

<sup>139</sup> J.D. Brown, "Cervical cancer screening programs." *CMAJ* vol. 115 (1976): 1078b

<sup>140</sup> *Ibid.*

negative is moot; more importantly these open forum dialogues demonstrate that physicians practicing in their own clinics were, in some cases, actually using the Pap smear as a tool to encourage well check-ups in their female patients, all the while educating them about the importance of a yearly Pap smear.

In 1980, the Task Force from the Walton Report of 1976 was reconvened to “review the conclusions and recommendations of the 1976 report in the light of new data that might support or modify the conclusions in which the original recommendations were based.”<sup>141</sup> In other words, some of the conclusions from 1976, such as the suggestions that non-high risk women should not be screened annually, caused enough of a stir for the same group of researchers to carefully reevaluate these findings. It was clear from the numerous editorials written in the *CMAJ* responding to the 1976 findings that many Canadian doctors were troubled and often offended by the conclusions printed. The findings of the 1982 report were similar to the 1976 report and offered a few new additions. Stressing the importance of focusing on high-risk women who had never been screened, all others (such as women over the age of 35 with previous normal smears) should be screened either as per request of the patient or based on an evaluation by a physician.<sup>142</sup> The additional chapters included in this report were focused on “groups at risk, mathematical models of screening, quality control in screening programs, cytologic screening of the Canadian population and management of patients with abnormal

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<sup>141</sup> 1982 Task Force. “Cervical cancer screening programs: summary of the 1982 task force report.” *CMAJ* vol. 127 (1982): 582.

<sup>142</sup> *Ibid.*, 588.

smears.”<sup>143</sup> Also, this newer report offered suggestions with regard to quality control in labs, frequency of screening, and various ideas for follow-up mechanisms.<sup>144</sup>

By the mid-1980s, both as a result of the 1976 Walton Report and the reconvened Task Force in 1980, there was an explosion in numbers of articles about cervical cancer (and its connection with HPV infection) in the *CMAJ*. Between 1983 and 1990 there were seven “original research” articles and numerous editorials written in the *CMAJ* debating not only the 1982 recommendations, but also arguing about who should provide and promote preventive health care. There were also reports about individual approaches to cervical cancer screening. The first two “original research” articles were focused on the problems in the accuracy of reporting and registration of invasive cervical cancer. Aileen Clarke and Shelly Hilditch reported on their study which illustrated the problems in interpreting data from different cancer registries. Since up until more recently cancer registries had not consistently monitored indexes of reliability of reporting and rarely “endeavour[ed] to correct problems as they occur[ed],” without such corrections cancer registry data had to be taken subjectively.<sup>145</sup> Clarke and Hilditch’s study revealed that while registries are vital to understanding cervical cancer incidence in Canada, “reporting procedures must be assessed before differences are ascribed to other causes, such as socioeconomic conditions or the extent of cervical cytologic screening in the population served by the registry.”<sup>146</sup>

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<sup>143</sup> Ibid., 582.

<sup>144</sup> Ibid.

<sup>145</sup> E. Aileen Clarke and Shelly Hilditch. “Problems in determining the incidence of cervical cancer.” *CMAJ*, col. 129 (1983): 1273.

<sup>146</sup> Ibid.



Janice Husted, Terence Anderson and Richard Gallagher published an article in the same issue focusing solely on British Columbia and the inherent problems in their reporting system. The problem they found was that an invasive cancer was reported immediately after the first pathology report; however, if the secondary pathology report showed no cancer at all, the initial report was not changed. This, obviously, was causing serious false “high” rates of invasive cervical cancer. The solution they offered was clear – to provide a system of quality control procedures for “checking the reliability of the information received and the consistency of the coding practices.”<sup>147</sup> All other articles up until 1990 that were related to cervical cancer focused on ethnicity, treatment, provincial preventive screening, and HPV.<sup>148</sup>

Editorials in the *CMAJ* were also common after the 1982 Task Force report was printed. Seven editorials and letters to the editor were printed between 1982 and 1985, most focusing on the challenges of screening and who should be in charge of promoting and providing preventive health to women in Canada.<sup>149</sup> One of the intriguing responses written was by Clair Marcus – allowing Dr. Boyes from B.C. to respond both the 1976

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<sup>147</sup> Janice A. Husted, Terence W. Anderson, and Richard Gallagher. “Accuracy of registration of invasive cervical cancer.” *CMAJ*, vol. 129 (1983): 1277.

<sup>148</sup> Aileen Clarke, Nancy Kreiger, and Robert Spengler. “Second primary cancer following treatment for cervical cancer.” *CMAJ* vol. 131 (1984): 553-556; T. Kue Young and N.W. Choi. “Cancer Risks among residents of Manitoba Indian reserves, 1970-79.” *CMAJ* vol. 132 (1985): 1269-1272; Renaldo Battista, Cynthia Palmer, Beatrice Marchand, and Walter Spitzer. “Patterns of preventive practice in New Brunswick.” *CMAJ* vol. 132 (1985): 1013-1015; and Deoraj Caussy, Loraine D. Marrett, Ann Worth, Mary McBride, and William Rawls. “Human Papillomavirus and cervical intraepithelial neoplasia in women who subsequently had invasive cervical cancer.” *CMAJ* vol. 142 (1990): 311-317.

<sup>149</sup> Please see: T.W. Lees, “Frequency of screening for cancer of the cervix.” *CMAJ* vol. 125 (1981): 696; Peter Morgan, “Challenges in screening for cancer of the cervix: delivery, technology and evaluation of programs.” *CMAJ* vol. 127 (1982): 571-572; Peter Grantham, “The annual physical: what should we be doing.” *CMAJ* vol. 128 (1983): 271; Gerry Hill, “Counting cancers.” *CMAJ* vol. 129 (1983):1262-1263; Clair Marcus, “Pap test frequency: still controversial.” *CMAJ* vol. 130 (1984): 1373-1375; Kathryn Wilkins and John Hoey, “Who should promote health and provide preventive care.” *CMAJ* vol. 132 (1985): 903-905; and Hilary Southhall, “Who should promote health and provide preventive care? A cautionary note.” *CMAJ* vol. 133 (1985): 97-99.

and 1982 reports. Dr. Boyes reported that it was “not the time to give up on Pap smears,” and that asking women to come in every three years as opposed to annually for a Pap smear would ultimately result in the loss of the patient. It was hard enough for doctors to convince their patients to come in every year, resulting in most of them showing up every two years for a Pap smear.<sup>150</sup> Dr. Boyes argued that most of the recommendations made by either report were looking to evaluate the usefulness of the Pap smear from an “epidemiological and statistical point of view, rather than from the physician’s or patient’s point of view.”<sup>151</sup>

Hilary Southall discussed the use of other health care providers in her article, “Who should promote health and provide preventive care? A cautionary note”. Nurse-practitioners, for example, could be used to alleviate some of the stresses of primary care services on family physicians.<sup>152</sup> Such practices would reduce the cost of prevention and screening. These editorials are indicative that the use of the Pap smear within physicians’ offices or via a more organized screening program was not a straightforward concept. While the science of Pap smear was well-established by the 1980s in Canada, questions of cost-effectiveness, lab quality control, and screening intervals were still up for debate.

### **Conclusion:**

The long history of the etiology of cervical cancer demonstrates that two risk factors stayed constant – sexual activity and a viral connection. Whether it was related to parity, trauma to the cervix, or eventually disease, sexual activity continued to be a risk

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<sup>150</sup>Marcus, 1374, 1375.

<sup>151</sup> Ibid., 1375.

<sup>152</sup> Southall, 98.

factor for developing cervical cancer well into the twenty-first century. Equally consistent was evidence of a constant search for a viral connection to the development of cervical cancer. Starting with a vague connection made between prostitutes with syphilis, to the herpes type 2 virus, and eventually the HPV in the 1980s, it was clear that the medical community was convinced a virus of some sort played a role in the development of cervical cancer. My research revealed that this was an era of uncertainty in terms of the clear cause of cervical cancer, and it was not until the late 1980s that the medical community felt like they could confidently say they had found an undisputable risk for cervical cancer. Cervical cancer was not like other cancers such as breast or uterine cancer; it was consistently treated as a venereal disease throughout the twentieth century and medical researchers designed many of their studies accordingly. Even after decades of cancer conferences, symposiums, and government-funded task forces, cervical cancer was still connected to sexual activity. Once understandings of the connections between HPV and cervical cancer development (and later the vaccine to prevent HPV) were made the medical community finally had a scientific basis for this long-standing concern about sexual activity and cancer development. Also, this enduring concern tended to discourage women from seeking out screening simply because they did not feel comfortable disclosing this type of information to their health practitioner – or to risk being labelled promiscuous. Some doctors were even openly criticized for putting too much stress on the importance of loose sexual activity and cancer risk – resulting in fewer women seeking screening opportunities.

Despite the extensive debates about disease etiology and the validity of the Pap smear within the confines of medical journals and organized cancer conferences, doctors openly supported (and sometimes debated) the prevention of this disease via the Pap smear in more public arenas. Not only did many doctors openly support the Pap smear, but they also pushed for more public education with regard to prevention strategies that all Canadian women could employ. But as the next chapter will demonstrate, the physician's voice was not alone in attempting to educate the public about the prevention of cervical cancer. Prevention was not simply about the epidemiology of cervical cancer; the question was also how the Pap smear could effectively be mobilized throughout the mass population? *Chatelaine* magazine and women's health activists played distinctive roles in educating Canadian women about the need for Pap smears.

## **Chapter Two – Working Together: *Chatelaine*, Other Magazines, Health Activists, and Progressive Doctors talking about Cervical Cancer**

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This chapter, a study of all articles on cancer and cervical cancer published in *Chatelaine* from the 1940s to the 1990s, illustrates the vital role this magazine played in the public dissemination of cervical cancer information to Canadian women. This chapter also places *Chatelaine* features alongside other key feminist publications, and some of the literature that emerged out of the Women's Health Movement. This chapter illustrates how this movement influenced public dialogue about cervical cancer in key feminist publications from the 1970s onwards.

During the later decades of the twentieth century, *Chatelaine* played a prominent role in the dissemination of knowledge about cervical cancer. While much of the health information that was distributed related to mother and baby care and popular health topics like menopause and the birth control pill, ideas about prevention, viral connections, treatment options, and certainly medical advances in the understandings of cervical cancer slowly became part of feature articles and news releases. In the earlier decades of the twentieth century, it was clear that *Chatelaine* printed little information specific to cervical cancer. This was a time when public discussions about cancer focused on treatment and “conquering” cancer in general, and certainly not about prevention and cancers particular to women's reproductive organs. However, with the medical community slowly piecing together a stronger understanding of the

epidemiology and prevention of cervical cancer, the lack of focus on this particular disease drastically changed in the 1960s.

Who was reading *Chatelaine* during these decades and why is this factor important? Through Valerie Korinek's extensive research on *Chatelaine* in the 1950s and 1960s, we know that the average woman reading this magazine was "working class, of average or less than average incomes, and from both rural and urban locations."<sup>1</sup> And, unlike its American counterparts, *Chatelaine* continually embraced feminist material, representing what was important to its modern readers. Also, the all-female editorial staff (except for one male editor – only briefly) and several key female writers played a crucial role in the "final look" of each issue, reinforcing this reader-focussed material.<sup>2</sup> As Korinek argues, Canadian women could identify with the chief editors and writers of this magazine, as they were all from modest backgrounds, one even an immigrant. This connection also allowed Canadian readers to feel that they were actively taking part in the editorial design of each issue.<sup>3</sup> Cervical cancer may not have been a leading highlight of features and news releases during the 1950s and 1960s simply because Canadian women were not talking about it.

During the 1950s, arguably the peak of *Chatelaine's* existence, the editors and publishers focused on catering to a "mass, national audience of women because television did not offer much programming specifically devoted to women's issues."<sup>4</sup> Cervical cancer was hardly talked about within the private confines of the physician's office, let

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<sup>1</sup> Valerie Korinek. *Roughing it in the Suburbs: Reading Chatelaine Magazine in the Fifties and Sixties*. (Toronto: University of Toronto Press, 2000), 31.

<sup>2</sup> *Ibid.*, 70.

<sup>3</sup> *Ibid.*, 31.

<sup>4</sup> Korinek, 5.

alone on nationally broadcasted television. But as the most famous editor of *Chatelaine*, Doris Anderson, wrote in an article in the *Canadian Women's Studies Journal* in 1980,

now that I look back on the 1960s, I feel *Chatelaine* was a kind of closet feminist magazine. We had to be. We had a circulation of over a million women. *Chatelaine* had to appeal to all women in Canada. We also were frequently reminded through letters, of our middle-class, traditional audience. I was accused of 'breaking up the family.' For two years after we ran the first article urging that abortion be made legal in 1960, I was the target of a threatening letter-writing campaign aimed at closing the magazine and having me fired.<sup>5</sup>

This more conservative approach may have discouraged discussion of more racy health issues such as cervical cancer, as Anderson points out, in order to maintain healthy circulation numbers.

It is important to note that *Chatelaine* was not the only woman-focused periodical that Canadian women were reading, particularly in the 1970s and 1980s. *Healthsharing*, *Kinesis*, *Homemaker's Magazine*, and for a short period, *Makara*, were all widely distributed and read woman-only (and arguably feminist) publications in Canada that directly, or indirectly, dealt with women's health issues. *Healthsharing*, obviously, was keenly aware of key health care issues that affected Canadian women, but surprisingly cervical cancer only made one key feature in its 15 year existence. However, throughout those 15 years, *Healthsharing* writers openly discussed clinic service access, establishment of a health network, and issues such as literacy and health education that all were indirectly connected to cervical cancer prevention, education, and treatment. This chapter demonstrates that despite the existence of numerous woman-only

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<sup>5</sup> Doris Anderson. "Women's Magazines in the 1970s." *Canadian Woman Studies Journal* vol. 2/2 (1980): 16.

publications in Canada, *Chatelaine* proved to be the key location for a public dialogue about cervical cancer in the mid-twentieth century.<sup>6</sup>

This chapter will first discuss pre-1950s *Chatelaine* issues, and whether or not cervical cancer appeared as part of the health information printed. It was clear that cancer was on the minds of the editorial team during this decade, as there were often feature articles on women's experiences with cancer and information pieces written by doctors helping women know more about the signs of cancer. Cervical cancer, however, was seldom, if at all, discussed in an exceptionally clear manner. References to abnormal vaginal bleeding and how women needed to seek medical advice if such bleeding were noticed hinted towards awareness of cancer of the reproductive organs – but the words *cervical cancer* were never used directly. However, also without directly referencing cervical cancer, life insurance advertisements in the magazine during this period promoted fear of cancer in general and encouraged women to be wary of vaginal abnormalities. They also reinforced gendered assumptions about women's responsibility to stay healthy for their families.

The 1960s were much different from earlier decades. While they were still a “closet feminist magazine,” the editorial team was making notable strides in discussing more socially unacceptable sexual behaviours, such as promiscuity, and its potential connections with cancer development. From the early years of the 1960s cervical cancer continued to be a part of “Health News” in *Chatelaine*. There was often a focus on the

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<sup>6</sup> *Healthsharing* writers even admitted that most of their readership were probably had a post-secondary education, recognizing that this excludes at least 2 million women in the late 1980s. Mary J. Breen, and Janis Wood Catano. “Can She Read it? Readability and Literacy in Health Education.” *Healthsharing* vol. 8/2 (1987): 28.



key risk factors women needed to be aware of, such as early sexual activity, ethnicity and religious practices, and promiscuous sex. In the early 1960s, there was even the mention of the potential role a sexually transmitted virus, the herpes type II virus, had in the subsequent development of cervical cancer. This viral connection was the start of a trend that continued in the 1980s and 1990s. In the 1990s, a clear connection between HPV and cervical cancer development was made and was then reported in *Chatelaine*.

This chapter ends with an evaluation of the 1980s and 1990s issues of *Chatelaine*. As a result of the hard work of the women of the Women's Health Movement of the 1970s, cervical cancer was finally a comfortable part of the discussion of women's health and health awareness. There were several key features with direct focus on cervical cancer, in addition to several health news releases. While women's sexual activity remained a large part of the discussion, there was less judgment made about women's choices and more of a focus on how women could protect themselves from this type of preventable cancer – via annual Pap smears and awareness of their general reproductive health.

The chapter explores the degree to which *Chatelaine* managed to put medical knowledge into the hands of Canadian women in accessible terms. While most health information in the mid-twentieth century was presented in a more conservative fashion and reflected the limited medical understandings of the time, by the 1980s *Chatelaine* was successful in educating women about how to take an active role in protecting themselves from cervical cancer. Despite the fact that most of the main feature articles and news releases focussed on cancer, with mentions of cervical cancer, it was the self-

help pieces of the 1980s and 1990s, reflecting the influence of the Women's Health Movement, that were most empowering for women. While these features and some news releases during these later decades were clearly information-based, they were using a language that called on women to take the driver's seat in their health protection and described ways they could protect themselves from cancer. This empowerment, however, was not totally free of the "all-knowing" physician leading the way. Women were pushed to know more about their health care system and health care needs, but were also reminded that they needed to always consult their physician to assist them in making any key health care decisions.

#### **Pre-1950s:**

As early as 1930, *Chatelaine* was printing articles related to cancer. In an article written by "one of the best-known Canadian medical authorities" of the time, Dr. John W.S. McCullough, the prevention of cancer was discussed.<sup>7</sup> This was unique in that most articles or popular discourse on cancer at this time were focused on the diagnosis and treatment of the disease. Dr. McCullough stressed in this article that the general lack of public education on cancer resulted in more people dreading the disease. He believed, first and foremost, that the public needed to be educated if there was to be any hope of eradicating cancer.<sup>8</sup> He also argued that more diagnostic centres, special treatment centres in hospitals and properly trained staff were all vital to "clearing the Highway of Health [*sic*] of this affliction."<sup>9</sup> While he mentioned that cancer of the breast and womb

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<sup>7</sup> John W.S. McCullough. "The Prevention of Cancer," *Chatelaine*, November 1930, 15.

<sup>8</sup> *Ibid.*, 32.

<sup>9</sup> *Ibid.*

were the most common sites of cancer in women, he offered few prevention strategies other than early diagnosis. Clearly, as the first chapter in this dissertation demonstrates, understandings of the causes of cervical cancer (or cancer of the womb) still focused on childbearing with little understanding of its prevention. This article in *Chatelaine* represented the current medical understandings of the disease in the 1930s. Doctors were experts on cancer and even a women's periodical was comfortable in leaving these matters to the experts.

It was clear that, by the 1940s, *Chatelaine* was interested in printing features openly discussing cancer. For example, in November of 1945, Adele Saunders wrote an article titled "Plain Talk about Cancer." Adele Saunders was not a medical expert, and with "plain" in the title this implied that the information given was to be more accessible to lay women and did not require any formal medical knowledge of cancer. In this article, Saunders argued that it was the fear of cancer that was more "treacherous" than the disease itself.<sup>10</sup> Boostering the medical triumphs in the understanding of cancer in the twentieth century, Saunders clearly wanted people to believe that "cancer caught in its early stages is the most curable of all major causes of death, yet is the second greatest killer of our time. If prompt and adequate treatment is carried out, 70 to 80% of all early cancer is curable."<sup>11</sup> She mentioned cancer of the uterus and how in Canada at this time, it was responsible for 900 deaths a year. She reiterated the medical understanding of the time that women who had many children were more susceptible to cancer of the neck of

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<sup>10</sup> Adele Saunders, "Plain Talk about Cancer." *Chatelaine*, November 1945, 63.

<sup>11</sup> *Ibid.*, 13.

the womb. She believed that any abnormal bleeding should be a clear danger sign to all women.<sup>12</sup>

In the 1940s, in addition to features on cancer, numerous advertisements educated readers about the “danger signs” of cancer. Many of these ads (in small print attempting to sell life insurance) mentioned the “danger signs” and there were generally six or seven of them. They usually included the following: “any unusual lump or thickening; any irregular or unexplained bleeding; any sore that does not heal; loss of appetite or persistent unexplained indigestion; noticeable changes in the form or colour of a mole or wart; and any persistent changes in the normal habits of elimination.”<sup>13</sup> Some of the ads in the 1940s challenged how often people went to their doctors for regular check-ups. In 1947 the catch-phrase of one ad was “Had your health checked lately?” This ad further discussed the importance of visiting your doctor even when, ultimately, you might feel quite well. Another ad stated that “health is more than an absence of disease. A medical examination permits your physician to determine whether you are as healthy as you can be and *should be*, to live and work at your best.” This statement reinforced the idea that it was the individual’s responsibility to be an active and healthy addition to society and that there were remarkably basic ways to prevent disease. This ad further asserted that poor lifestyle choices would more than likely result in disease and sickness. Using the doctor as the authority figure, the ad stated that “by faithfully following his [the doctor’s] instructions you can do a lot to help assure yourself a longer, happier life.”<sup>14</sup>

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<sup>12</sup> Ibid., 31.

<sup>13</sup> Metropolitan Life Insurance Company, New York sponsored ad, *Chatelaine*, December 1945, 28.

<sup>14</sup> Metropolitan Life Insurance Company, New York sponsored ad, *Chatelaine*, October, 1947, 82.

As much as many ads in *Chatelaine* in the 1940s were promoting cancer awareness, sponsoring companies were also gaining considerable profit. Metropolitan Life Insurance Company based out of New York, with a Canadian office in Ottawa, sponsored most of these ads during the 1940s and 1950s. By contributing to the fear of cancer, Metropolitan Life Insurance ensured that people thought seriously about securing loved ones' futures, especially after their own deaths. From the standpoint of an insurance company, having people continue to fear cancer would encourage them to buy more life insurance. At the bottom of each ad the Ottawa office address was given, usually to order a cancer-related booklet, but also providing contact information for people interested in buying life insurance.<sup>15</sup> Cancer (or the fear surrounding it) was clearly exploited by companies such as Metropolitan Life. These types of ads were prevalent well into the 1950s.

Metropolitan Life had, and has, a long history of being involved with health care and health care prevention. For example, in the early twentieth century, Met Life insured about 80,000 people in Montreal. As early as 1909 the company offered some health services in areas where they insured a lot of workers in an attempt to lower mortality rates. By 1929 there were twenty-one nurses working in different municipalities across Quebec offering various health care services. Many of these services focused on hygiene during pregnancy, pre and post-natal visits, and the importance of nutrition and rest.<sup>16</sup> Met Life continued to have a vested interest in health care, and later, as was discussed, in

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<sup>15</sup> For an example of this, see any of the prior footnotes for Metro Life ads in *Chatelaine*.

<sup>16</sup> Denyse Baillargeon. *Un Québec en mal d'enfants. La médicalisation de la maternité, 1910-1970*. (Montreal: Éditions du remue-ménage, 2004), 155-158.

advertising for prevention of diseases such as cancer. In order to encourage the general public to reach for a “longer [and] happier life,” they had to have a sense of fear when facing diseases such as cancer. In the case of this research, Met Life invested a considerable amount of their advertising budget on gynecological cancer during the 1950s and 1960s.<sup>17</sup> The question, of course, was whether or not such fear mongering actually worked? Fear is an immensely powerful motivator when it comes to an unknown illness. Fear mongering can also be seen as unsuccessful, as numbers demonstrated that women were still not being screened as often as they should have been, and mortality and morbidity rates still existed for this disease.<sup>18</sup> In fact, fear mongering could push women to resist surveillance.

What is unique about the articles on cancer in *Chatelaine* by the late 1950s was the focus on patient experience. Some women were starting to speak out about their own experiences with cancer and their medical practitioners. This was an intriguing shift from general public cancer discussions to more publicly shared intimate experiences with cancer. This against-the-grain approach to articles, according to Korenik, was *Chatelaine*'s mantra of the 1950s. Not only were women of the 1950s and 60s not supposed to be talking about cancer because it was taboo, but also they were supposed to be focusing on post-war “affluence and good times of breadwinning dads and fulltime

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<sup>17</sup> For further detail of the success of screening during the 1950s and 60s see, Miller et al. “Mortality from cancer of the uterus in Canada and its relationship to screening for cancer of the cervix.” *International Journal of Cancer* vol. 17/5 (1976): 602-12.

<sup>18</sup> Canada did not establish a National Cancer Incidence Reporting System until 1969. Statistics Canada created this system in collaboration with the National Cancer Institute of Canada and various provincial cancer registries. Cancer mortality and morbidity data prior to 1969 is difficult to obtain. While by 1969 most provinces and territories were legally obligated to report cancer cases, a few provinces remained voluntary (Newfoundland, New Brunswick, and Ontario). In 1969 there were 1886 new cases of cancer of the cervix uteri reported. *Statistics Canada*, “Cancer Incidence in Canada, 1969-1993.” (Minister of Industry, 1997), xiv, 10.

moms.”<sup>19</sup> Women were also under considerable pressure to behave in particular ways with regard to their sexuality, knowledge of their bodies and deference to (male) authority. Through this new type of writing, women were validating themselves as experts about their own bodies, and proving that they no longer required physicians to authenticate their experience or their knowledge.

During the mid-1950s a gynecologist and obstetrician by training, Dr. Marion Hilliard, published many articles in *Chatelaine*. Who exactly was Dr. Hilliard? Dr. Anna Marion Hilliard graduated from the University of Toronto Medical School in 1927. Her first appointment was as the assistant to Dr. Marion Kerr, Chief of the Department of Obstetrics and Gynecology (also at the University of Toronto) in 1928. She was eventually appointed as the Chief of the Department in 1947 and she remained in this position until her retirement in 1956.<sup>20</sup> She spent some time in the 1930s traveling abroad furthering her studies in obstetrics and methods of overcoming sterility in women.<sup>21</sup> She is particularly famous for her involvement in the establishment of the Cancer Detection Clinic at the Women’s College Hospital, claiming to be the first of its kind in Canada, which opened in 1948. Although the idea of the clinic was the diagnosis of cancer and not necessarily its prevention, it was a pivotal part of Ontario’s activity in cancer control. The clinic was originally opened with the support of a provincial grant and later funded by the Ontario Cancer Research and Treatment Foundation (OCRTF). Hilliard was fundamental to its success through her constant and enthusiastic lobbying.

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<sup>19</sup> Korenik, 7.

<sup>20</sup> [www.womenscollegethosptial.ca/about/who-was-Hilliard-html](http://www.womenscollegethosptial.ca/about/who-was-Hilliard-html)

<sup>21</sup> Ibid.

Within two decades of its establishment, asymptomatic and symptomatic women and men were being examined and treated at the clinic.<sup>22</sup> All patients had to be referred to the clinic by their own physicians and the clinic simply did not “take patients off the street.”<sup>23</sup> The OCRTF could no longer subsidize the clinic after a short while, and fees were required of all patients. Eventually the cost per patient reached as high as \$19.13. This fee included the doctors’ fees, x-ray, laboratory fees, a nurse, supplies, and administration.<sup>24</sup> This clinic was reaching only a small portion of Ontario’s female population – those who lived in the Toronto area and had the funds to pay for such a health service.

Other notable accomplishments on Dr. Hilliard’s record included chairing the doctors’ committee for the hospital’s building campaign in 1952 and establishing the Women’s College Hospital as a teaching hospital in 1956. During the early campaigning for the hospital’s building committee, Dr. Hilliard convinced CBC radio to broadcast, live, the birth of a baby on November 30<sup>th</sup>, 1952. This, of course, was in hopes of generating interest and funding for the new building project. Other fund-raising campaigns included writing her two books, *A Women Doctor Looks at Love and Life*, and *Women and Fatigue*, with all proceeds going towards the hospital’s new wing. She also wrote several articles for *Chatelaine* during the mid-1950s.<sup>25</sup>

Dr. Hilliard passed away on July 15, 1958, tragically, from cancer. Even after her death, *Chatelaine* continued to publish many articles Hilliard had already prepared. Her

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<sup>22</sup> Women’s College Hospital Archives. N4-Container 45, “History of the Cancer Detection Clinic.”

<sup>23</sup> Women’s College Hospital Archives. N4-Container 59 –file #1 “History of the Cancer Detection Clinic – Women’s College Hospital.”

<sup>24</sup> Ibid.

<sup>25</sup> Ibid.



book, *Women and Fatigue*, was also published posthumously. Also in 1964, Marion O. Robinson, a good friend of Hilliard's, published a four-part series chronicling Dr. Hilliard's life. She told the story of Hilliard's childhood, with her Methodist Sunday school teacher and downtown lawyer father and a mother who was also active in the Methodist church and was said to be full of laughter. Robinson told of Hilliard's success at school, even at a very early age, setting the stage for great things. Hilliard was also a famed campus athlete, starring in everything from hockey to tennis.<sup>26</sup> Robinson also focused on Hilliard's contributions to the YMCA, overseas work, lectures at Victoria College, and her introduction of the Pap smear at not only the outpatient clinic at the hospital, but also at the newly formed cancer clinic in Toronto in 1947.<sup>27</sup> Ironically, however, despite her work with regard to the Pap smear, she did not exploit her position at *Chatelaine* to expand such efforts.

Instead, Dr. Hilliard wrote about love, sex, passion, menopause, fatigue, and marriage. In 1954, Hilliard published her first article in *Chatelaine* titled, "Woman's Greatest Enemy is Fatigue." Her last article published before she died was entitled, "How do I know that I love him?" – the difference between love and passion." At the time, Hilliard held the position of marriage counselor for the National Committees of the Church of England and the United Church of Canada, positioning her as a leading authority on how to have a strong marriage. What she brought her readers was not medical jargon, but personal, plain language with a common-sense style that readers

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<sup>26</sup> Marion O. Robinson, "The Story of Marion Hilliard: First of Three Parts." *Chatelaine*, September 1964, 32-33, 111-123.

<sup>27</sup> Robinson, "The Story of Marion Hilliard: Third of Three Parts." *Chatelaine*, November 1964, 50-60.

could relate to.<sup>28</sup> As popular culture historian Valerie Korinek argues, some of Hilliard's frank and open discussions of sex and passion were, alongside the Kinsey publications, the first of their kind to break the silence that had hindered public discussion of sex.<sup>29</sup>

Among Dr. Hilliard's discussions of sexuality within marriage, she never once discussed cancer. Despite her medical training as a gynaecologist and obstetrician, and her key involvement in the development of the cancer clinic in Toronto in 1948, she did not discuss the importance of cancer screening and prevention. As a clear advocate of cancer prevention in her professional world, she appeared to have missed the opportunity to use this popular culture avenue to educate women about the risks of cervical cancer. As Korinek argues, Hilliard was more interested in talking about issues beyond obstetrics and gynaecology and wanted to use her medical training to give her an unspoken authority in her column in *Chatelaine*. Korinek points out that Hilliard did not "patronize the reader; instead, the reader was treated to a conversational, personalized approach."<sup>30</sup> Hilliard's failure to talk about gynaecological cancer, as a woman, feminist, and gynecologist, seems odd, as she surely could have used her power to further convince women about the importance of early detection of cervical cancer.

Even beyond this personal authentication of experience, women proved that while not having much autonomy, they did possess a certain level of agency. Wendy Mitchinson discusses women's agency in regards to their health care needs at length in her article "Problematic Bodies and Agency" and argues that in the past traditional

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<sup>28</sup> Korinek, 295-296.

<sup>29</sup> Ibid., 298.

<sup>30</sup> Ibid., 296.

medical historians “often overlooked the dynamic that existed between physician and patient.”<sup>31</sup> While this dissertation does not use actual medical records of women diagnosed with cervical cancer, it is equally pertinent to hear women’s voices through published works. Mitchinson discusses the value of the use of the patient records not only to see what the physician actually did, as opposed to what they said they did, but also to expose “the harshness of some women’s lives and their resiliency in living them,” in addition to understanding how women often have a decidedly different “concept of health and view of their bodies than their physicians.”<sup>32</sup> This conclusion also applies to the contrast between physician features and patient features about cancer in *Chatelaine*.

Patient stories in *Chatelaine* could almost be seen as a form of medical case file, only written by the patient and not the physician. Mitchinson points out that medical case histories are a form of narrative and stories of experience<sup>33</sup> and these magazine features could be defined in the same way. At the same time, however, these features do not tell the whole story. We cannot learn about family history or the possibility of inaccuracies in the details. Mitchinson argues the same about case files; they “can never be assumed to represent fully that life.”<sup>34</sup> Despite these potential falsities, magazine features written by patients offered a new dimension to the agency and experience for people who attempted to navigate the Canadian health care system. It is not necessarily essential to validate the authenticity of the details within these stories; what is noteworthy is that women were writing at all. Clearly women’s stories were different from the articles

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<sup>31</sup> Wendy Mitchinson, “Problematic Bodies and Agency: Women Patients in Canada, 1900-1950,” in *On the Case: Explorations in Social History*. (Toronto: University of Toronto Press, 1998), 266.

<sup>32</sup> *Ibid.*

<sup>33</sup> *Ibid.*, 267.

<sup>34</sup> *Ibid.*

being written by physicians, as they were less about advice and more about the experience and the interaction of their bodies and the health care system.

In 1954, one of the earliest articles about a woman facing cancer in *Chatelaine* was published. Written by Dorothy Sangster, the article told the story of Jean Shaw, of Toronto, a mother of 6, and how she stood strong in the face of a diagnosis of cervical cancer. By the end of the article the main themes are clear: medical science treated and cured Jean of cancer, and Jean suddenly realized the joy in motherhood, housework, and grocery shopping. Despite being written by another woman, much of Jean's voice and personal experience were present throughout. By the third paragraph the reader gets a sense of who Jean really was: a woman who loved her family; who was determined to have everything in order in case she got really sick and died; and who "never found crying a solution to anything."<sup>35</sup> The impression given was that she was a strong woman and never allowed any pity from anyone, her husband or her physician. The reader also learns that Jean demanded honesty early in her relationship with her physician, especially if the diagnosis was cancer. Even so, the physician still "softened the blow by declaring the disease was still in an early stage, and that early diagnosis and treatment resulted in many a cure."<sup>36</sup> Despite Jean's strong personality, the doctor was concerned about her fragility and wanted to give her some reassurance that she had a reasonable chance of surviving this diagnosis. Jean also claimed that it was the trauma she had experienced with her numerous childbirths that had caused the development of cancer. Voicing these conclusions to her physician, Jean was told that there was not a medical explanation for

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<sup>35</sup> Dorothy Sangster. "I Faced Up to Cancer," *Chatelaine*, September 1954, 51.

<sup>36</sup> *Ibid.*

her diagnosis, and up to that point, there was no conclusive evidence to prove that childbirth trauma led to the development of cervical cancer.<sup>37</sup> The doctor was not interested in her evaluation of her diagnosis, reinstating his knowledge and power by telling her that she was wrong in her conclusions.

Continuing a focus on the value of the physician's expertise, an article in 1958 by Leonard Bertin entitled "Are we winning the war against cancer in women?" was published. Bertin had gone on an assignment as a guest of the American Cancer Society and toured many research institutions in the US. It is not clear whether or not Bertin was a medical researcher himself, but clearly he had some sort of medical professional status in order to visit these facilities and speak about them to researchers in Canada upon his return. Specifically about cancer of the womb, Bertin reported that "a great deal has been done recently to improve techniques used to detect it."<sup>38</sup> He noted that women were often misinformed and sometimes mistook abnormal bleeding as a sign "they [were] not as old as they thought they were."<sup>39</sup> He mentioned the importance of the Pap smear and the newly discovered dye technique found by University of Ottawa visiting associate professor and director of biological research at Mount Sinai hospital in Los Angeles, Dr. Ludwig von Bertalanffy. This new technique allowed physicians to read smear samples right in their offices as opposed to sending them off and flooding already understaffed laboratories. While he discussed leukemia and breast cancer, his grand message was

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<sup>37</sup> Ibid., 13.

<sup>38</sup> Leonard Bertin. "Are we winning the war on cancer in women?" *Chatelaine*, October 1958, 29.

<sup>39</sup> Ibid., 104.

simple: trust the experts, go to the doctor's office regularly for check-ups, and learn to recognize the early signs of cancer.<sup>40</sup>

Another example of patient experience is Kathleen L. Nouch's story, written in 1959, about her experience with breast cancer. She explained how after three different doctors insisted she had "imagined" the lump she had found in her breast, she desperately tried to forget it. After 14 months she discovered a noticeable abnormality in her breast, and after one visit it was confirmed as breast cancer.<sup>41</sup> This article reveals the breakdown of the medical community's monopoly on cancer discourse and authority over women's bodies. It also provides a telling critique of the doctor-patient relationship. More important to note, however, is that there were only two examples of actual experiences with cancer during this decade. Most articles during the 1950s were written by doctors, and even when articles were focused on a cancer patient's experience, the doctor was usually highlighted as the most valuable part of the story.

### **1960s:**

It is clear by the series of articles written about Dr. Marion Hilliard, women's health matters were on the minds of the team of editors at *Chatelaine* in the 1960s. The question is how often was cancer part of the health concerns during this particular period? It was surprising to find that gynecologic cancer appears in the special health topic section only a few times in the 1960s, with only two feature articles making some

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<sup>40</sup> Ibid., 106.

<sup>41</sup> Kathleen Nouch. "I learned to live with Cancer," *Chatelaine*, June 1959, 30, 85-88.

mention of women-specific cancer. Other key medical issues, including the birth control pill and childbirth, made key features in *Chatelaine* during this decade.<sup>42</sup>

Similar to previous decades, Metropolitan Life Insurance Company was still investing in health-specific ads in *Chatelaine*. There was a slight shift in their ad focus, straying away from cancer to other health and safety concerns such as teen drivers, first aid, and financial security. In February of 1963, Metropolitan Life Insurance placed an advertisement on page two with a focus on the need for family financial security. Using language similar to the cancer ads, Met Life argued that it was important to “check your family’s financial health, just as your physical health.”<sup>43</sup> The following month Met Life changed their focus to teen drivers and stressing the importance of being fully aware of the dangers of the road.<sup>44</sup> In April, they went back to a focus on family’s obligation to ensure financial security.

The only ad in the 1960s that focused on cancer was in the 1963 May issue. This ad, in its regular page two slot, claims that, “at the first sign of trouble – and cancer usually causes early warning symptoms – see your physician right away. In doing so, the chances of cure are greatly increased. In fact, it is estimated that if all cancer patients were treated early and adequately, on half could be saved.”<sup>45</sup> Using this optimistic estimation, the ad further confirms that that if women submitted to “the so-called ‘Pap

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<sup>42</sup> Dr. Geraldine Maloney (as told to June Callwood). “The Modern-Day Cult of Childbirth,” *Chatelaine*, March, 1964, 24, 42-44; and Constance Mugall. “The Pill and its Side Effects today,” *Chatelaine*, November 1966, 33, 117.

<sup>43</sup> Met Life. “Family Security Check-up.” *Chatelaine*, February 1963, 2.

<sup>44</sup> Met Life. “Safety Sense.” *Chatelaine*, March 1963, 2.

<sup>45</sup> Met Life. “Cancer...like a small spreading flame...demands prompt action.” *Chatelaine*, May 1963, 2.

Smear' ...the type of cancer that it reveals could almost eliminated as a cause of death."<sup>46</sup> Ending the ad, Met Life reminds the reader the important of annual checkups, and the importance of watching for the seven warnings of cancer.<sup>47</sup> The majority of the following issues printed Met Life ads focusing on life insurance and financial security concerns. The only ads that did not focus on these two issues were in September 1964 and February 1965 with themes on vaccination and VD prevention. Beyond Met Life ads, the 1960s in *Chatelaine* marked a transition in content on health. Placing cancer alongside heart disease, arthritis, and other more commonly discussed diseases, *Chatelaine* was working towards a more candid discussion of cervical cancer that is more notable in the 1970s and 1980s.

In September of 1963 *Chatelaine* printed a feature article, written by popular press science writer Ron Kenyon, focusing on "The 5 Diseases that Trouble Women Most." Alongside heart disease, diabetes, hypertension, and arthritis, cancer was listed as one of the five diseases that at least one in five Canadian women over the age of 21 were suffering from in 1963.<sup>48</sup> Cancer, discussed second to heart disease, was claimed to be the disease that women feared the most. Early diagnosis was the key theme in the cancer section, quoting the Canadian Cancer Society, "half (of the 10,000 women estimated to die from cancer in 1963) could be saved by early diagnosis."<sup>49</sup> The tone of this section was that if women would simply submit to regular check-ups, the numbers of women dying from cancer would not be so high. The top three cancers women were most

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<sup>46</sup> Ibid.

<sup>47</sup> Ibid.

<sup>48</sup> Ron Kenyon. "The 5 Diseases that Trouble Women Most." *Chatelaine*, September 1963, 43.

<sup>49</sup> Ibid., 44.



diagnosed with in the early 1960s were breast (22%), genital organs (19%), and skin (13%), all three “probably cured if detected early.”<sup>50</sup> Cervical cancer posed a compelling concern, since it was considered to be “virtually eliminated with regular examinations,” assuming that because not all women were getting regular gynecologic exams the possibility of cervical cancer being eliminated was still not a reality.<sup>51</sup> *Chatelaine* used an American doctor to back the claim that high rates of cancer that could be “treated and probably cured” were a result of women simply not getting screened.<sup>52</sup> Coinciding with discussions in the medical community during the 1960s, this feature mentioned that there was hope that a cancer virus would be found and a vaccine developed that would prevent this disease. There was recognition that there might be a link between viruses and cancer development, but the complexity of the number of cancer-causing viruses and how all of them affect the cell’s genes were something that research at Toronto’s Princess Margaret Hospital was looking to figure out.<sup>53</sup>

Discussions of women’s health were frequent in *Chatelaine* in 1964. The pressures of childbirth, breast feeding and “mother-baby-togetherness” were discussed in “The Modern-Day Cult of Childbirth” in March of 1964.<sup>54</sup> Despite all the focus on women and health throughout this year, cancer only managed to make it into the “What’s New: Health” section. In October of 1964 a news update announced the arrival of a ‘do-it-yourself’ kit for screening for cervical cancer. An American doctor, Dr. Hugh J. Davis,

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<sup>50</sup> Ibid.

<sup>51</sup> Ibid.

<sup>52</sup> Ibid.

<sup>53</sup> Ibid.

<sup>54</sup> Dr. Geraldine Maloney (as told to June Callwood). “The Modern-Day Cult of Childbirth,” *Chatelaine*, March 1964, 24, 42-44.

while working in Denmark, had developed a method by which a woman could take her own cervical smear and send it away to be processed, all the while in the comfort of her home. Dr. Davis compared the potential success of his “direct-mail diagnostic kit” to the successes of portable x-ray machines and mass tuberculosis control.<sup>55</sup>

Cervical cancer continued to be a part of ‘health’ news in *Chatelaine* in the 1960s. In July of 1965 risk factors such as marriage, religion, barrier types of contraceptives, early intercourse, and socio-economic status were all highlighted. The subheading read “Marriage and Cervical Cancer,” and clearly focused on the role of sex and cultural practices such as circumcision on cervical cancer rates. This news brief referenced an article in the *British Journal of Cancer*, written by Dr. J.T. Boyd and Dr. R. Doll, who stated that “marriage, particularly early marriage, and frequency of intercourse are factors in the cause of cervical cancer.” These doctors were clear in their claims that the circumcision of young Jewish males had a direct impact on the well-known low rates of cervical cancer among Jewesses in comparison to Gentiles.<sup>56</sup>

The same news section then discussed socio-economic influences in cervical cancer incidence. This news brief claimed that there was “plenty of evidence to show that cervical cancer [was] commoner among women in lower socio-economic groups,” without giving any reference for this information. The section finished by stating that doctors assumed that the higher rate of cervical cancer rates among lower socio-economic groups had something to do with “the greater hormone stimulation and a higher

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<sup>55</sup> “What’s New: Health,” *Chatelaine*, October 1964, 10.

<sup>56</sup> “What’s New: Health,” *Chatelaine*, July 1965, 10.

susceptibility of young tissue,” and that “there [were] also differences in contraceptive methods between lower and higher socioeconomic groups.”<sup>57</sup>

In June of the following year, 1966, another “What’s new in health” section focused on cervical cancer. This time the focus was on women’s age-related assumptions as to whether or not they were at risk of developing cervical cancer. It was noted that women under the age of 30 assumed that they were too young to develop cervical cancer, and as a result, did not have annual pelvic examinations. Using a study done at the Miami University School of Medicine, *Chatelaine* made the claim that this common assumption about age and cervical cancer risk was incorrect. This particular study took smears from women aged 20 to 30 years over a five year period. The results were staggering and certainly in opposition to the common assumption that women under the age of 30 did not develop cervical cancer; “it was found that 424 (2.3%) of these women had positive smears, and out of this number 122 were found to have cancer of the cervix.”<sup>58</sup>

A fascinating medical debate highlighted in the later 1960s was the role the contraceptive Pill might play in the development of cervical cancer. In November of 1966 a feature article was printed, “The Pill and its Side Effects Today,” focusing on the various side-effects of the Pill, such as pregnancy when some tablets were missed in a month. Later in the article cancer was mentioned as a possible side-effect. However, the author, Constance Mugall, mentioned the numerous studies done in Saskatoon, Calgary, Toronto, London, as well as larger studies in the U.S. and Britain that showed a marked

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<sup>57</sup> Ibid.

<sup>58</sup> “What New: Health,” *Chatelaine*, June 1966, 12.

*decrease* in breast and genital cancer among women who took the Pill. But, as Mugall made clear, there was no definite proof, according to the FDA report.<sup>59</sup>

In complete contradiction of this 1966 “Health News” feature, in 1969 the “Health News” section printed the findings of Dr. George Wied, who made the claim that he “found a sixfold increase in early cancer of the cervix among women on the Pill.”<sup>60</sup> This news piece also mentioned that other researchers, Drs. Myron Melamed and Milliard Dubrow of the Sloan-Kettering Research Laboratory in New York had come to similar conclusions.<sup>61</sup>

There was, however, one issue not debated, and that was the role the Pap smear played in decreasing cervical cancer rates in Canada. In 1967 it was clear that British Columbia was the leading province in cervical cancer screening with 41.3 percent of women over the age of 25 having had a smear test. Rated at a low fifth, Ontario only reported 14.6 percent of women over the age of 25 having had a smear test. Despite some of the lower numbers in provinces such as Ontario, Quebec and Saskatchewan, the average for Canada was 17 percent in 1965, showing a dramatic increase from 6 percent in 1962.<sup>62</sup> Without a doubt, the medical community was convinced of the importance of the role of screening in preventing cervical cancer. With more women being screened by 1965 than in 1962, it is clear that more doctors were on board in using the Pap smear as part of a regular check-up agenda for their female patients. British Columbia’s efforts were highlighted again in the July 1968 “Health News” section which showed remarkable

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<sup>59</sup> Constance Mugall. “The Pill and its Side Effects Today,” *Chatelaine*, November 1966, 118.

<sup>60</sup> “Health News – Cancer Conflict,” *Chatelaine*, June 1969, 12.

<sup>61</sup> *Ibid.*

<sup>62</sup> *Ibid.*

statistics regarding the drop in the incidence of cervical cancer from 28.4 cases per 100,000 in 1955 to 13.6 per 100,000 in 1966.<sup>63</sup>

Up to and including the 1960s, *Chatelaine* printed health-related articles that were either written by, or reinforced by, medical experts. While the articles were informative and allowed women to educate themselves about health topics particularly pertinent to them, including cervical cancer, women were directed to seek advice and consultation via their healthcare professionals. As the next few sections will demonstrate, this trend would start to change in the 1970s, and particularly in the 1980s and 1990s. In the following decades in *Chatelaine* there was a new focus on encouraging women not only to be educated about their bodies and their health care needs, but also to use key disease-prevention tools and to make lifestyle choices that would protect them from diseases such as cervical cancer.

### **1970s:**

In terms of the distribution of health information, the 1970s were an extraordinarily captivating decade. The 1970s introduced a wide range of new feminist health literature that allowed many women to become more aware of their bodies, their health, and their health care needs. This network of literature continually pushed women to rethink their relationships with their current healthcare providers and to further their personal understandings of their own bodies and health. The Women's Health Movement was based on this new push for self-knowledge and much of the literature that emerged out of this movement reflected just that. Not surprisingly, these trends are

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<sup>63</sup> "Health News: Pap beats cancer," *Chatelaine*, July 1968, 8.

evident in *Chatelaine*. There was a clear shift from the types of literature that were available to women as early as the 1950s to the 1970s. The 1950s was a time when women learned how to be better wives and mothers and simply were not encouraged to know too much about their health – that knowledge was left to the professionals. However, by the 1970s, feminist health literature became an integral part of the much larger consciousness-raising campaign that not only attempted to break down the power relationship between a woman and her doctor, but also to encourage women to be experts with regard to their own bodies and health. This feminist publishing phenomenon in the 1970s was not only knowledge-based but was also fuelled by the politics of the time.

One of the foundation publications of the Women's Health Movement, in the U.S. and certainly eventually in Canada, was the *Our Bodies, Ourselves* book created by the Boston Women's Health Book Collective. This book started out with a group of women responding to a conference held in Boston in the spring of 1969. It was a conference by and for women only. As the women stated in the preface to the 2<sup>nd</sup> edition, it was the first time that they "had joined together with other women to talk and think about our lives and what we could do about them."<sup>64</sup> Even before the end of the conference, a few of the women decided that they would continue to meet as a group to further discuss issues the conference had highlighted. These unique women ranged in age from 25-40 and had a wide variety of experiences and levels of education.

What was acknowledged very early on in the group's meetings was that they all shared feelings of frustration and anger towards both medical institutions and those who

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<sup>64</sup> The Boston Women's Health Collective. *Our Bodies, Ourselves: A Book by and for women*. (New York: Simon and Schuster, 1975), 11.

worked within them. Beyond these frustrations, these women realized that they had a lot to learn about their bodies and quickly decided to design a course that would address this exact issue: to teach women about their bodies. They collected published medical material and personal testimonies and experiences into a bound edition used primarily for teaching the course. However, after many revisions the book grew larger, and it became much more difficult to meet the growing number of requests through their original publisher, the New England Free Press. Realizing they wanted to reach beyond those taking their course, they decided in 1973 to publish their book commercially.<sup>65</sup>

In addition to wanting to educate women about their bodies, this book attempted to change how women learned about their bodies. These women realized that “people don’t learn very much when they are simply passive recipients of knowledge. [They] found that each individual’s response to information was valid and useful, and that by sharing our responses we could develop a base on which to be critical of what the experts tell us.” Moving beyond “rote memorization” these women were looking to give women a chance to learn about their bodies using sharing and “real knowledge” techniques.<sup>66</sup> The benefit to this type of learning, they argued, was that women would be better prepared to “evaluate the institutions that are supposed to meet our health needs – the hospitals, clinics, doctors, medical schools, nursing schools, public health departments, Medicaid bureaucracies and so on.”<sup>67</sup> They also argued that when women are ignorant about their bodies, they suffer one major consequence – pregnancy. They believed “it was not until

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<sup>65</sup> Ibid.

<sup>66</sup> Ibid., 12.

<sup>67</sup> Ibid., 13.

we researched carefully and learned more about our reproductive systems, about birth-control methods and abortion, about law governing birth control and abortion, and not until we put all this information together with what it meant to us to be female, that we began to feel we could truly set out to control whether and when we would have babies.”<sup>68</sup> They believed that body education was the core of education. They lived by the idea that “learning to understand, accept, and be responsible for our physical selves, we are freed of some of these preoccupations and can start to use our untapped energies.”<sup>69</sup>

The Canadian equivalent to the Boston Women’s Health Collective, the Vancouver Women’s Health Collective, published *Caring for Ourselves: An Alternative Structure for Health Care* in 1978. While this book did not attempt to distribute detailed information about women’s bodies and health in the manner of *Our Bodies, Our Selves* book, it did chart the VWHC’s history and their clear ties with the Women’s Health Movement. It also detailed what happened during cervical self-examination workshops, the clinic setting, and the numerous other services offered early in its existence. While this was one of the few Canadian feminist publications focusing on women’s health in the 1970s, it was clear that numerous American publications were infiltrating Canadian women’s homes and influencing the burgeoning Women’s Health Movement in Canada. Not only were books moving, so were people and ideas.

There were a few other feminist health publications that were politically charged. These include *Woman’s Body, Woman’s Right*, written by Linda Gordon, and *Vaginal*

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<sup>68</sup> *Our Bodies, Ourselves*, 13.

<sup>69</sup> *Ibid.*



*Politics* by Ellen Frankfort, published in 1972. These books discussed the struggles women experienced in the 1970s with the health care system and health care delivery in the U.S, in particular around issues such as abortion and birth control. Different from Gordon and Frankfort's more politically-charged books, another genre of women's health books were released which primarily focused on basic gynecological and general health education. *It's Your Body: A Woman's Guide to Gynecology*, written by Niels Lauersen M.D. and Steven Whitney, was published in 1977 by Playboy Paperback Press. This book is an excellent example of this genre of books released as it has chapters on self examination, how to choose a gynecologist, abortion and contraception, pelvic abnormalities, cancer, sex, and sexual dysfunctions. In their introduction, Lauersen and Whitney recognized that the woman of the 1970s was becoming "increasingly concerned with the well-being of her body." They believed that there was a real need for accessible information for women about their bodies and key medical procedures relating to women's bodies and health. Their hope was that *It's Your Body* would do just that.<sup>70</sup> As their cover claimed, "a detailed and comprehensive guide to the female body, including the latest research on estrogen, contraception, and abortion," this was the book women of the 1970s needed to read.<sup>71</sup>

Despite the fact that *It's Your Body* did not focus on the Women's Health Movement and was designed and written by two men, it may have had its own politics in place. Dr. Niels Lauersen was a gynecologist, a representative for the American Board of

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<sup>70</sup> Niels Lauersen and Steven Whitney. *It's Your Body: A Woman's Guide to Gynecology*. (New York: Playboy Paperback Press, 1977), intro page.

<sup>71</sup> *Ibid.*, cover.

Obstetrics and Gynecology, and a professor of Obstetrics and Gynecology at Mt. Sinai Hospital in New York City. Steven Whitney was an editor and journalist at the time of publication. Dr. Lauersen may have recognized the new candid public discussions of women's health in the 1970s and wanted to capitalize on this shift by publishing a book that women would want to read. For the most part Dr. Lauersen would have been used to educating doctors in training, and now he could reach the broader population of women by offering them, as one critic claimed, "a virtual textbook of gynecology translated into readable, sensible, practical information" while still controlling what information was distributed.<sup>72</sup>

Other books published that focused on gynecological and general health for women were *The Ms. Guide to a Woman's Health*, written by Cynthia W. Cooke M.D. and Susan Dworkin in 1979, Ann Kramer's edited collection of health information for women entitled, *Woman's Body: An Owner's Manual*, published in 1977, and a popular British publication, *The New Women's Health Handbook*, originally published in London in 1976. These books encouraged women to know what their bodies, including their cervixes, looked like when they were healthy so that when needed it was easier to notice abnormalities early. These books also looked to demystify what the doctors were looking at through their speculums and to allow women to familiarize themselves with their own internal organs.

In Canada, during the same period, there is no doubt that *Chatelaine* picked up on the growing health literature and played a role in not only disseminating second-wave

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<sup>72</sup> Ibid., backcover.

feminist ideas, but also ideas of the burgeoning Women's Health Movement.<sup>73</sup> Just as Korinek argues that *Chatelaine* furthered the march of "feminist awareness and organizing in Canada,"<sup>74</sup> I would argue it did the same for women taking back the power to manage their own health and health care opportunities. This was demonstrated in the magazine with a clear shift from straightforward ads for the "fight against cancer" to more editorials and several page features focusing on specific cancers such as cervical and breast cancer. Many of these articles focused on preventive health and ways in which women could manage their own health care. It should also be pointed out that during this period with the introduction of Medicare in Canada, insurance companies, notably Metropolitan Life, lost a lucrative health insurance market.

Despite *Chatelaine's* underlying feminist agenda at the time, it seems as though in regards to cervical cancer, the editors still played it safe and focused on the voice of the all-knowing physician. There was a slight indication that women needed to know more about their bodies, but it was clear that information needed to come from a more traditional source. As a result of independent feminist health literature of the 1970s, public periodicals began to change their approach to women's health topics. For example, in 1973 *Chatelaine* published an article introducing the "breast Pap" smear and how it was able to find "cancers as small as rice grains."<sup>75</sup> Also in 1973, a controversial feature article was published on male chauvinist gynecologists. The article entitled, "Your Gynecologist: Show Me a Gynecologist and I'll show you a Male Chauvinist

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<sup>73</sup> By the 1960s *Chatelaine* had a circulation of over a million women in Canada. See Doris Anderson's article, "Women's Magazines in the 1970s," *CWJ* vol. 2/2 (1980): 16.

<sup>74</sup> Korinek, 365.

<sup>75</sup> Derek Cassels, "Now the Good news...about Breast Cancer," *Chatelaine*, June, 1973, 50.

(even if she's a woman)"<sup>76</sup> sparked considerable discussion and numerous letters to the editors. Most women were ecstatic that *Chatelaine* would publish such an article, as they could easily relate to their own terrible experiences with their gynecologists. But some women were appalled that it was even published. Dr. Charlotte S. Dafoe of Edmonton could not believe that *Chatelaine* would publish such an "utterly sick article." She believed that it was a true "disservice to women" and argued "the vast majority of gynecologists [were] intelligent men and women who [were] doing their best to practice their profession in a satisfying way."<sup>77</sup> Other features in 1975 not only focused on breast cancer, but also brought up other healthcare issues such as unnecessary hysterectomies.<sup>78</sup>

The introduction of a regular "Health" column in the 1960s demonstrated a keener awareness of women's health care needs and this continued well into the 1970s. The "Health" column was particularly appealing as it was usually used to disseminate the newest information from the medical community, but also often divulged the biases held by medical professionals. Often cervical cancer would appear with descriptions of how often to get a Pap smear and risk factors associated with the disease. In January of 1972, Dr. Robert Kistner<sup>79</sup> was reported as finding that cervical cancer was becoming more common among promiscuous "hippy type" women on oral contraceptives "who have coitus four or five times a day with different partners when they are using drugs." While

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<sup>76</sup> Michele Landsberg. "Your Gynecologist: Show me a gynecologist and I'll show you a male chauvinist (even if she's a woman)," *Chatelaine*, August, 1973, 42,64-66.

<sup>77</sup> "The Last Word is Yours," *Chatelaine*, August, 1973, 134.

<sup>78</sup> Jack Batten, "Is this Operation Necessary?" *Chatelaine*, August, 1975, 48, 56-58.

<sup>79</sup> Dr. Robert W. Kistner was a Harvard Medical School professor who specialized in the treatment of endometriosis. He was a gynaecologist and was part of the early medical advocacy of the birth control pill. He died in 1990 at the age of 72. "Obituaries." *New York Times*, February 19, 1990 (<http://www.nytimes.com/1990/02/10/obituaries/robert-w-kistner-72-gynecologist-is-dead.html> - accessed March 23, 2011).

this may not paint a particularly likeable picture of women of the “hippy type,” Dr. Kistner was further associating sexual activity with cervical cancer risk. He added that cervical cancer was rare in nuns and Jewish women because of a strict or abstinent sexual lifestyle.<sup>80</sup> Also in 1972, the “Health” column discussed how often adult women should have Pap smears. Dr. J. Edward Hall, obstetrician and gynecologist, believed that women up to 35 should have a Pap smear once a year, and after 35 as often as every six months.<sup>81</sup> In January of 1974, Dr. John Wakfield, renowned British gynecologist, claimed that the occupation of the husband might be a risk factor to the wife for developing cervical cancer. He argued that women married to miners, quarrymen, and other labourers “had the highest incidence of cancer of the cervix, while those married to artists, technical workers or professional men, had the lowest.” Beyond the conclusion that the dirtier the man’s job, the more likely the women would develop cervical cancer, there were not any more observations.<sup>82</sup> Beyond the health knowledge that these professionals were hoping to distribute, classism, sexism, and certainly racism were underlying all their advice. These were barriers that women of the Women’s Health Movement were attempting to eradicate by creating their own health clinics, libraries, and publications.

*Chatelaine* also provided evidence that other women’s centres, much like the Vancouver Women’s Health Collective in B.C., were being established all over the country in the 1970s. For example, in Montreal, in 1974, a women’s centre was established offering a busy schedule of activities in addition to workshops on women and

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<sup>80</sup> “Health,” *Chatelaine*, January 1972, 10.

<sup>81</sup> “Health,” *Chatelaine*, May 1972, 12.

<sup>82</sup> “Health,” *Chatelaine*, January 1974, 11.

their bodies, self-defense, etc... Other established women's centres listed included: Nanaimo, B.C.; Yellowknife, N.W.T.; Kingston, Ont.; and Halifax, N.S.<sup>83</sup> These women's centres were other places where women could access knowledge about their health and health care needs and *Chatelaine* was a facilitator to direct women to these locations. Some of these women's health centres were located on university campuses.

### **1980s:**

While there may have been an increase in, or keener awareness of, women's health needs in *Chatelaine* during the 1970s, it seems as though the decade of the 1980s was the real turning point in terms of discussion of cervical cancer more specifically. There was even evidence that *Healthsharing*, another feminist, woman-only Canadian periodical, was picking up on the increased discussion of this cancer. In *Chatelaine*, cervical cancer, its risk factors, diagnosis, treatment, and even prevention, were all highlighted numerous times throughout the 1980s. Most information appeared in the "Health News" section, but there were a few examples of information about this woman-specific cancer in full-length features. There were several key points that were focused upon: the importance lifestyle/clean living, frequency of annual exams including the Pap smear, the developing viral connection to cervical cancer, general information about the disease, and medical advances in diagnosis and treatment. While most of these points appear several times, the most frequently discussed aspect of cervical cancer was the Pap smear and how often women should be screened.

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<sup>83</sup> "Hotline on Women," *Chatelaine*, February 1974, 45.

*Healthsharing* printed one feature article on cervical cancer in 1982. While it detailed various stages of cervical cancer and techniques on how to prevent it, the most revolutionary aspect of this article is that it openly criticized the medical community's definition of key risk factors. It also gave attention to the lack of support and acceptance for women who were diagnosed with this cancer. The author, Cheryl Adams, who had been recently diagnosed with cervical cancer, argued that "the medical community continues to debate the causes of the disease, we must regard the media verdict of promiscuity as both premature and misleading." She believed that it was important to "fight the stigma" of promiscuity attached to cervical cancer so that women would not avoid having a Pap smear.<sup>84</sup>

As with the *Healthsharing* article by Adams in 1982, news features in *Chatelaine* were a reflection of the medical community's main concern, which was lifestyle, or rather a high-risk lifestyle, as the most significant risk factor in the development of cervical cancer. Often when the social constructions of cervical cancer were discussed, proper lifestyle and a modest sex life were mentioned. In a featured article in *Chatelaine's* April 1980 issue, Marni Jackson discussed the problems with "treating the Pill and IUD as talismans that protect us from every kind of sexual consequence."<sup>85</sup> This article continued to list the increase in gynecological problems resulting from "liberated sex." Even more distressing to the doctors quoted in this article was the fact that there was an increasing number of younger women, ages 17-19, engaging in early sexual activity, with multiple partners, thus increasing their vulnerability to a variety of

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<sup>84</sup> Cheryl Adams. "Cervical Cancer: The Facts." *Healthsharing* vol. 3/3 (1982): 14.

<sup>85</sup> Marni Jackson. "Health Consequences of Liberated Sex," *Chatelaine*, April 1980, 41.

gynecological problems, including cervical cancer. What becomes clear by the end of the article is that, while many doctors at the time were obviously focusing on sexual activity and its role in gynecological problems, some doctors saw problems in this medical approach. Jackson pointed out that doctors and patients all too often “put the blame on too much sex, rather than on the one-dimensional health care (medical advice focused on symptoms rather than the entire patient) and inadequate sex education.”<sup>86</sup> She also pointed out that sexual mores should be a choice and that women should not avoid sex out of fear of pregnancy or disease. She posed the question: “given the known risks and our muddled desires, how should we behave?” Interestingly, she seemed to have given the power back to women to make educated sexual choices. They should not simply rely on their doctors to know the risks for gynecological diseases. She further argued that while a “liberated” lifestyle had introduced women to a whole host of new health problems, these newly defined risk factors carried a “highly exploitable element of ‘I told you so.’” And, as Chapter 1 of this thesis has demonstrated, risk factors do not leave the social consciousness very quickly. They often become historically ingrained. In this case, she was pointing to the fact that cervical cancer was still sometimes constructed as a punishment for being promiscuous, and carried guilt associations through generations.<sup>87</sup> Dr. Peter Cole, a medical consultant for the city of Toronto at the time, felt unease about blaming sex for increased dysplasia (precancerous stage); he argued that because there “is absolutely no evidence linking frequency of intercourse to cervical dysplasia...it is often

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<sup>86</sup> Ibid., 136.

<sup>87</sup> Ibid.



the medical profession that can't tolerate the thought of young women being sexually active."<sup>88</sup>

Throughout most of the articles it was clear that there was much debate about how often women should be screened, via the Pap smear, for cervical cancer. Many articles recommended annual Pap smears for women who were sexually active, since once they reached childbearing years, and had children, their potential multiple partner sexual activity would level off. Regardless of what the 1976 Task Force recommendations were<sup>89</sup>, the decision was still left up to the doctor. In 1981, *Chatelaine* printed a feature article helping women to make informed choices about the doctors and hospitals they would use. In its second section, after advice about how to "choose a GP," the feature discussed the value of annual checkups. Depending on the recommended frequency, according to each individual patient, there were several aspects to the examination that *should* happen – this included the Pap smear. As the article stated clearly, "the Pap smear accurately detects cervical cancer at an early curable stage. How often you need it is up to your doctors; frequency should be annual if you're on the Pill, have had many sexual partners or begun sexual activity at an early age."<sup>90</sup>

There were also examples of the debate within the medical community making its way into the Health News section and the editorial section. In October of 1983, in the Medical News section, Dr. Diane Crocker openly challenged the recommendations of the 1976 Task Force report. She argued that many women develop cervical cancer more

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<sup>88</sup> Ibid.

<sup>89</sup> The Task Force recommends a Pap smear at the onset of sexual activity, a recheck within a year, then every three years to age 35, then every five years.

<sup>90</sup> "Chatelaine's informed patient's guide to Doctors and Hospitals," *Chatelaine*, February 1981, 49.

quickly than previously expected. In a fairly substantial medical study on the efficacy of the Pap smear, she found that “about one third developed the disease within an average of 2.6 years after their last negative Pap smear.”<sup>91</sup> She further advised that all women continue to have annual Pap smears, regardless of the recommendations of 1976, except virgins and women who had had hysterectomies.<sup>92</sup>

Earlier in the same year, January 1983, even a cytotechnologist weighed in on the debate. In the editorial section, Colleen Kelly, of Hamilton, Ontario, was “enraged” to hear *Chatelaine* had printed an article recommending less frequent Pap smears. She argued “since the recommendation to reduce the frequency does not define high-risk patients, confusion occurs between physician and patients. Nor does it take into account the changing sexual morals in recent years, especially young women who are in a higher risk group for cervical cancer.”<sup>93</sup> Most other articles in *Chatelaine* in the 1980s referred to “regular” Pap smears, assuming that this meant yearly smears, especially when the connection was made between the human papilloma virus and the development of cervical cancer.<sup>94</sup>

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<sup>91</sup> “Health Centre – Medical News,” *Chatelaine*, October 1983, 18.

<sup>92</sup> *Ibid.*

<sup>93</sup> Colleen Kelly, “The Last Word is Yours – Medical Controversy,” *Chatelaine*, January 1983, 136.

<sup>94</sup> For examples, refer to: “The Concerned Woman’s Guide to Female Health Problems,” *Chatelaine*, September 1982, 70; “Health Centre – Medical News,” *Chatelaine*, April 1983, 22; Sidney Katz, “Medical News – New Treatment for Cervical Cancer,” *Chatelaine*, March 1984, 16; Katz, “Medical News – Good and Bad News about Cervical Cancer,” *Chatelaine*, April 1984; Katz, “Cancer: A Progress Report,” *Chatelaine*, October 1984, 71; Dr. Cynthia Carver, “Free for the Asking: Ask a Doctor,” *Chatelaine*, January 1985, 24; Katz, “Medical Tests: Are the Benefits worth the risks?” *Chatelaine*, March 1987, 70; Evelyne Michaels, “Health Centre – The facts about a sexual virus: Genital warts seem to be more common,” *Chatelaine*, October 1988, 40; “Health News – Pap tests after a hysterectomy,” *Chatelaine*, March 1989, 50; Dr. Elaine Herer, “5 doctors’ family health secrets,” *Chatelaine*, April 1989, 128; “Health News – Frequency of Pap Tests,” *Chatelaine*, October 1989, 44.

Early theories about the viral connection between herpes type II infection and the development of cervical cancer were first mentioned in *Chatelaine* in April of 1980. A feature article written by Marni Jackson, while clearly recognizing the lack of reliable statistics, mentioned that doctors and gynecologists were reporting that “among their own patients, sex-related problems were increasing and that according to some doctors, herpes could possibly increase a woman’s chances of developing cervical cancer.”<sup>95</sup> Other than two brief mentions of the connections between having had a herpes type II infection and a higher risk of developing cervical cancer in feature articles about female-specific health problems and information about 10 common laboratory tests, the herpes connection was not discussed in *Chatelaine* again.<sup>96</sup> The herpes connection was replaced with the human papilloma virus (HPV).

In a 1988 February issue, *Chatelaine* printed an article about the viral connection between HPV and the development of cervical. In the Health News section it was reported that the most common sexually transmitted disease was no longer herpes; it was human papillomavirus. Dr. Alex Ferenczy, the director of gynecologic pathology at Montreal’s Jewish General Hospital in 1988, argued that in a study done of 55,000 routine Pap smears it was found that 12% of adolescent girls were infected with the virus. Dr. Ferenczy pointed out that while warts, as a result of the HPV infection, were usually benign and could be treated simply with drugs or removed by freezing, about 10 percent of the infections were more serious, causing cancer of the cervix, or rarely, cancer of the

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<sup>95</sup> Marni Jackson. “Health Consequences of Liberated sex,” *Chatelaine*, April 1980, 41, 134.

<sup>96</sup> Julianne Labreche. “The Informed Patient’s guide to 10 Common Lab Tests,” *Chatelaine*, June 1982, 44, 158-168; and “The Concerned Woman’s Guide to Female Health Problems,” *Chatelaine*, September 1982, 70.

vulva or vagina.<sup>97</sup> In October of the same year, *Chatelaine* printed a full length feature article on HPV and its various symptoms, strains, and connections to cancer. It was clear by the time this article was written that researchers had already figured out that only certain strains of this virus caused genital warts and therefore only a few strains were connected with the development of cancer. However, it still was not clear what role the virus might play in the development of cervical cancer. Dr. Fred Engle, a gynecologist at Mount Sinai Hospital in Toronto at the time, suggested that women with a history of genital warts should unquestionably have annual Pap smears to detect potential precancerous conditions.<sup>98</sup> The connection was further complicated in 1989 when researchers, as a result of a Canadian study at Memorial University in St. John's Nfld., found that women who were using the contraceptive pill and were infected with HPV had an even higher susceptibility to developing cancerous conditions of the cervix.<sup>99</sup> These discussions were on track with very current medical discussions in Canada and even internationally. Clearly *Chatelaine's* medical investigators were following current medical debates and were interested in keeping Canadian women informed.

### **1990s:**

Discussions of cervical cancer in *Chatelaine* in the 1990s were similar to the 1980s in that there were still debates about how often women should have Pap smears, key risk factors and ways of prevention, and advances in the treatment of this disease. The interesting difference between the 1990s and the 1980s is that most of these

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<sup>97</sup> "Health News: Sexually Transmitted Disease," *Chatelaine*, February 1988, 30.

<sup>98</sup> Evelyne Miachels. "Health Centre – The facts about a sexual virus: Genital Warts seem to be more common," *Chatelaine*, October 1988, 40.

<sup>99</sup> "Health News – Canadian Study on the Pill and virus," *Chatelaine*, April 1989, 56.

discussions did not just appear in the “Health News” section, but they were occurring in major feature articles. Information relayed in the “Health News” section was a key supplement to the information delivered in the seven feature articles that discussed health matters specific women.

In the early 1990s *Chatelaine* started a “Reduce your Health Risks” feature series. The first feature focused on breast cancer and the second feature focused on reproductive cancer. This article proved to be one of *Chatelaine*’s most informative features to date about cancers particular to women’s reproductive organs. The first two cancers discussed were ovarian and uterine cancers – cervical cancer was a distant third. Each section was broken down into three key sections: definition of the disease, risks, and protection. The cervical cancer section was quite straightforward: do not smoke, get a regular Pap smear, limit your number of sexual partners and ask them to use condoms, and be aware of your own cervical health.<sup>100</sup> All other features focused on the Pap smear, its importance, and how to educate oneself about what was essential to maintain one’s own health.<sup>101</sup>

Similar to the 1980s, many discussions of cervical cancer in “Health News” reports in 1990s *Chatelaine* were about how often women should have Pap smears. While recommendations about annual pelvic examinations (including a Pap smear) were often connected with a woman’s use of the birth control pill, there was still “no consensus about how often women should have pelvic exams or Pap smears” among the medical

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<sup>100</sup> Evelyne Michaels. “Reduce your Health Risks Part 2: Reproductive Cancer,” *Chatelaine*, March 1992, 83.

<sup>101</sup> Refer to, Lesley Barsky and Deborah Jones. “A doctor-approved guide to women’s health,” *Chatelaine*, March 1993, 39; Evelyne Michaels, “These tests could save your life,” *Chatelaine*, Sept 1993, 87; Sidney Katz, “How accurate are medical tests? Protecting yourself from false reports,” *Chatelaine*, April 1995, 28; Trish Snyder, “Mind and body: Prevention – A safer Pap smear,” *Chatelaine*, May 1997, 144.

community. However, Dr. Cynthia Carver, the staff doctor answering readers' questions in the 1990s, followed the Task Force recommendations of 1982 – “all women should have Pap smears done annually for three consecutive years in order to establish a normal baseline. Thereafter, if there are no complications, Pap smears, and pelvic exams can be done at intervals of one to five years, depending on your age and medical history.”<sup>102</sup>

The following year, 1991, in a Health News report, *Chatelaine* staff writer Deborah Smyth further reinforced these 1982 recommendations stating that the new report of the Task Force took careful consideration of sexually active women and their risk, taking into account their age, and changed the guidelines to indicate “screening every three years is the most effective for women of all ages.”<sup>103</sup>

However, not all members of the medical community were fully supportive of the 1982 adjusted recommendations. Luci Golab, a nurse, was “appalled at the government’s attitude toward annual Pap smears.” She argued that “playing down the need for an annual Pap smear is dangerous” because not only does the Pap smear detect cervical cancer, but it also can “detect various sexually transmitted diseases.” She also pointed out that the government was clearly finding that “socialized medicine” was finding “preventive medicine costly.”<sup>104</sup> There were even professional medical societies that were not convinced by 1991 of the Health and Welfare Canada suggesting that women only need a Pap smear every three years after two normal tests. After the report in 1991, the Society of Obstetricians and Gynecologists of Canada continued to recommend

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<sup>102</sup> Dr. Cynthia Carver. “Free for the Asking – As a Doctor,” *Chatelaine*, April 1990, 206.

<sup>103</sup> Deborah Smyth. “Health Centre – News – Pap Tests,” *Chatelaine*, November 1991, 40.

<sup>104</sup> Luci Golab. “The Last Word is Yours: Pap Tests,” *Chatelaine*, January 1992, 136.

yearly tests for women. In a feature in *Chatelaine* in 1991, Dr. Roy Clark – an oncologist at the Princess Margaret Hospital in Toronto – argued that since we already know that early detection of cervical cancer improves chances of survival considerably, annual tests were vital to continue successful survival rates. He believed that annual testing should begin “when a woman becomes sexually active and continu[e] until age 70.”<sup>105</sup>

Beyond discussions of how often women should have a Pap smear, *Chatelaine* demonstrated its investment in protecting women from false negative results of their Pap smears. In 1995, after a computerized screening program was developed by researchers in New York, *Chatelaine* announced that the same option might be available to Canadian women for a fee of about \$30. These New York researchers claimed that this new computerized program, PAPNET, checked cells individually and was more than 97% accurate at detecting precancerous cells vs. the conventional method.<sup>106</sup> *Chatelaine* even revealed in 1997 that they were financially invested in the Centre for Research in Women’s Health. This Centre focused on funding research into “some of women’s most pressing health issues, including breast cancer and osteoporosis.” Cervical cancer obviously made it on the radar of this Centre and *Chatelaine*. In May of 1997, writer Trish Synder wrote a news update on “A Safer Pap Smear,” revealing that cytotechnologists simply did not have the advance medical devices they needed to read the results of a Pap smear effectively. By funding the Centre, *Chatelaine* argued that this new technique would allow cytotechs to focus on “what she [*sic*] does best: interpret the results,” and not on the tedious task of looking at “cells one by one without the help of a

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<sup>105</sup> Dr. Roy Clark. “These Tests could save your life – Pap Test,” *Chatelaine*, September 1993, 87.

<sup>106</sup> Nancy Deutsch. “Health Centre – News – Computer Check for Pap tests,” *Chatelaine*, April 1995, 30.

computer.”<sup>107</sup> The staff writer, Mary Denbow, even referred back to an earlier page so that, as the reader, you could also make an individual monetary contribution to the cause via “Chatelaine’s Partners in Health” initiative.<sup>108</sup>

While *Chatelaine* was clearly marking advances in the prevention of cervical cancer, there were also advances in treatment that did not go unnoticed throughout the 1990s. In December of 1990s Dr. Gregory of Sutton’s (an Indiana University) findings that women with cervical cancer did not necessarily need their ovaries removed was revealed. Dr. Sutton believed that many women with cervical cancer had their ovaries removed needlessly, simply because doctors were afraid the disease had moved beyond the cervix. His review of 490 cases revealed that only .06% of them had ovarian malignancies and that there was a clear advantage to keeping the ovaries in place as “they continue to produce estrogen, so hormonal therapy [was] unnecessary.”<sup>109</sup> There were other advances in treatment noted in the 1990s, including better programs of radiation, uninterrupted regimens<sup>110</sup>, and the trial of a topical cream derived from Vitamin A applied to the cervix of women with cervical dysplasia in hopes that it would make surgery unnecessary someday.<sup>111</sup>

The 1990s were similar to other decades in that most articles on cervical cancer in *Chatelaine* during this time focused on how often women should have Pap smears, constant reinstating of key risk factors (sexual activity, smoking, HPV) and advances in

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<sup>107</sup> Mary Denbow. “Mind and Body: Prevention – A Safer Pap Smear,” *Chatelaine*, May 1997, 144.

<sup>108</sup> Ibid. (page referred to was page 94)

<sup>109</sup> “Health Centre News – Cervical Cancer Treatment,” *Chatelaine*, December 1990, 20.

<sup>110</sup> Evelyne Michaels. “Health Centre News – Radiation for Cervical Cancer,” *Chatelaine*, October 1992, 28.

<sup>111</sup> Evelyne Michaels. “Health Centre News – Cervical Treatment,” *Chatelaine*, October 1994, 30.



both the prevention and treatment of this disease. Another constant was that the majority of these articles were written by medical experts. Even if an article was written by a staff writer, not necessarily with an MD, there were always several reinforcements throughout from medical experts and results of medically supervised studies. The main difference was that cervical cancer made its way into more feature articles and maintained a consistent place in Health Centre News pieces. While the words cervical cancer were not necessarily plastered on the front covers of *Chatelaine* during this decade, clearly cervical cancer was being discussed more frequently and more openly amongst Canadian women. This widely read women's magazine successfully contributed to increasing public awareness of this disease.

**Conclusion:**

*Chatelaine* was a vital hub of health information for women in the twentieth century. Clearly following medical discoveries and understandings of cervical cancer, *Chatelaine* printed features and news releases that educated women about this disease, its detection and prevention. Once viral connections were made, medical professionals were able to clearly lay out what women had to do in order to decrease their chances of developing cervical cancer. *Chatelaine* successfully provided Canadian women with a source of current health care information. While cervical cancer did not necessarily make headlines throughout the twentieth century, by the 1980s and 1990s *Chatelaine* was printing informative news sections and various feature pieces with a clear focus on cervical cancer. Medical experts were continually asked to write articles related to cervical cancer and lend their knowledge, resulting in a public discourse about this

disease. Occasionally, women wrote about personal experiences with this disease but the majority of the discourse came from the progressive doctors writing educational articles. Through editorials and questions submitted to the staff medical advisor, it was clear that once the medical community wanted to publicly talk about cervical cancer, so did the average Canadian woman. As the next chapter will demonstrate, supplementing *Chatelaine*, government sponsored films and print materials were also noteworthy media through which women could educate themselves about cervical cancer.

### Chapter 3 – Making Cervical Cancer Public – Films and Newspapers

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Throughout much of the mid to late-twentieth century Canadian women had access to many other sources of information beyond *Chatelaine*, such as film, posters, and newspapers, through which to learn about cervical cancer. The National Film Board (NFB) of Canada and the Canadian Cancer Society supported many different films on cancer from the 1950s right through to the 1980s. While some of the films were produced in the United States or Britain, they were internationally shared and were often shown in Canada as part of a much larger cancer prevention project in the twentieth century. The Canadian Cancer Society (CCS), for the most part, was responsible for organizing showings of educational films (in schools or public arenas). In addition to these films, the CCS printed numerous posters throughout the post-WWII period that focused on cancer prevention. Despite the fact that most of these posters no longer exist, the Canadian Cancer Society Fonds at the Library and Archives Canada have preserved a few for the public to view. Most of the posters in these Fonds are focused on the no-smoking campaign; only one focusing on cervical cancer prevention exists. Although films and posters were key contributors to the dialogue on cervical cancer prevention, this chapter will demonstrate that newspapers played a much larger role in the distribution of information about this disease to Canadian women. Newspapers have subscription numbers and often survey their readership to define demographics. This chapter will first discuss films focused on cancer and cancer prevention from the 1950s through to the later 1980s. The chapter will then provide a brief discussion of the CCS poster collection at

the Library and Archives Canada and will finish with the discussion of various types of Canadian newspapers and their valuable contribution to the dissemination of information about cervical cancer and its prevention. While all of the newspapers cited were searched in their entirety, there was significant variation in the degree to which different papers addressed the issue of cervical cancer, reflecting both regional differences and the political persuasion of individual media and editors. Surprisingly, for example, university papers contained significantly less material about cervical cancer than did mainstream papers such as the *Toronto Star*.

### **Films:**

The National Film Board (NFB) of Canada was created in 1939 as a result of the report sent by Vincent Massey, Canada's High Commissioner in London, to Mackenzie King's government on the state of Canadian cinema. Since then, literally thousands of films have been produced and screened around the world.<sup>1</sup> The Massey report highlighted the four key categories of cinema in Canada: educational, promotional, ministerial, and "films designed to promote specific ideas, or a sense of belonging among the citizenry."<sup>2</sup> The body that existed prior to the NFB the Motion Picture Bureau was found to be lacking real governance, and it was exclusively serving the needs of the Department of Commerce and other sectors were required to set up their own film services, causing a lack of cohesiveness. In May of 1939, as a result of an act of

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<sup>1</sup> Zoë Druick. *Projecting Canada: Government Policy and Documentary Film at the National Film Board*. (Montreal: Ithaca, 2007), 15. Other great books that track the history of the National Film Board are: Gary Evans, *In the National Interest*. (Toronto: UofT Press, 1991); and Donald Bidd, *NFB Film Guide: The Productions of the National Film Board of Canada from 1939 to 1989* (Montreal: The Board, 1991).

<sup>2</sup> <http://www.nfb.ca/historique/about-the-foundation>. "Chapter 2: The NFB Foundation." (viewed April 11, 2012)

Parliament, the National Film Board was created. Headquarters were set up in Ottawa, and the new mandate was "...to make and distribute films across the country that were designed to help Canadians everywhere in Canada understand the problems and way of life of Canadians in other parts of the country." The new NFB even embraced the responsibilities of filmmaking activities of various other federal departments.<sup>3</sup>

Since Canada went to war the same year as the NFB was established, most film production during these early years was patriotic. John Grierson, known as an expert in "the psychology of propaganda," was the first Government Film Commissioner and remained in the position until 1945.<sup>4</sup> While the focus of this chapter is films produced after 1950, the new NFB mandate remained strong as a result of some of the earlier films focusing on the advances of science and a focus on community education. The distribution of NFB films was extensive as distribution agreements were signed with producers of newsreels in the U.S.A. and Famous Players of Canada.<sup>5</sup> Even with the private sector criticizing the NFB for securing public funds "to which the private sector did not have access," the NFB remained true to its mandate and distribution responsibilities.<sup>6</sup> In 1950, a new National Film Act was passed not only making the NFB independent of the state, but also redefining its mandate. It read as follows:

...the Board is established to initiate and promote the production and distribution of films in the national interest and, in particular: a) to produce and distribute and to promote the production and distribution of films designed to interpret Canada to Canadians and to other nations; b) to represent the Government of Canada in its relations with persons engaged in commercial motion picture film activity in connection with motion picture films for the Government or any department

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<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

<sup>5</sup> Ibid.

<sup>6</sup> <http://www.nfb.ca/history/1950-1959/>. "Chapter 4: 1950-1959," (viewed April 11, 2012).

thereof; c) to engage in research in film activity and to make available the results thereof to persons engaged in the production of films; d) to advise the Governor in Council in connection with film activities; and e) to discharge such other duties relating to film activity as the Governor in Council may direct the Board to undertake.<sup>7</sup>

It was unmistakable that the NFB was continuing to redefine itself in the interest of educating the Canadian public and was diversifying to compliment all aspects of a growing Canadian society. In response to criticisms about bilingualism and the Conservative environment of Ottawa, the headquarters was moved to Montreal in 1950.<sup>8</sup> In 1950 alone, the NFB made 187 mostly black and white films. Eighteen of these films won awards in Canada, Europe, and in the U.S.<sup>9</sup> Clearly the NFB was making an impact on society in its early decades.

Film was one avenue to distribute knowledge about technological advances of the 1950s. One key technological advance the National Film Board (NFB) of Canada wanted to capture was the medical profession's attack on the country's number one killer, cancer. The approach in film was similar to what was in print, focusing on the problem of cancer, the technology involved in conquering it, and what "you" could do to contribute to the cause. One of the earliest films by the NFB on cancer was *Progress Report on Cancer*, produced in 1951. NFB cancer-related films during this early period focused on general technological advances in understanding cancer, but did not exclusively discuss cervical cancer and its prevention. The 1950s were still early in terms of general understandings of the prevention of cancer. For example, the implications of smoking in the

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<sup>7</sup> Ibid.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

development of lung cancer were not yet understood, and there was little push from either health experts or the government to prevent smoking. These films were also a new way for cancer experts to educate the public by breaking down literacy and class boundaries thus reaching a more diverse population. As historical film expert Natalie Zemon-Davis argues, films utilize “techniques for narration and representation” that further evoke emotional responses that reading text simply might not.<sup>10</sup> For the historian, however, the only problem is that, in comparison to newspapers, it is much more difficult to assess the impact of films. How many people viewed a particular film? And who would be found in such audiences?

This 1951 film attempted to chronicle the progress science had made in the “fight” against cancer up to this point. Using a villainous theatrical mode, cancer was portrayed in this film as something that science needed to “attack” and “conquer.” The language used by the narrator focused on creating a dichotomy between science and disease, in this case, cancer. This type of language choice also seems to fit the time period, as the Second World War was just over and images of war were still fresh in the minds of Canadians. Countries were also focusing on restructuring, recovery, and rebirth. Canada was no different, as many historians have argued; the 1950s were a time when the government focused on a new sense of modernity and a return to normalcy, the family and repopulation, reviving lost industry, and the rebirth of the Canadian economy.<sup>11</sup> The same can be argued for the United States during the post-WWII period.

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<sup>10</sup> Natalie Zemon-Davis. *Slaves on Screen: Film and Historical Vision*. (Canada: Vintage Canada, 2000), 5.

<sup>11</sup> For an interesting discussion on Post-WWII society and change, see Douglas Owsam, *Born at the Right Time: A History of the Baby Boom Generation*. (Toronto: University of Toronto Press, 1996).

In 1951, the NFB produced a film called *The Outlaw Within: Cancer*. This was a film with a basic storyline – a man with a sore on his cheek and how science cured him - and focused on the impressive strides research scientists were making in solving the “mystery of life and the riddle of cancer.”<sup>12</sup> There was no mention of concepts of prevention and very little focus on the actual “curing” of the patient other than the scientific advances being made in x-ray and radiation treatments. Viewers were constantly reminded of how they needed to have complete “confidence” in their doctors. The narrator confirmed numerous times that “the power of our attack on the mystery of cancer mounts steadily.” The music in the film was dark, adding fuel to the idea of the need to “conquer” cancer.<sup>13</sup>

In 1958, the NFB produced a similar film, *The Fight: Science Against Cancer* that also featured a storyline of a man with a sore on his cheek and the processes of treatment he endured. This film started by listing all the latest conquered diseases of the time, such as diabetes, lockjaw, and meningitis. Since diseases continued to “attack” man, it was, therefore, science’s job to protect him. The film then traced “by means of greatly magnified sequences, the growth and multiplication of a single fertilized cell into an adult man, and asks why, after the body has reached maturity, some outlaw cells begin a persistent and subversive growth on their own.”<sup>14</sup> The narrator continued to follow these “outlaw” cells into both diagnosis and treatment.

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<sup>12</sup> Canadian Cancer Society Fonds, *The Outlaw Within – Cancer*, Directed By Morten Parker (1951; Canada: National Film Board of Canada), Library and Archives Canada, accession number R9308-0-6-E, box 05842, VLTSF# 8503-0283, VHS.

<sup>13</sup> Ibid.

<sup>14</sup> *The Fight: Science Against Cancer* (jacket cover) DVD, directed by Morten Parker (1951: Canada: National Film Board of Canada).



As a case study, several male doctors examined a man's face, which was showing the early signs of skin cancer. The film used this opportunity to celebrate modern science, technology and progress. The first scene starts in the lab, examining the specimen using several high-tech machines for the 1950s such as advanced magnifying devices and various machines to process specimens. Eventually, demonstrating the treatment of cancer, radiation machines were shown at work while treating the patient's skin cancer. Advances in modern surgery were also discussed in terms of how much could be done during this decade to treat malignant cancers.<sup>15</sup> Even the music in this film created an atmosphere of conflict. When discussing cancer or science's triumphs over it, the music was dark (in a minor key) and sounded much like a gunfight scene in an old John Wayne western. Scenes of actual treatment procedures were partnered with softer, more soothing music to evoke empathy in viewers and an air of hope for the cancer patient being treated. The music even sounded curious while the narrator discussed x-ray therapy and the "multi-million voltage weapons" that were being used to "destroy cancer cells".<sup>16</sup> One of the main purposes of this film was to educate the general public about science's progress in the fight against cancer. While the film used one case study of man with a cancerous sore on his cheek, there were few specific references to different types of cancer or ideas about prevention. This film focused on treatment and cures for a disease that continued to kill people every day. The NFB of Canada also produced a few other films in the 1950s such as *Report on Cancer* (1959) directed by Julian Biggs and

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<sup>15</sup> Ibid.

<sup>16</sup> *The Fight: Science Against Cancer*. DVD, directed by Morten Parker (1958; Canada: National Film Board of Canada).

*Cancer Clinic* (1954) produced by Allen Stock. While copies of these films no longer exist either at the NFB or any archival collection, it seems likely that these films were of the same genre as the two discussed in detail.

In 1953, the NFB produced a television series called *On the Spot* that travelled around Canada to see what was going on with Canadians. They also produced a French equivalent, *Sur le vif*. Some of the pan-Canadian topics explored were Alberta's petroleum industry, dance, Korea, gold-mining, and trapping.<sup>17</sup> They also produced a special episode on cancer called "On the Spot: Cancer is your Problem." Set in the Canadian Cancer Society office in Montreal, the host Fred Davis opened the show by standing in front of posters with slogans such as "fight cancer – give now!" After a brief introduction, Davis turned to introduce and interview the current president of the National Cancer Institute, Dr. Jean Bouchard. One of the key questions that Davis asked was, "is there still advancement being made in the fight against cancer?" Dr. Bouchard answered confidently, "yes there is definite progress being made, but there is still a great deal to be done."<sup>18</sup> Similar to other films produced in this decade, the music was dark and had a sense of battling something. Most of the commentary focused on the causes of cancer and debunking the myths of cancer at the time – heredity and contagion. Another focus was on how crucial it was to seek counsel and advice from your physician. Several situations were filmed showing women in a waiting room of their physician's office. One woman is shown talking to her cancer clinic doctor after she was referred by her

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<sup>17</sup> <http://www.nfb.ca/history/1950-1959/>. "Chapter 4: 1950-1959." (viewed April 11, 2012)

<sup>18</sup> Canadian Cancer Society Fonds. *On the Spot*. "Cancer is your Problem." VHS (copied), directed by Allen Stark (unknown date-estimated 1950s; Canada: National Film Board of Canada), Library and Archives Canada, R9308-0-6-E, Box 05842, VLTSLF# 8511-0237.

family physician because of a lump in her right breast. The doctor said to this woman, “you were wise to go to your doctor as soon as you noticed a lump.” He further commended the woman and then the film transitioned to Dr. Bouchard talking about the importance of early detection.<sup>19</sup>

In 1957, a film was produced by the American Cancer Society, *Time and Two Women*. This film was used by cancer societies, not just in the United States, but also in Canada and Britain. Hosted by a consulting gynecologist to the Vincent Memorial Hospital in Boston, Massachusetts, and produced by Audio Productions in New York, *Time and Two Women* would prove to be a vital vehicle for the distribution of information about cervical cancer for decades. The National Cervical Cancer Prevention Campaign in Britain showed this film at various public meetings and always recommended that a medical professional (doctor or nurse) be present to field any questions or concerns from the audience.<sup>20</sup> A copy of this film was also found in the Library and Archives Canada, Canadian Cancer Society files, indicating that the Canadian Cancer Society used this film as part of their public education campaign about cervical cancer.

*Time and Two Women* starts with a lecture from Dr. Meigs about the cancer of the uterus (including cervical cancer). After a brief introduction, he gets up from his desk and walks over to a diagram of a woman’s internal reproductive organs. He details all parts of the internal reproductive organs and includes a definition of what menstruation

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<sup>19</sup> Ibid.

<sup>20</sup> Wellcome Institute Archives. SA/MWF/F.13/1. *Time and two Women*. 16mm Sound/Colour, 18 minutes.

entails. He wants to be clear “to the both of us, what we are talking about.” He lets the viewer know clearly that his main focus is the cervix because “most of the cancer of the uterus occurs in the cervix.” He stresses the importance of knowing more about this disease because 23,000 women were dying from uterine cancer every year (at this point).<sup>21</sup>

After his brief introduction lectures, he sets up his two key examples, one woman who died from cervical cancer and one who was successfully treated and cured. In a flashback sequence, Dr. Meigs reminisces about a woman, age 52, and a widow, who died from advanced stage cervical cancer. Upon her first meeting with her doctor, in an accusing tone, he says to her “according to what you have told me, you haven’t been examined, but once, since the birth of your child, that was about 12 years ago, is that correct?” The woman stutters in response and tries to reassure her doctor by stating “until this trouble began, I have always been healthy.” She nervously talks about the “change of life” and how she had not had any “female trouble until now.”<sup>22</sup> She details how about eight or nine months before this meeting with her doctor she had noticed a watery vaginal discharge that lasted about two days. This appeared for two weeks, but she attributed it to her “change of life” and did not pay much attention to it. Again, with an accusing tone, the doctor responds by asking “did it occur to you that this discharge wasn’t normal?” Flash-forwarding to the present, Dr. Meigs goes through the details of her diagnosis, and how it developed – mentioning often how the “early signs were

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<sup>21</sup> Canadian Cancer Society Fonds. *Time and Two Women*. American Cancer Society, VHS (copied), narrated by Dr. Joe V. Meigs (1957; Audio Productions Inc., New York), Library and Archives Canada, R9308-0-6-E, Box 05842, VLTSLF# 8303-0284.

<sup>22</sup> Ibid.

ignored.” He asks, “why did these patients die [referring to the pile of patient files marked ‘deceased’]? Because they ignored danger signals, abnormal vaginal bleeding.” He then details what abnormal vaginal bleeding is, including bleeding between periods and unduly heavy bleeding. Clearly the responsibility was on this woman to take action when she recognized early signs – but she did not and she ended up needlessly dying. Dr. Meigs stresses to the viewers at this point in the film that “only a physician can tell you [if it is cancer] through a thorough pelvic examination.” He explains why only a physician is able to recognize cancer through extensive training and education.<sup>23</sup>

The film contrasts the women who “ignore danger signals” to women who successfully battled their cancer diagnoses by notifying their physicians immediately after early signs of vaginal abnormalities were noticed. Going through files labeled “cured,” Dr. Meigs introduces a housewife and mother who had a history of going to her doctor regularly for check-ups. Appearing healthy, she has a pelvic examination by her doctor who promptly takes a vaginal smear. The camera shoots to the view of a woman comfortably lying on an examination table reassuring the doctor that “she was feeling no pain or discomfort.” The doctor, with a gloved hand, examines the external and internal (via bimanual examination) organs and inserts a speculum to retrieve a smear specimen. Going to a shot of laboratory technicians at work, the narrator announces that abnormal cells were found and, upon a follow-up examination, a cancer diagnosis was confidently made. The patient was then treated promptly and examined for five years allowing her to have “never felt better in all her life.” Cancer was said to have never been found again.

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<sup>23</sup> Ibid.

A screen then pops up stating “cure rate of uterine cancer, WHEN DISCOVERED EARLY, is nearly 100%.” The film closes with another lecture from Dr. Meigs urging women to go to their doctors and request uterine smear tests. It then states that a “physician among you will be introduced shortly,” indicating that this film was shown at an organized meeting or information session where a doctor was directly involved and willing to answer questions afterwards.<sup>24</sup>

In addition to the 1950s films found at the Canadian Cancer Society files at the National Archives, there were also a few films produced in the 1960s. A film entitled, *A Story for Women*, produced for the Canadian Cancer Society by the Photographic Studio, while undated, was clearly made in the mid-1960s. While only a filmstrip exists, with no audio, the storyline is straightforward – a woman, mother, and wife visits her doctor, receives some grim news and is treated and promptly returns to her normal life.<sup>25</sup> Frames 26 through 31 show the woman fulfilling her responsibilities as a mother and wife: dishes, ironing, sewing, and cleaning – typical for the 1960s. However, frame 32 is different; she has stopped doing her tasks and is looking directly at the viewer with her eyebrows lifted, indicating that “you” should have known better. In frame 36 the screen reads, “detected early – treated promptly,” reinforcing the woman and her lifted eyebrows. Several frames follow showing various women in doctors’ offices, and even a woman being examined by a doctor. Frames 45 through 50 are images of doctors speaking to their female patients and of lab technicians reading slides. The final few

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<sup>24</sup> Ibid.

<sup>25</sup> Canadian Cancer Society Fonds. *A Story for Women*. Canadian Cancer Society, filmstrip, (unknown date-estimated 1960s; Canada: Commercial Photographic Studio, Eaton’s of Canada), Library and Archives Canada, R9308-0-6-E, Box 05842, VLT# 1986-005 5842.

frames show the original woman from the start of the filmstrip looking healthy and getting back to the normal tasks of life before her diagnosis. She is dressed conservatively, her hair is perfectly styled, and she is smiling, confirming the success of her treatments. The final frame reads “this life-saving message for women is made possible by your contributions to the Canadian Cancer Society.”<sup>26</sup> This film is indicative of many educational health films during this period – women were instructed to be responsible and have regular check-ups by family physicians and to not ignore the early signs of cancer. A maternal message was also often present: women owed it to their families to stay healthy, and this film, *A Story for Women*, is an excellent example of this.

There were also a few more general health films produced in the 1960s, and they resembled the same messages being delivered in the 1950s. Three films in particular, *Cancer: The Elusive Enemy*, *Horizons of Hope*, and *The Choice*, all focused on the significant advances being made by science in the battle against cancer. *Horizons of Hope* confirmed that “to conquer Cancer, scientists are working all over the world.”<sup>27</sup> *The Choice* was about a young man who is trying to decide whether or not to become a general practitioner, like his father, or to specialize in cancer research. Early in the film the stage is set for the parallels to be made between battling forest fires and battling cancer. Percy, a fire fighter, is told by his fellow firefighters to leave the fire to them, as he needs to go and see the doctor – stressing to the viewer the importance of keeping regular appointments with your physician. The film then goes back to the young doctor

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<sup>26</sup> Ibid.

<sup>27</sup> Canadian Cancer Society Fonds. *Horizons of Hope*. John Sutherland Production, VHS (copied), (unknown date-estimated 1960s; US: John Sutherland Production), Library and Archives Canada, R9308-0-6-E, Box 05842, VLTSLF# 8303-7814.

who initially feels that cancer research is “too big, there is too many unknowns.” Despite his lack of confidence, his father (a retired GP) continually pressures him to focus on cancer research with hopes of him becoming the “man who discovers the secret of cancer.”<sup>28</sup> While the son stresses about this decision the film goes through the various developments in cancer research – the Pap smear, virus and cancer connection, mass screening for early detection, and predicts that the 1970s and 1980s will only bring more advancements. The film ends with putting the connections between fighting forest fires and fighting cancer together. Percy states to the doctors, “sorry it took so long, had to stop and help the boys with a forest fire.” The doctors respond by stating, “you can always put out fire if you catch it early enough. It’s a good thing they found that forest fire in time. As Percy says, you can do something about it if you find it in time, it is just like cancer, it’s a matter of time.” Predictably, the film ends with the young doctor making a commitment to cancer research.<sup>29</sup>

*Cancer: The Elusive Enemy* delivered similar messages, but also highlighted, much like *The Choice*, the importance of the prevention of cancer. After debunking myths about cancer, this film focused on cancers exclusive to women. After cutting to an image of a woman’s breasts, the narrator stated, “certainly woman’s disease, particularly of the reproductive organs, prevention can be particularly advantageous.” While the narrator was clearly talking about breast cancer and how self-examination is vital to its prevention, this addition of a discussion of prevention was relatively new in health

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<sup>28</sup> Canadian Cancer Society Fonds. *The Choice*. Directed by Robert Clotheir (unknown date – estimated 1960s; Chetwynd Films Production), Library and Archives Canada, R9308-0-6-E, Box 05842, VLTSLF# 8303-0188.

<sup>29</sup> Ibid.



education films on cancer. There is concern voiced, however, that people in general are less than receptive to concepts of prevention. The narrator attributes this notion to pure ignorance: “people like to play with fire, maybe that is why people don’t want to learn about cancer, its treatment and prevention.”<sup>30</sup> The film ends as most cancer films did, with stressing the importance of seeing your doctor immediately if early signs of cancer are found. It also stressed the importance of not smoking.<sup>31</sup>

Looking more internationally, evidence exists that there were numerous films written and produced focusing directly on cervical cancer in England during the 1960s. Some of these films include, *The Airway of Life*, *Calling all Women*, *Take Action*, *Emergency Stop*, and *A Building Site*. Evidence also exists that some of these films actually made their way to Canada. During the 1960s the National Cervical Cancer Prevention Campaign (NCCPC)<sup>32</sup> also produced and/or distributed several films focusing on cancer prevention. Most films were either focused on cervical or breast cancer. One early film, *From One Cell*, had a specific purpose and was designed to introduce the subject of cancer “objectively and unemotionally” in terms of its cell growth and cell diversion. The idea was to provoke discussion in mixed audiences about the “as yet unanswered questions of abnormal cell behaviour.” The film shows several time-lapsed

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<sup>30</sup> Canadian Cancer Society Fonds. *Cancer: The Elusive Enemy*. Pacific Films Production, VHS (adapted from an original of the Cancer Society of New Zealand), (unknown date-estimated 1960s; New Zealand: Pacific Films Production), Library and Archives Canada, R9308-0-6-E, Box 05842, V12012-01-0011.

<sup>31</sup> Ibid.

<sup>32</sup> The NCCP (later the Women’s National Cancer Control Campaign) was an early grassroots organization that focused on distribution of information about cervical cancer and providing screening opportunities to British women from all walks of life. This Campaign went from a small group of women interested in cervical cancer to a well-organized cancer prevention force in the matter of only one year. One of the key concerns addressed early in the Campaign’s existence was the focus on bridging the gap between the need for screening and what services were being offered in doctor’s offices. One of the most unique aspects to the WNCCC was its use of a mobile clinic in 1969.

sequences of specimens of normal and abnormal living tissue.<sup>33</sup> The American Cancer Society produced this film. These films were part of the same genre of films the NFB were producing at the same time.

Another early film, *The Airway of Life*, was produced in part in 1965, by Patrick Steptoe, one of the first members of the Medical Advisory Committee for the WNCCC. This film was designed to “inform and educate all women to respond to a cytology test.”<sup>34</sup> The film ran for eighteen minutes. The Campaign sponsored the production and received two 16mm copies. They were made available to any group upon request, and it was recommended to have a medically trained individual attend the showing because of the dense medical content.<sup>35</sup> Steptoe did not stay long with the WNCCC as his work took him in the direction of test tube babies, and he resigned shortly after his initial involvement.<sup>36</sup>

In 1968, a film titled *Calling All Women* was produced and designed by the Campaign specifically for British women to replace *Time and Two Women* that had been created much earlier in the US. This film was a simple-style animated documentary explaining the test for cervical cancer. The film starts with a background shot of the House of Commons with a voice-over discussing the formation of the campaign as “a pressure group under the auspices of the first president Mrs. Butler M.P., the Campaign persuaded the Minister of Health to set up cytology facilities throughout the country.”<sup>37</sup>

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<sup>33</sup> Wellcome Institute Archives. SA/MWF/F.13/1. *From One Cell* – 16mm Sound/Colour, 14 minutes.

<sup>34</sup> Hackney Archives. D/S/54/3. Obituary for Patrick Steptoe, March 1988 (unknown newspaper).

<sup>35</sup> Hackney Archives. D/S/54/3. “1967 Campaign Newsletter”, page 4.

<sup>36</sup> Hackney Archives. D/S/54/3. Obituary for Patrick Steptoe, March 1988 (unknown newspaper).

<sup>37</sup> Wellcome Institute Archives. SA/MWF/F.13/10. Film Working Party Files – “Calling All Women” Script.

The film continues to tell the story of Mrs. Jones who eventually and reluctantly goes for a smear test. When they find suspicious cells, she instantly worries about the children and who would take care of them when she has to go into the hospital for one or two days of follow-up tests. Her practicing physician, Dr. Brown, recommends that she undergo a small operation to remove the suspect tissue. The exchange was as follows:

Mrs. Jones: How serious is this operation Doctor? Will I be able to have any more children?

Dr. Brown: Yes, of course you will and it won't make any difference to your married life either.

The film ends with images of Mrs. Jones having holiday celebrations with her family and growing old with her grandchildren.<sup>38</sup>

There were several other script ideas during the late 1960s in Britain that may, or may not, ever have been produced. For example, a film was scripted aimed directly at the factory and trade women in order to break down the fear of cancer. This film was called *Take Action*. Another film, pitched as a cartoon, *Emergency Stop*, had a “light touch to take the fear out of cancer.” This film was going to be aimed at the widest audience possible and was “designed to relax the viewers making them receptive to the idea of having a cervical test.” One film scripted targeted a popular past-time, bingo, and how women were candid enough to discuss the “cancer test” even when they were playing bingo in a public place. There is some humour in the film, as the women become confused about their discussion while trying to keep track of the bingo calls and eventually the caller shouts “FULL HOUSE” and sends them all off to have the test.

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<sup>38</sup> Ibid.

This film was only 90 seconds long, and there is a note that this film was produced and sent out to bingo halls and factories.<sup>39</sup>

A unique film was also proposed that was directed at men and how to cope if their wives were gone for a few days following a positive smear test. The film, *A Building Site*, starts with several men sitting around discussing one man's wife who has gone for treatment after a positive smear. The scene starts with his mates making fun of him, but they stop when they realize this situation could happen to them. They then start to ask questions about the test. The husband whose wife is being treated acts rather "blasé about the whole thing because his wife is doing so well, and gives a reassuring account of what his wife had to do ending with 'if you want to know any more get your old woman to go along to the clinic.'"<sup>40</sup>

These films demonstrate that in Britain, the NCCCP had a keen awareness of the need to use various types of communication to educate the British public about cancer prevention and cervical cancer. Many of these films were written and/or produced during a time when women were reluctant to go to screening facilities to be tested for "cancer," and knew little about cancer prevention in general. While newspapers, press conferences and various poster campaigns were all influential types of knowledge distribution, films were unique in their approach. Films gathered women together for a viewing and upon reflection often created a safe atmosphere for women to ask questions that they might not have asked when visiting their family physicians. The NCCCP was sensitive to what was needed to educate the public about cervical cancer, and these films and their international

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<sup>39</sup> Ibid.

<sup>40</sup> Ibid.

travel, are clear indicators of this sensitivity. By the 1970s, the British cervical cancer prevention campaign was similar to some provinces in Canada in that they embraced many other varieties of public education techniques. In Canada, we would not only see more cancer information being released to the public in more accessible ways, but we would also see a direct focus on the preventive techniques for cancers such as cervical cancer.

Films provided Canadian viewers in the 1970s with visual examples of a disease they might only have read about in newspapers and magazines. The 1970s were a particularly unique time in Canadian film as the “women’s unit” of the National Film Board, Studio D<sup>41</sup>, was established. The principal advocate for creating a women’s film studio was Kathleen Shannon. Between 1971 and 1973, just prior to the start of Studio D, Shannon created a set of ten documentaries focusing on the plight of working mothers.<sup>42</sup> The overwhelming response from the Canadian public caused the National Film Board to seriously consider budgeting a “long-term women’s program within the structure of a documentary film unit.”<sup>43</sup> More specific to health, the National Film Board of Canada produced and financed a few films in the 1970s focusing on breast and cervical cancer. *Still A Woman*, (1973) directed by Dina Lieberman openly discussed the post-mastectomy experiences of women, and in 1974, Cheryl Wright produced a film, *Cancer in Women*. Wright’s film attempted not only to demonstrate various preventive procedures for cancer, but also brought the brutality of cancer to the screen. The

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<sup>41</sup> For a more comprehensive history of the Studio D, refer to Gail Vanstone’s, *D is for Daring: The Women behind the films of Studio D*. (Toronto: Sumach Press, 2007).

<sup>42</sup> Chris Scherbarth. “Canada’s Studio D: A Women’s Room with an International Reputation.” *Canadian Woman Studies* vol. 8/1 (1987): 24.

<sup>43</sup> *Ibid.*, 25.

message was clear in print and films such as Wright's; the onus remained with women to know their bodies and to know cancer.

Wright's film focused on the prevention of breast and cervical cancer. Not only did she show graphic images of cancerous cervixes, but she also filmed an entire pelvic exam and explained how to perform breast self-examination. Cheryl Wright was a medical photographer at a large Nova Scotia hospital at the time she produced this film, and she argued that the majority of the cancer cases she had seen had been cancers restricted to women. She was appalled by how many women chose to neglect their health and simply did not participate in routine screening procedures. Many women, she argued, simply knew nothing about any of the pelvic cancers or breast cancer and how easy it can be to prevent and even treat them.<sup>44</sup>

The visual experience in this film is the instructional session of breast self-examination. The image is of a woman's bare chest. Her head is not part of the shot as a way of depersonalizing this procedure, with a male physician instructing how to examine your own breasts. His movements are relatively quick and firm, followed by the headless woman performing the examination herself using a much softer technique. This instructional session is followed by graphic images of breast cancers with various quotations from women who chose to neglect their breast health (even if a lump is present) playing in the background. These quotations included: "I'm too old," "My husband doesn't make very much money," or "I've nobody to watch the children."<sup>45</sup>

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<sup>44</sup> *Cancer in Women*. Produced by Cheryl Wright. (NFB of Canada – Atlantic region, 1974).

<sup>45</sup> *Ibid.*

Although more visually graphic, the film takes a similar approach to cervical cancer as it had done with breast cancer.

The section on pelvic cancer focuses on the Pap smear, its preventive qualities, and how straightforward the procedure actually is. After listing the various pelvic cancers, including cervical cancer, the film shoots an entire pelvic exam, including a Pap smear. The shot starts with a view of a woman's vagina with both her legs in stirrups. A male physician then narrates and performs a pelvic exam, including both sample taking and a rectal exam. What is particularly odd about this examination is that the male physician only has one of his hands gloved, while the other, used to separate the labia majora in order to insert the speculum, is not gloved. This may be simply because the ungloved hand is not going to be inserted directly into the vagina. Similar to the breast exam, the physician is quick and fairly rough in his technique and the woman's face is never shown. After the exam is finished, various graphic images are shown of types of pelvic cancers while quotations of women giving excuses for not participating in routine pelvic screening are playing in the background. Some of these quotations include: "I thought it was just my age, with menopause and all"; "being examined is so humiliating"; "I don't have time"; and "I feel fine."<sup>46</sup>

Closing the film, Norma Mosier, Executive Secretary of the Women's Institutes of Nova Scotia at the time, argues that while this film is difficult to watch and graphic at times, all women need to see the ramifications of "neglecting their health." She recognized that Nova Scotia had high rates of cervical cancer in comparison to western

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<sup>46</sup> Ibid.

provinces and urged women to participate in routine screening to prevent cancer or to catch abnormalities early enough to treat them.<sup>47</sup> This film is representative of the cancer awareness campaign of the 1970s. Recognition of high rates of incidence and deaths as a result of preventable cancers such as cervical cancer pushed health advocates to demand that women take more ownership of their own health and not only learn about their health care options, but also routinely participate in screening programs.

The only 1980s film I was able to watch was, *Its your Decision*, that was produced and facilitated by the Canadian Cancer Society with a focus on the prevention of cervical and breast cancer and the importance of self-examination. Alongside broader public discussions about preventive health care approaches and the Women's Health Movement, this film is certainly a product of its time. Reminding the viewer that "every year thousands of women contract cervical and breast cancer [and] medical authorities say this is a needless waste," this film gives women the impression that it is, indeed, within "her powers to practice two simple health habits to protect her from cancer."<sup>48</sup> This film is incomplete, as the second section focusing on cervical cancer is missing. The current copy only includes the detailed section on breast self-examination. The doctor, Dr. Sue Coberg, goes into great detail about how to properly examine your breasts.<sup>49</sup> Often cervical cancer is coupled with discussions of breast cancer and this film is clearly an excellent example of this partnership; it is certainly unfortunate that the part of the film most pertinent to this dissertation is missing.

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<sup>47</sup> Ibid.

<sup>48</sup> Canadian Cancer Society Fonds, *Its your Decision*. Narrator - Michelle Martin (Canadian Cancer Society, 1981), Library and Archives Canada, R9308-0-6-E, Box 05842, V1 2012-03-0001.

<sup>49</sup> Ibid.



Films produced by the National Film Board and the Canadian Cancer Society, without a doubt, made an impact on educating Canadian women about cervical cancer. Two questions remain: who watched these films? One film, *Today's People*, shows a man taping up a poster in the main office of mining company that says, "Early Diagnosis! Cancer facts for men."<sup>50</sup> There is no doubt that this happened in other workplaces around Canada. Also, there is no doubt that the films in the Canadian Cancer Society Fonds were shown in communities across Canada. In the film just mentioned, *Today's People*, there are several CCS volunteers profiled. Several of these volunteers are seen handing out pamphlets in public places, and one volunteer is seen talking about cancer prevention on a local radio show. The Canadian Cancer Society relied heavily on volunteers during the twentieth century for continuous knowledge distribution. This film in particular focussed on how becoming a volunteer was a powerful way to give back to your community and reminds viewers that when you "lend a hand – you are gonna feel good too."<sup>51</sup> While films were a powerful tool used by the government and the CCS to distribute information about cancer, its diagnosis, treatment, and prevention, it is difficult to track exactly how many people actually viewed the films being produced. Newspapers in Canada, however, have consistently tracked their readership and have been able to track the demographics of the people who are reading their issues. Similar to *Chatelaine* discussed in the previous chapter, newspapers were excellent sources of information in the homes of Canadians throughout the twentieth century. As the next section of this

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<sup>50</sup> Canadian Cancer Society Fonds. *Today's People* (Undated (possibly the 1970s?): Produced for the Canadian Cancer Society by the Profile Communications Inc.), Library and Archives Canada, R9308-0-6-E, Box 05842, VLTSLF# 8306-0005

<sup>51</sup> Ibid.

chapter will demonstrate, newspapers (dailies and university papers) were successful in giving Canadian women an accessible place to find information about cancer and even particularly about cervical cancer.

**Newspapers:**

While newspapers such as the *Toronto Star*, *The Globe and Mail*, *The Halifax Chronicle Herald*, and *The Vancouver Sun* did not necessarily focus on personal experiences with cancer, they did contribute to the new popular discourse on cancer prevention in the mid-twentieth century. Many articles, mostly written by medical professionals, provided constant pressure for women to undertake Pap smears and make preventive lifestyle choices. Despite the reluctance of some Canadian doctors about the validity of the Pap smear throughout much of the 1950s and early 1960s, there is evidence that there were several doctors who were on board with screening their female patients for cervical cancer. The appearance of the cervical cancer discourse in newspapers was indicative of a major shift in ideas about who the primary players were in the eradication of the disease. Newspaper articles about cervical cancer point to a few key ideas in particular: the public was prepared (even if only at some basic level) to be engaged and informed by the debate; authors were aware of the bridge that needed to be built between medical practitioners and the public; and lastly, that the airtight walls that had surrounded the cervical cancer debate were crumbling. Most articles were further reinforced by statistical data and various studies on the successes of population screening. Most importantly, this provided women, in accessible language, with the tools to engage

in their own preventive health care. Upon a close examination of these newspapers, articles pertaining to cervical cancer only really started to grace their pages in the 1950s.

Most of the articles during the decades of the 1950s and 1960s were written by male medical professionals claiming expertise on the subject of cancer. During 1950s, *The Toronto Star* demonstrated its awareness of cervical cancer by printing a couple of articles focussing on the importance of screening for this disease. An early article printed in *The Toronto Star* in 1955, based on American statistics, claimed that women would individually recognize the importance of the newly developed techniques to “diagnose cervical cancer, not only in its earliest stages, but, in some instances, before it becomes a cancer.”<sup>52</sup> Interestingly, later in the same year, *The Toronto Star* printed another article claiming that the Pap smear and a mass screening based on prevention may not be “the most useful way of spending available funding.”<sup>53</sup> One doctor stated that “cancer of the cervix makes up less than 15% of the total cases of cancer in women in Ontario,” implying that 15% was simply not enough to invest in a mass screening program. The article was referring to a program launched in Memphis, Tennessee, where women walking down the streets were bombarded with signs encouraging them to take a voluntary screening test for cancer of the neck of the womb which took only ten minutes. While the Memphis project claimed to have screened at a success rate of 100%, medical leaders in Ontario were skeptical that investing in a test that only focused on one site was worth it. In the 1950s the Women’s College Hospital was still running their well-women

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<sup>52</sup> “Women! You need no longer die from your No. 1 Cancer Killer.” *The Toronto Star*, March 31, 1955, 38.

<sup>53</sup> “Doubt U.S. Cancer Test Economical for Ontario.” *The Toronto Star*, October 21, 1955, 62.

cancer clinic, and for \$15 women were screened for numerous diseases including TB and various STDs. It did not seem practical to the medical officials at the time to invest “\$1000 of public funds to uncover any unexpected cases of cancer early enough that the chances of cure rise from one out of five to three out of four.”<sup>54</sup> While the article mentioned a conference held in Toronto that concluded that the “test was not practical for province-wide application,” it was a test that was very much accepted and encouraged at the Women’s College Hospital clinic. Dr. Florence McConhey, head of the clinic at the time, said that she was in favour of “anything that will lead to earlier examination and detection of cancer in women.” However, it was recognized that since women had to pay for any examination at this time, a more complete examination alongside a Pap smear would help to encourage women to pay fees and take part in well-examinations.<sup>55</sup>

*The Halifax Chronicle Herald* was not far off both the *Globe and Mail* and the *Toronto Star* in what it was printing between 1950 and 1970. Articles in the 1950s often focused on general concern about cancer – either how men were more susceptible to cancer than women or how polls were showing how Canadians were generally ignorant about the early symptoms of cancer. For example, in August of 1955 the *Halifax Chronicle Herald* printed an article reporting on a national-wide survey asking Canadians what they knew about the early signs of cancer. It was reported that “the survey indicated an alarming lack of knowledge about the symptoms and nature of the disease.”<sup>56</sup> Only a few weeks later, another article was printed that stated “men are more

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<sup>54</sup> “Doubt U.S. Cancer Test Economical for Ontario.” *The Toronto Star* (October, 1955): 62.

<sup>55</sup> *Ibid.*

<sup>56</sup> “Poll Shows Ignorance of Cancer Symptoms.” *The Halifax Chronicle Herald*, August 1, 1955, 6.

susceptible than women in all but 3 types of cancer.”<sup>57</sup> *The Vancouver Sun*, arguably a smaller newspaper than the *Globe and Mail*, the *Toronto Sun*, and the *Halifax Chronicle Herald*, printed an article in 1955, “Almost All Cancer Sufferers Want Doctor to Tell the Truth,” discussing the importance of open communication between doctors and their patients.<sup>58</sup>

By the mid-1960s, the *Toronto Star* and *The Globe and Mail* were publishing a few cervical cancer articles a year. Many of the articles discussed key risk factors such as early marriage, early sexual activity, and multiple births and continued to endorse the Pap smear as the most efficient tool in detecting this cancer early. In February of 1965 the *Toronto Star* published an article discussing the high rates of cervical cancer found among women who were attending a birth control clinic at the Toronto General Hospital. The article stated that the doctors involved in this report concluded that all women attending a family-planning clinic should be screened for cancer as “studies have shown that women who have borne children – the kind of women who attend the clinic – are more prone to cancer of the cervix than others.”<sup>59</sup> There was also reference to lack of education as it was stated that “it is not unusual for a woman having heard something about the pill and family planning, to attend this clinic and following examination to be admitted to hospital because of serious disease of which she was unaware.”<sup>60</sup> The lack of education in Ontario was reinforced when an article in the *Star* in 1966 compared Ontario’s work with cervical cancer with that of British Columbia and found that Ontario

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<sup>57</sup> “Men more Susceptible to cancer Than Women.” *The Halifax Chronicle Herald*, August 16, 1955, 13.

<sup>58</sup> Walter Alvarez. “Almost All Cancer Sufferers Want Doctor to Tell the Truth.” *The Vancouver Sun*, September 17, 1955, 5.

<sup>59</sup> “Clinic cancer rate three times normal.” *The Toronto Star* (February 9, 1965).

<sup>60</sup> *Ibid.*

was not only slow in accepting the value of the Pap smear, but was also guilty of not having any education programs reaching high-risk groups.<sup>61</sup>

There were other articles discussing cancer in 1966 that demonstrated a keen public awareness of the need for organized screening facilities. In February of 1966 an article was published, “Fear of the unknown: Cancer Death Factor?”, that focused on the “needless deaths from cancer of the cervix each year” in Canada.<sup>62</sup> Following the experience of *Star* columnist Lotta Dempsey, the article detailed the procedures of screening and follow-up at the Cancer Detection Clinic at the Women’s College Hospital in Toronto, Ontario. Dempsey, working with Dr. H.E. Banting, attempted to break down the anxieties women might feel about a Pap smear test by chronicling her examination and test results, in addition to reassuring the reader “the fear of the unknown” was a common feeling among many women. While Dempsey’s test results came back negative and she celebrated with her husband with some champagne, the article nonetheless discussed those who were not so lucky and the importance of regular examinations.<sup>63</sup> By connecting experience with education, both Dempsey and Dr. Banting were hoping to reach more women by stressing how “simple” the procedure can be and how the Cancer Detection Clinic at the Women’s College Hospital created a sense of support and community.

Alongside discussions at the Cancer Conference in Montreal in 1967 of self-sampling, the *Toronto Star* printed an article highlighting the idea of a “do-it-yourself”

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<sup>61</sup> “Doctor: Test can end cervical cancer.” *The Toronto Star* (June 25, 1966), 3.

<sup>62</sup> Lotta Dempsey. “Fear of the Unknown: Cancer Death Factor?” *The Toronto Star*, February 11, 1966.

<sup>63</sup> *Ibid.*

Pap smear. Four doctors in Chicago argued that this technique could be tremendously effective in treating cervical cancer. Resulting from a study published earlier that year, these doctors believed that the accuracy was at a level that would make the do-it-yourself Pap smear effective in the fight against cervical cancer. They tested over 4000 female Illinois Bell Telephone workers and found that after being given the kit more than 30% of the specimens collected were of high enough quality to be tested.<sup>64</sup> While not a replacement for an actual visit with your physician, these doctors believed that this move to a self-sampling kit might reach hard-to-reach groups of women and continue to lower cervical cancer mortality rates.<sup>65</sup>

There were also a couple of articles published in 1967 voicing a concern regarding teenagers and cervical cancer risk. On April 3, 1967, an article written by Marilyn Dunlop, “‘Pap’ test for teenagers gives early warning of cervical cancer,” was printed. A New York Pathologist, Dr. Ralph M. Richart, claimed that the “tissues of women who get cancer of the cervix may have begun to change when they were teenagers.”<sup>66</sup> He claimed that by focussing on women in their teens and taking routine Pap smears, doctors would have more success in detecting cancer in its *pre-cancerous* stage, thus avoiding the development of advanced stages of cancer. The weekend before this article was printed an annual seminar of the American Cancer Society had just taken place for all writers of science, and the Society claimed to have a primary focus on

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<sup>64</sup> Betsy Bliss. “Do-it-yourself cervical cancer test.” *The Toronto Star*, June 20, 1967, 46.

<sup>65</sup> *Ibid.*

<sup>66</sup> Marilyn Dunlop. “‘Pap’ test for teenagers gives early warning of cervical cancer.” *The Toronto Star*, April 3, 1967, D9.

prevention and “prediction” of cancer.<sup>67</sup> Another article published in 1967 discussed the work of Dr. J.H. Walters, an associate professor of obstetrics and gynecology at the University of Western Ontario. He told the reporter that at the annual meeting of the Canadian Cancer society in 1966 it was noted that only 12% of Ontario’s women had a Pap smear. This statistic was compared against the 66% of women screened in British Columbia in the same year. Dr. Walters was using these statistics to demonstrate that physicians in Ontario needed to be encouraged to screen more of their female patients for cervical cancer. He also mentioned his concern for the lack of public education regarding cervical cancer in Ontario. He suspected that women in low socio-economic groups were less likely to know about the importance of a Pap smear and were more at risk than other socio-economic groups.<sup>68</sup> He was concerned about teenage pregnancies. Dr. J.H. Walters stated that “64% of all cervical cancers in Canada are found among women who were married or pregnant as teenagers,” further reinforcing the concern for increasing cancer risk with sex at an early age.<sup>69</sup>

Arguably a more conservative publication in comparison to the *Toronto Star*, the *Globe and Mail* nonetheless showed interest in printing articles discussing cervical cancer as early as 1961. Referring to a screening trial done in Florida, it was noted that denying teenage women a Pap smear was detrimental because of “practically 100%” cure rate for cervical cancer when detected early. During the early 1960s, most Pap smears

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<sup>67</sup> Ibid.

<sup>68</sup> Margaret Weiers. “Doctor says teen mothers prone to cervical cancer.” *The Toronto Star*, April 27<sup>th</sup>, 1967, 61.

<sup>69</sup> Ibid.



were saved for women between 30 and 35 when cervical cancer was more prevalent.<sup>70</sup> Joan Hollobon<sup>71</sup>, who wrote the article in 1961, wrote a couple more articles in the following year stressing the importance of the Pap smear. Each article, “Cancer Cure Rate for Women Encouraging,” and “Annual Examination for Cancer Advised,” stressed not only the importance of a yearly check-up including a Pap smear for all women, but also attempted to label high-risk groups – such as the poor and young, sexually active women. Both of these articles mentioned American-based studies (Kentucky and New York State) and how “the most rewarding yield of cervical cancer detection was among the income group least able to afford the examination.”<sup>72</sup>

By 1964 articles in the *Globe and Mail* either focused on the success of the early B.C. cervical cancer screening program and dropping mortality rates, or the lack of such a program in Ontario. In an letter published in February of 1964 titled, “Why not Ontario?”, a reader blatantly marked the B.C. screening a success and asserted that Ontario was disgraceful for not providing the same service to its female population. The reader argued that “this is a state of neglect which must not be allowed to continue. The funds which are available to establish a laboratory in British Columbia are equally available in Ontario, and be better employed in saving all cervical cancer patients than in

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<sup>70</sup> Joan Hollobon. “March of Medicine.” *The Globe and Mail*, November 2, 1961, 17.

<sup>71</sup> Joan Hollobon was a medical reporter for the *Globe and Mail* for 25 years. She retired in 1986. A Health Care Public Relations Association of Canada award is presented annually to a member of the media “whose work has contributed significantly to the public’s understanding of health care.” (<https://www.hcpra.org/en/HollobonGuidelines> - accessed March 23, 2011)

<sup>72</sup> Joan Hollobon. “Annual Examination for Cancer Advised,” *The Globe and Mail*, October 25, 1962, 25.

losing half of them.”<sup>73</sup> This reader, of course, was being highly critical of the provincial government’s Minister of Health at the time, Dr. Matthew Dymond.

In a letter to the editor in 1964, a woman responded to the earlier letter-to-the-editor stating that Ontario was slow in screening its female population for cervical cancer. Mrs. Evelyn Nash of Don Mills, Ontario, stated that the earlier letter was simply wrong. She said that while she was undergoing other unrelated medical testing her doctor suggested she have a Pap smear. She said that she did not request this test, but rather her doctor was the one who suggested it. She argued that her doctor “was urging all his all his women patients to have the test.”<sup>74</sup> Physicians seemed to argue that it was not the lack of availability of the Pap smear within their offices that was contributing to the high mortality rates of cervical cancer, but rather that it was the failure of women to submit to being tested. Dr. D.A. Boyes, from Vancouver, argued that the success rates in British Columbia were a result of a “concerted drive by doctors, health departments, and the Canadian Cancer Society” to “cajoling women...to go to their doctors” to be tested for cervical cancer.<sup>75</sup>

In Halifax, by March of 1965 the *Chronicle Herald* was printing articles on educational campaigns by various branches of the Canadian Cancer Society and how valuable the Pap test was. For example, the St. Mary’s, West Pictou, and Bridgewater branches of the Nova Scotia Cancer Society were all active in 1965, and North Hants in 1968, and were all meeting in high schools and various community centres educating the

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<sup>73</sup> “Why Not in Ontario?” *The Globe and Mail*, February 14, 1964, 6.

<sup>74</sup> Evelyn Nash. “Smear test for cancer (editorial).” *The Globe and Mail*, March 20, 1964, 6.

<sup>75</sup> “Urges every woman to get cervical check.” *The Globe and Mail*, June 1, 1966, 11.

local population about the importance of not only supporting your local Cancer Society branch but also about heeding the early signs of cancer.<sup>76</sup>

In 1966 alone, three articles were printed with a focus on cervical cancer in the *Globe and Mail*. In June, Joan Hollobon was active again in writing about cervical cancer, only this time she noted how the Canadian Medical Association felt that too many private doctors were not trained in the proper method of taking cervical smears. The CMA's General Council felt "cell screening [was] still not reaching many women among whom cancer [was] most prevalent." These groups included rural women, native women, women without family doctors, and the poor.<sup>77</sup> Some of the key reasons compounding the problem were the shortage of laboratory facilities and trained technicians that made it "impossible to extend mass screening programs, such as that in British Columbia, across the whole country."<sup>78</sup> One suggestion noted in early 1966 to remedy the shortage of trained technicians was to train paraplegics to handle "Papanicolaou cancer smears." It was noted that a "province-wide campaign to promote early detection of cervical cancer in women by Pap smears [was] slowed down by the lack of trained technicians," one that "women [were] entitled to under Ontario Hospital Insurance."<sup>79</sup> The doctor who suggested this remedy, Dr. Jack Walters of St. Joseph's Hospital in London, Ontario,

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<sup>76</sup> "Address on cancer at Sherbrooke," *The Halifax Chronicle Herald*, March 25, 1965, 15; "West Pictou Cancer Unit Holds Meeting," *The Halifax Chronicle Herald*, November 2, 1965, 24; "Cancer Society Aim is More Education," *The Halifax Chronicle Herald*, November 24, 1965, 5; "Cancer Unit Holds Meeting," *The Halifax Chronicle Herald*, November 5, 1968, 5.

<sup>77</sup> Joan Hollobon. "CMA criticizes private doctors on cancer tests," *The Globe and Mail*, June 15, 1966, 31.

<sup>78</sup> *Ibid.*

<sup>79</sup> Unknown author. "Doctor suggests paraplegics could handle Pap cancer tests." *The Globe and Mail*, February 16, 1966, 10.

noted the success of the B.C. screening program and how such a program did not exist in Ontario at that point.<sup>80</sup>

Often articles printed in newspapers that focused primarily on cervical cancer risk pressured women to get Pap tests by reminding them how vital it was to their families that they stayed healthy. This maternal focus further pressured women to take part in screening programs by making them aware that the mother's "health is of vital importance to her family, not only because of their love for her but also because of their great need of her and that in neglecting her own health she not only is doing an injustice to herself but to her family as well."<sup>81</sup>

There was also a change in the number of articles published in the *Toronto Star* at the turn of the 1970s, marking the start of the Women's Health Movement. In the 1970s columns and letters-to-the-editor were printed with some mention of cervical cancer. One of the key elements of the Women's Health Movement was public health awareness, and cancer education was part of that new mantra. Women's health activists worked to help women access more public places to learn about their health care needs. Several articles published during the 1970s focused directly on cervical cancer. In 1971, an article was written by Marilyn Dunlop discussing Dr. Carl Burton French and his involvement in setting up various cancer detection clinics in the city of Toronto. He was the early campaign chairman for the Canadian Cancer Society and was the leader in initiating the set-up of cancer detection clinics in both Toronto Western Hospital and St.

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<sup>80</sup> Ibid.

<sup>81</sup> Delos Smith. "Thousands of Women Would live if They Took Regular Pap Tests." *The Halifax Chronicle Herald*, November 15, 1965, 23.

Michael's Hospital. He later used his efforts to set up similar clinics in the Caribbean and South and Central America.<sup>82</sup> Other articles included discussion of various 'new' causes of cervical cancer such as DES and even a discussion of a virus men might carry that might contribute to women's risk of cervical cancer. The virus they were talking about is the herpes type-2 virus, that both men and women carry, but it was clear that the article was focusing on the idea of a man passing this virus on to his female partner. The study the article refers to mentioned that women rarely carry this disease and that it was clearly the male partner who should be the focus of disease control.<sup>83</sup>

By the late 1960s and early 1970s, the *Globe and Mail* printed several articles that argued that cervical cancer had a direct link with venereal disease. In the 1960s the *Globe and Mail* printed 26 articles, columns, and letters-to-editor that mentioned or highlighted cervical cancer. This number increased to 28 in the 1970s. In 1968, an article was published noting a study done in New York that made the direct link between the development of cervical cancer and type 2 herpes virus. It asserted that the type 2 herpes virus was found "in a high percentage of women with cervical cancer but only rarely in women without cancer."<sup>84</sup> Another article published in 1971 also made the clear link between cervical cancer and type 2 herpes. This article was even so bold as to state that cervical cancer itself is a venereal disease.<sup>85</sup> After noting that the connection between using birth control pills and the development of cervical cancer was one that was

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<sup>82</sup> Marilyn Dunlop. "Pioneer of the A-Bomb now making war on Cancer." *The Toronto Star*, July 5, 1971, 5.

<sup>83</sup> Marilyn Dunlop. "Men may hold virus that causes cancer in women: Scientist." *The Toronto Star*, April 5, 1973, 49.

<sup>84</sup> "Cervical cancer has VD link, study indicates." *The Globe and Mail*, September 21, 1968, 28.

<sup>85</sup> "Cancer of Cervix viral VD, doctor says," *The Globe and Mail*, April 7, 1971, W3.

not scientifically definite, the article clearly stated “much more definite, is evidence that cancer of the cervix [was] a venereal disease transmitted through sexual contact.” It also noted that “cervical cancer [was] extremely rare in virgins and most common in prostitutes and women who [had] numerous sexual partners.”<sup>86</sup> In 1973 many articles in the *Globe and Mail* focused on giving a scientific explanation for the medical community’s concern about women’s sexual activity and their cancer risk.

This debate around recommendations made from the Walton Report also infiltrated the *Toronto Star*. In an article published in 1980, “Pap test debate: What price safety?”, Dr. Perry Phillips from Toronto East General Hospital was very nervous about the idea of suggesting to his female patients that they only needed to come in for a Pap test every three years – according to the Report’s recommendations. He argued that “doctors don’t deal in the air, fairy world of medical statistics. We aren’t looking at the vast majority; we’re looking for and dealing with the lives that are at stake.”<sup>87</sup> One solution proposed by Dr. Boyes in B.C. was to group women into risk groups/levels and screen accordingly; this would be more cost efficient than attempting to screen every woman annually. He proposed three groups: high, average, and low risk. High risk women, he proposed, should be screened annually. He further stated “average-risk” women should be tested once they became sexually active and again one year later. If both tests were “satisfactory,” they should then be checked every three years.<sup>88</sup> A similar

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<sup>86</sup> Ibid.

<sup>87</sup> Catherine Patch. “Pap Test Debate: What Price Safety.” *The Toronto Star*, July 31, 1980, E1.

<sup>88</sup>“MD says cervical cancer should be viewed as VD.” *The Toronto Star*, August 19, 1980, A13.

article, which also quoted the interview with Dr. Boyes, was printed in the *Globe and Mail* on August 19, 1980.<sup>89</sup>

A common pattern throughout the 1970s was the amount of questions sent into the *Toronto Star's* health expert, Dr. Lindsay Curtis, focusing on cervical cancer. Dr. Curtis was a practicing obstetrician and gynecologist in Utah and established the Ogden Women's Clinic specializing in OB-GYN. He wrote many editorials for several medical publications and more popular newspapers, including the *Toronto Star*, for several years. He also authored an exclusive newspaper column, "For Women Only," for many years. He passed away in 2006 of congestive heart failure.<sup>90</sup>

Many women wrote to Dr. Curtis asking specific questions relating to cervical cancer. For example, in 1973 a woman wrote asking for advice after having a positive smear test.<sup>91</sup> In 1974 Dr. Curtis wrote an article telling the story of a seemingly healthy young woman in the first few months of her second pregnancy. When her Pap smear came back positive, Dr. Curtis discussed options with this young woman, who at first was in complete denial. The key lesson of Dr. Curtis' story was that this type of cancer is almost always caught early enough and is highly treatable. This story served as a reminder to all women to keep up with their yearly examination schedules.<sup>92</sup> Other "Your Health" columns in the 1970s included, "Pap Test Reveals Cancer" in 1974 and "Routine Checkup showed women had cervical cancer" in 1976. Even with a new expert

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<sup>89</sup> "Cervical Cancer likened to VD by B.C. doctor." *The Globe and Mail*, August 19, 1980, 9.

<sup>90</sup> "Obituary: Lindsay R. Curtis." *Deseret News*, January 12, 2006.

(<http://www.deseretnews.com/article/1034439/Obituary-Lindsay-R-Curtis-MD.html> - accessed march 23, 2011).

<sup>91</sup> Dr. Lindsay Curtis. "Your Health." *The Toronto Star*, September 5, 1973, E4.

<sup>92</sup> Dr. Lindsay Curtis. "Your Health." *The Toronto Star*, January 25 1974, D2.

doctor giving advice, Dr. Robert C. Newman<sup>93</sup>, many articles and letters focused on cervical cancer. Many of the discussions in this health column in the later 1970s were focusing on the herpes type-2 virus and cervical cancer, in addition to genital warts. In 1978, Dr. Newman dealt with one woman's concerns with her husband thinking she was "loose" because she had genital herpes (NOT contracted through intercourse). Dr. Newman reminded her that up to 20% of genital herpes cases are contracted in swimming pools and from public toilet seats, obviously attempting to quell this one husband's worries about his wife.<sup>94</sup> Clearly the point of many of these columns was to continually remind women to have regular Pap smear tests, but these reminders were not without their moral judgments.

A growing concern about venereal disease in the early 1970s followed the lead of the medical community's connection between genital herpes and cervical cancer risk. An article in the *Chronicle Herald* in early 1971 discussed the problem with the lack of sex education in high schools and how physicians were often reluctant to both report incidences of venereal diseases and to treat cases that appeared in their offices.<sup>95</sup> At this point in Nova Scotia, sex education was not part of any school's curriculum and, aside from the director of communicable disease control, few were supportive of such a venture.

The daily column, the "Medical Column," was often a hot spot in the *Chronicle Herald* for the discussion of new techniques in the medical field. In March of 1971 Dr.

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<sup>93</sup> Coincidentally, Dr. Robert C. Newman was also a practicing OB-GYN in Ogden, Utah, along with Dr. Lindsay Curtis.

<sup>94</sup> Dr. Robert C. Newman. "Your Health." *The Toronto Star*, July 27, 1978, D8.

<sup>95</sup> Len Pace. "Growing VD problem – school boards and doctors criticized." *The Halifax Chronicle Herald*, March 4, 1971, 2.



Walter C. Alvarez, the writer of the “Medical Column,” wrote about a new technique to detect “cancer of the womb which has advantages over the “Pap” test, which helps in recognizing cancer in the neck of the womb (the uterus).”<sup>96</sup> This particular column even took time to pat “good” gynecologists on the back for always including the Pap test while examining women, at the same time criticizing women for simply not “bother[ing] to go to their physicians regularly.”<sup>97</sup>

Surprisingly enough, the *Vancouver Sun* in the 1970s printed few articles focusing on cervical cancer. This is surprising because Vancouver was a remarkably active location for Women’s Health Movement activities and the Vancouver Women’s Health Collective was working to make cervical cancer more public during this period. However, the *Vancouver Sun* did publish about abortion and birth control in the 1970s.<sup>98</sup>

Among the articles in the *Globe and Mail* talking about studies linking sexual activity and cervical cancer risk, such as “Scientist links sex with cervical cancer,” “Sex and cancer linked by 2 British Surveys,” one article stood out as unique. In a letter to an editor entitled, “Chides MD,” Jennifer Bankler from Downsview criticized another article written a few days earlier when a doctor was quick to assume “both that women who are high risks for cervical cancer because they start sexual activity early in life and are sexually promiscuous are by definition too stupid to have regular checkups, and (implicitly) that they are not worth saving.”<sup>99</sup> The article Miss Bankler responded to was

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<sup>96</sup> Walter C. Alvarez. “Medical Column,” *The Halifax Chronicle Herald*, March 25, 1971, 6.

<sup>97</sup> Ibid.

<sup>98</sup> Betty Flynn, “Not really abortion, just induced period,” *The Vancouver Sun*, January 10, 1973, 64; “U.S. abortion ruling praised, critized,” *The Vancouver Sun*, January 23, 1973, 12; “Medical Service to women inferior,” *The Vancouver Sun*, September 17, 1973, 17.

<sup>99</sup> Jennifer Bankler. “Chides MD.” *The Globe and Mail*, June 20, 1973, 7.

written by both a professor and head of the Department of Epidemiology and Biometrics at University of Toronto, Dr. W. Harding le Rich. He was quick to label the women considered most at risk of developing cervical cancer as those who did not seek preventive care of their bodies. He stated that “if we study the epidemiology of cancer of the cervix, for instance, we find quite soon that its greatest prevalence is in those women who start sexual activity very early in life and who are sexually promiscuous. They are the people who do not come for checkups, no matter how often offered.”<sup>100</sup> This doctor’s response was a clear example of the early stigma attached to this particular cancer, a stigma to which the Women’s Health Movement during this period was attempting to respond.

Marking the Women’s Health Movement and the Vancouver Women’s Health Collective’s<sup>101</sup> attempt to encourage women to self-examine their cervixes, an article was published in November of 1977 in the *Globe and Mail* talking about a government-funded self-examination clinic run by the Collective. The article, written by Anne Roberts, special contributor to the *Globe and Mail*, spoke of the clinic as successful in not only educating women about their bodies, but also in its attempts to prevent breast and cervical cancer via screening techniques. The article spoke about what a woman might actually experience at this type of clinic and the importance of laywomen and volunteers in its success. While it was noted that a female physician was always on hand, it was the laywomen and volunteers who were at the heart of the self-help clinic experience. As Anne Roberts wrote, “the use of lay women and volunteers, the unhurried

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<sup>100</sup> Dr. W. Harding le Rich. “Preventive Medicine.” *The Globe and Mail*, June 12, 1973, 6.

<sup>101</sup> The history of the Vancouver Women’s Health Collective is detailed further in the next chapter.

concern for each woman, and the opportunity to become involved in one's own health care is the health collective's response to their dissatisfaction with the normal health care system, particularly the emphasis on curing rather than preventing and the tendency of doctors to keep medical knowledge in the hands of the professionals."<sup>102</sup>

In December of the same year, Dr. Gifford-Jones, a pseudonym, wrote in his column, "The Doctor game," an open criticism of allowing women to perform tasks, such as cervical examination with a speculum, that he believed should only be done by medically-trained professionals. Entitled, "Self-Examination Clinics need more than good intentions," Dr. Gifford-Jones made it clear that he was against the idea of women being in charge of their own preventive health. He argued that he could not "see how this part of the self-examination [as opposed to breast self-examination] will add much to their knowledge or well-being. But it will result in confusion and the wrong diagnosis. And I believe it will also bring together a rather odd crowd."<sup>103</sup> Rather odd crowd? Is the definition of a "rather odd crowd" one that is made of women who have not only viewed their own cervixes but have gained knowledge about how to notice abnormalities? He was even so bold as to accuse the B.C. government of wasting their money – "I think it would be wise to put a fly on the wall to see how the money is being spent. If I controlled the purse strings I would question the advisability of paying for amateur opinions."<sup>104</sup> Even with the Women's Health Movement in full swing by 1977, newspapers such as the *Globe and Mail* were still printing articles attempting to

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<sup>102</sup> Anne Roberts. "Clinic teaches women to examine selves for symptoms of disease." *The Globe and Mail*, November 10, 1977, F5.

<sup>103</sup> Dr. W. Gifford-Jones. "Self-Examination Clinics need more than good intentions," *The Globe and Mail*, December 8, 1977, F5.

<sup>104</sup> Ibid.

discourage women from gaining knowledge about their own bodies as opposed to simply going to the doctor and ‘letting them handle’ their health care needs.

A professional debate exploded in the *Toronto Star* in April of 1981 between long-time columnist Michelle Landsberg and various readers. Landsberg originally wrote “Best doctors are those who do nothing,” in response to a recently published book by Dr. Robert Mendelsohn entitled, *Confessions of a Medical Heretic*. Landsberg argued that he claimed that the “best doctors are the ones who do practically nothing.”<sup>105</sup> She claimed that he was one of a kind, in a sense, because she argued that most doctors at the time were quick to medically intervene with new (and risky) procedures that were often dangerous and “extreme.”<sup>106</sup> She listed his “revealing facts,” which included death rates falling when a doctor strike was in place, the inaccuracy of the Pap smear and how there “[was] no conclusive evidence that there ha[d] been any reduction in cervical cancer since the introduction of mass screening,” and the damaging effects, particularly on women, of x-ray radiation.<sup>107</sup>

Landsberg, without a doubt, struck a nerve in the *Toronto Star* readers. Less than a month later, on May 1, 1981, Landsberg attempted to respond to disgruntled readers. The first letter published was from a medical doctor in Rexdale, Dr. Jay Balofsky, who reminded Landsberg that the use of the Pap smear in mass screening was quite useful, and in fact, had a detection rate of 95 percent. He highlighted the fact that “with the widespread use of the birth control pill, the early detection of cells suspicious of cervical

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<sup>105</sup> Michelle Landsberg. “Best doctors are those who do nothing.” *Toronto Star*, April 13, 1981, C1.

<sup>106</sup> Ibid.

<sup>107</sup> Ibid.

cancer becomes crucial.”<sup>108</sup> The next letter published was more disgruntled and accused Landsberg of writing an “unfair description of obstetricians” and “lump[ing] them all in one dirty laundry bundle.” While Landsberg defended herself, she stood beside her earlier published comments that obstetricians were often just technicians too willing to use their techniques when they are too invasive and often unneeded.<sup>109</sup>

In an attempt to validate her earlier comments, the last two letters published in Landsberg’s column defended her and further reinforced, what she believed, was often mis-leading and unnecessary information delivered by obstetricians. For example, the first letter was written by Ruth Wiltshire in Port Severn, Ontario, and she claimed that her two natural births were only a result of “shopping around” for a doctor that was supportive of a natural childbirth.<sup>110</sup> The last letter was written by a person who had undergone numerous tests for infertility. The tests concluded that her condition was a result of an infection from an intra-uterine device (IUD). She believed that had she known she was putting herself at risk of being unable to conceive, she would never have agreed to have the IUDs inserted. She argued that she was not informed of all the risks.<sup>111</sup> Landsberg ended her column with an educational note on encouraging women to “rigorously question every gynecological and obstetrical device, test, examination, and procedure, without exception.”<sup>112</sup>

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<sup>108</sup> Michelle Landsberg. “Readers jump to the doctors’ defence – and mine.” *Toronto Star*, May 1, 1981, C1.

<sup>109</sup> Ibid.

<sup>110</sup> Ibid.

<sup>111</sup> Ibid.

<sup>112</sup> Ibid.

Beyond Landsberg's exchange in the early months of 1981, the 1980s, in both the *Toronto Star* and the *Globe and Mail* were ripe with articles pertaining to cervical cancer. Most articles discussed the links between the contraceptive pill and cervical cancer development, in addition to continuing discussions of the role of the Pap smear and mass screening. Marilyn Dunlop, a former health writer at the *Toronto Star*, wrote an article in May of 1989 discussing Dr. Donald Thompson's address to the Ontario Medical Association about the scandal which involved at New Zealand gynecologist. In the mid-1970s, Dr. Herbert Green gave no treatment to 503 women with abnormal cells at the National Women's Hospital in Auckland. He reported that among the group of women there were six cases of cervical cancer. Dr. Green advocated a more conservative treatment of carcinoma in situ, as he argued that this stage did not necessarily develop into invasive cancer. He argued that a "minimal or wait-and-watch approach" was more useful, because he believed a more radical treatment of these early lesions could often worsen the condition.<sup>113</sup> However, the criticisms of Dr. Green were focused on how these women were denied treatment and caused a distrust in the medical profession and their ethical responsibilities to their patients.<sup>114</sup> In his address to the Ontario Medical Association, Dr. Thompson highlighted the dangers not only of utilizing the Pap smear, but also of not informing women that they are at risk of developing cervical cancer. A pathologist at the Banting Institute, and one of Canada's top experts in screening programs to detect cervical cancer at the time, Dr. Thompson said that Dr. Green's scandal had caused numerous Ontario doctors to argue against the Pap smear and mass

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<sup>113</sup> Bryder, 197.

<sup>114</sup> *Ibid.*, 199-200.

screening and that this was a dangerous way to approach patients with carcinoma in situ. He argued that because there was no way to tell whether or not patients with carcinoma in situ would develop cervical cancer, it was important to screen women and treat them accordingly.<sup>115</sup> As an interesting follow-up to the Dunlop article, an article printed in May of 1989 focused on an assessment program started in the mid-1970s by the Ontario Medical Association. This program was designed to “test Pap smears” to ensure that smears were properly labeled with either “normal” or “pre-cancerous” in the hope that laboratory errors would be something of the past. While it was noted that the error rate was improving, “70 per cent of Ontario’s labs [still] had error rates at the lower end of the 7 to 10 per cent scale.”<sup>116</sup>

By the late 1980s, many newspapers were touching on the topic of HPV and its connections with early cervical cancer development. The *Toronto Star* printed 3 key articles between 1988 and 1989 highlighting HPV and its clear connection with the development of this particular cancer. Recognizing HPV as one of the most commonly sexually transmitted disease, an article in July of 1988 stressed that as many as 20 percent of all women might harbor the disease and that screening is the only defense.<sup>117</sup> The problem was, as Halifax doctor, Dr. John Jeffrey argued, that “fewer than half of Canadian women have had even one Pap smear.” Recognizing that there was no treatment for HPV, noting the high rates of occurrence of this disease, and its connections to cervical cancer, Pap smears continued to be a vital part of women’s preventive health

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<sup>115</sup> Marilyn Dunlop. “Some doctors duped over cancer care U of T doctor says.” *Toronto Star*, May 20<sup>th</sup>, 1989, D8.

<sup>116</sup> “Program cuts errors in Pap Tests.” *Toronto Star*, May 26, 1989, H4.

<sup>117</sup> “MD sees an epidemic in sex-transmitted virus linked to cervical cancer.” *Toronto Star*, July 13, 1988, F9.

care.<sup>118</sup> Strengthening the medical community's connections made between HPV and cervical cancer development, the *Toronto Star* printed two more articles the following year focusing on this newly marked connection.<sup>119</sup>

The *Globe and Mail* published similar articles to the *Toronto Star* in the 1980s. However, in 1980 a very unique debate opened the decade questioning the labeling of cervical cancer as a venereal disease. Dr. David Boyes, the head of the British Columbia Cancer Control Agency at the time, clearly stated, in an interview, that he “accepted the idea that cervical cancer [was] a venereal disease.”<sup>120</sup> The article further noted his successes with a long-standing, cervical cancer screening program in BC, and his strong screening recommendations for young sexually active women.<sup>121</sup> However, in less than a month, the *Globe and Mail* printed a rebuttal article that focused on how Dr. Boyes' conclusions did nothing more than further “stigmatize the disease and ostracise [*sic*] the unfortunate individuals who contract it.”<sup>122</sup> The additional problems to Dr. Boyes' conclusions, as Saunders argued, were that he neglected to mention that condoms, circumcision, and hygiene were all legitimate “safeguards” against cervical cancer, considering its sexually transmitted features. Saunders was concerned that he was “resurrecting some medieval notion of female chastity to ‘prevent’ the disease.”<sup>123</sup>

Regardless of particularly targeted groups of women, the *Globe and Mail* printed articles highlighting the constant debate about the validity of the Pap smear itself. An

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<sup>118</sup> Ibid.

<sup>119</sup> See, “Cervical Cancer transmitted sexually, research shows.” *Toronto Star*, January 12, 1989, M3; Marilyn Dunlop, “‘Wildfire’ cancer blamed on wart virus.” *Toronto Star*, April 13, 1989, A1.

<sup>120</sup> “Cervical Cancer linked to VD by B.C. Doctor.” *The Globe and Mail*, August, 19, 1980, P9.

<sup>121</sup> Ibid.

<sup>122</sup> Joyan Saunders. “Cervical Cancer.” *The Globe and Mail*, September 6, 1980, P7.

<sup>123</sup> Ibid.



article printed in September of 1981, “Pap smear saves many: B.C. doctors,” used statistics to demonstrate that the Pap smear does save lives. Using one woman’s experience as an example of the validity of a Pap smear, this article clearly argued that routine Pap smears, as part of an annual medical check-up, are vital to overall women’s health.<sup>124</sup> Long-time columnist and medical expert, W. Gifford-Jones, wrote numerous articles reinforcing the importance of a Pap smear in the battle against cervical cancer. For the most part he suggested that Pap smears be yearly, particularly for women a high-risk (sexually active at a young age, many partners).<sup>125</sup> Alongside his focus on the importance of yearly Pap smears, he also highlighted the role condoms and birth control pills have in overall women’s health.<sup>126</sup>

However, the articles in the *Globe and Mail* were not without discussions of those groups of women at high-risk of developing cancer, and the role virus played in this disease. The high-risk groups of women labeled were generally women who were sexually active at a young age and women who had had numerous heterosexual partners. Dr. Anthony Miller, director of the University of Toronto’s epidemiology unit in the early years of the 1980s, had similar ideas to those of Dr. Boyes at the time. He stressed the importance of factors such as sexual intercourse at a young age, having several sexual partners, and poverty on cervical cancer development. He argued that it was these groups

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<sup>124</sup> “Pap smear saves many: B.C. doctors.” *The Globe and Mail*, September 30, 1981, 16. Other articles focused on the validity of Pap smears include: “Cervical cancer rise feared.” *The Globe and Mail*, August 24, 1984, 9; Paula Salvador. “Pap-test proof; cervical cancer kill-rate halved.” *The Globe and Mail*, October 3, 1987, D4; “Study finds cancer risk if pap tests infrequent.” *The Globe and Mail*, December 7, 1989, A13; “Cervical-cancer testing inadequate, doctor says.” *The Globe and Mail*, April 22, 1989, A12.

<sup>125</sup> W. Gifford-Jones. “Pap smear should be yearly.” *The Globe and Mail*, September 18, 1980, T5.

<sup>126</sup> See other columns by W. Gifford-Jones: “Yearly Pap smear vital for all women.” *The Globe and Mail*, July 26, 1984, CL7; “Annual pelvic examination important in cancer battle.” *The Globe and Mail*, August 19, 1986, A2; and “Women’s best defence is vinegar, magnifying glass?” *The Globe and Mail*, November 17, 1987, A2.

of women who needed to be screened more regularly, and that proper follow-up systems were vital to treating these women properly.<sup>127</sup> The Ontario Medical Association (OMA) child welfare committee even weighed in on the discussion of screening young, sexually active women. The OMA child welfare committee used current statistics noting an increase in cervical abnormalities found in increasingly younger women to urge physicians to “test for abnormal changes in the cervix as soon as adolescent girls become sexually active.”<sup>128</sup> The OMA committee argued that the increase in sexual activity resulted in more cases of sexually transmitted disease, particularly gonorrhea and herpes.<sup>129</sup>

Focusing on target groups was dangerous, as one letter-to-the-editor claimed, because labeling cervical cancer sufferers as having many sexual partners, or sexually active at too-young of an age discouraged women from screening. Recognizing that women diagnosed with precancerous lesions of the cervix often do have a history of numerous sexual partners, it was not always the case. George H. Anderson, Head of the Division of Cytology Cancer Control Agency of B.C., noted that it was quite “possible for a woman who has had only one sexual partner during her lifetime to become infected with the human papilloma virus, may subsequently develop a precancerous lesion of the cervix.”<sup>130</sup> He further argued that his letter was not necessarily to lecture about proper sexual mores, but “to correct the commonly held belief that women who develop pre-invasive cancer of the cervix do so as a result of past sexual promiscuity.” He believed

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<sup>127</sup> Joan Hollobon. “Pap tests stressed for young women.” *The Globe and Mail*, March 10, 1983, P18.

<sup>128</sup> Dorothy Lipovenko. “Check teen-agers for cervical cancer, OMA advises MDs.” *The Globe and Mail*, January 22, 1985, M2.

<sup>129</sup> *Ibid.*

<sup>130</sup> George H. Anderson. “Common misconception.” *The Globe and Mail*, November 11, 1987, A6.

that this “chauvinistic interpretation is incorrect,” and had negative effect on the successful screening programs in place.<sup>131</sup>

It was not necessarily gonorrhea and herpes that were the sexually transmitted viruses articles highlighted in the *Globe and Mail* in the 1980s. HPV was the virus often highlighted, and not always confidently, as the single-most contributing factor to the development of cervical cancer. Articles printed in the earlier years of the 1980s often referred to studies attempting to make the connection and evidence collected was described as “increasing suspicion” that this virus might be a precursor to cervical cancer.<sup>132</sup> While the herpes virus was not completely ruled out, HPV seemed to be getting more attention.<sup>133</sup>

Newspapers, particularly *The Toronto Star* and *The Globe and Mail*, picked up on the larger medical discussions about cervical cancer, its risk factors, and techniques on how to prevent it. While these discussions were happening as early as the 1960s and 1970s, they happen with more consistency, rigor, and intensity in the 1980s. The focus was on the role sexually transmitted viruses, particularly HPV, and age at first sexual activity, had on the development of cervical cancer. The concern about promiscuity was also always part of the discussion, even if it was not directly focused on. As a few letters-to-the-editor demonstrated over the years, not all cervical cancer sufferers were promiscuous, but the assumption was always there. Noting this was problematic, some

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<sup>131</sup>Ibid.

<sup>132</sup>“Wart virus, genital tumors linked.” *The Globe and Mail*, September 21, 1983, N10.

<sup>133</sup>Other articles include: Peter Newmark. “2 viruses, cancer tied.” *The Globe and Mail*, August 13, 1984, M7; Lawrence Surtees. “Pill use during viral infection linked to cervical cancer.” *The Globe and Mail*, November 2, 1988, A4; “Virus type linked to cervical cancer.” *The Globe and Mail*, October 27, 1988, A16.

readers responded with letters being critical of viewing cervical cancer as a sexually transmitted disease, and questioned the usefulness of focusing on hetero-sexual activity, and its potentially detrimental effects on screening programs in place.

Articles in the *Vancouver Sun* and the *Halifax Chronicle Herald* in the 1970s had similar foci as *The Toronto Star* and *The Globe and Mail*, but were fewer in number. By the 1980s, few, if any, articles were printed that had any direct focus on cervical cancer. However, this is not indicative of the action in both B.C. and Nova Scotia in terms of cervical cancer screening and public dialogues about the disease. As the final chapter of this dissertation highlights, both of these provinces had early organized screening programs, albeit fundamentally different, and had active women's groups working with their respective communities to prevent cervical cancer.

While there was a marked change in what the newspapers were printing in terms of women's health topics (cancer in particular), they were still generally written by experts. However, as discussed in the previous chapter, there was a different change in periodicals such as *Chatelaine*, as their feminist roots allowed them to approach women's health differently, especially in the context of the Women's Health Movement. University campuses, similar to *Chatelaine*, offered a different atmosphere for discussions of women's health matters. Usually student-run, many university papers were encouraged to focus on what was relevant to the student body at a particular time, and one could assume that women's health mattered during the 1970s and 1980s.

***University Newspapers:***

University campuses during 1960s through to the 1990s were another rich place for women to access information about their health. It seems as though university newspapers picked up on the Women's Health Movement (maybe not outwardly) and often printed articles specifically about women's health. Many university newspapers were clearly places women could seek such information. *The Varsity* (University of Toronto), *The Excalibur* (York University) and the *Ubysey* (University of British Columbia) were surveyed through the years 1940 to 1990. This survey revealed that these newspapers seldom directly dealt with cervical cancer facts and information, but did discuss protected sex and cancer risks and announced various fundraising events.

*Ubysey* was created in 1918 and students could purchase it for only two dollars.<sup>134</sup> Using the key term 'cervical cancer' while searching the paper from 1940 to 1990 the search engine only found twelve hits. The earliest search hit was March 31<sup>st</sup>, 1978 with an advertisement about venereal disease, "VD: Some straight talk from Julius Schmid." This paid advertisement claimed to be simply educating students about venereal disease and how it had become "epidemic in proportions."<sup>135</sup> One particular section, dealing with genital herpes, bold text alerts the reader "Stage II: A possible serious complication: recent studies suggest that herpes II may play a role in the development of cervical cancer. The virus is reported to be present in 36 percent of cervical cancer patients, and parts of the herpes II virus have been extracted from cervical cancer cells. Because of this, women who've been infected should be especially careful

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<sup>134</sup> <http://ubyssey.ca/about> (accessed November 4<sup>th</sup>, 2010).

<sup>135</sup> "VD: Some Straight talk From Julius Schmid." *The Ubysey*, March 31, 1978, 28.

to have regular Pap tests.”<sup>136</sup> While this advertisement pushed more for safe sex and even offered free samples via mail, it still disseminated valuable information about sexually transmitted diseases and cervical cancer risk. The same ad was printed again in the October issue of the same year and in November of 1979.

In November of 1980, *The Ubysey* ran a story reporting on an information session run by the Vancouver Women’s Health Collective on campus. The session focused on the potential risks of using the birth control pill, including heart disease, clotting, stroke, and breast cancer. Curiously, cervical cancer was not considered a risk among those highlighted in this report. The only cancer mentioned was breast cancer, as a result of a benign breast condition developing into a malignant disease.<sup>137</sup>

In February of 1982, *The Ubysey* ran a story about a book, *DES Daughter: The Joyce Bichler Story*. Joyce Bichler was diagnosed with late stage cervical cancer that she developed as a result of her mother taking DES in 1953 to prevent a potential miscarriage. The article focused on Bichler’s fight with Eli Lilly, the manufacturers of DES, and how she brought the story to the public.<sup>138</sup> While this article did not focus on any other potential risk factors for cervical cancer, it was clear that the connection between DES and cervical cancer was made and was finally being made public by DES daughters such as Joyce Bichler. Another article was printed in *The Ubysey* discussing DES in March of 1987.

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<sup>136</sup> Ibid.

<sup>137</sup> Heather Conn. “Pill, IUD users should be aware of health risks.” *The Ubysey*, November 18, 1980, 7.

<sup>138</sup> Julie Wheelwright. “Mrs. Bichler took a pill...” *The Ubysey*, February 12, 1982, 3.

The *Varsity* newspaper, published at University of Toronto, did not publish articles on women's health at the rate the *Ubysey* did during the 1970s and 1980s. York University's newspaper, *Excaliber*, was similar to the *Varsity* in that they printed few articles focusing on women's health. *Excaliber* did print some articles in the 1960s about birth control, and how they were distributing the infamous McGill Birth Control Handbook for only 10 cents.<sup>139</sup> More conservative in their politics, these universities likely avoided discussions of women's health because it was simply not a proper issue to discuss publically. Unlike universities such as UBC, York and Toronto had little student protest, even in the 1960s and 1970s, and the atmosphere remained relatively conservative.

### **Conclusion:**

Films, and more importantly, Canadian newspapers (both dailies and university) were rich sources of information for Canadian women on cervical cancer prevention, diagnosis, and treatment. As the previous chapter demonstrated *Chatelaine* was a valuable source of information because it was well-read, distributed widely, and reached the demographic of women that cervical cancer was most likely to effect. While it is difficult to measure the precise impact of films in educating women about medical understandings of cervical cancer and its prevention, this media did break down barriers with regard to literacy and socio-economic status. Newspapers also reached more women than *Chatelaine*, particularly daily newspapers such as the *Globe and Mail*, the *Toronto Star*, the *Vancouver Sun*, and the *Chronicle Herald*, as they were more

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<sup>139</sup> See, Olga Shpak, "York Slow on Birth Control, Glendon knows all about it." *Excaliber*, January 23, 1969; Val Grant, "Birth Control is here, but it's illegal." *Excaliber*, March 6, 1969.

affordable and written for a much wider audience. Newspapers were on the doorsteps of Canadian families on a daily basis, and even if women were not necessarily reading the paper for health news, they often came across feature articles on cervical cancer or columns by family physicians discussing the importance of a yearly Pap smear. Newspapers, however, lacked the self-consciously feminist focus of *Chatelaine*. Varsity papers, surprisingly, while discussing safe sex, did little to educate students about cervical cancer prevention, perhaps because they wanted to avoid discussions of moral behaviour and disease risk (although such work may have been done in women's centres or health clinics on campuses).

The public dialogue about cervical cancer and its prevention expanded dramatically in the 1960s, 1970s, and 1980s. Once the connection started to be made between sexually transmitted viruses, initially the herpes type 2 virus and ultimately HPV and the development of cervical cancer, there was an increase in public discussion in newspapers. Doctors actively used daily newspapers to distribute knowledge about cervical cancer, whether it was via a report on a particular study or new recommendations about how often women should be screened for this disease. It was clear that progressive doctors were using these public mediums to educate women about cervical cancer, but there was also a level of blame that stayed consistent. Dr. Meigs made it clear in the 1957 film, *Time and Two Women*, that the woman was to blame for not staying up-to-date on her yearly examinations that her cancer was found so late. And it was made clear in many articles in the *Globe and Mail* throughout the 1960s that women's *common anxieties* were hindering them from making proper health care choices. It was this



constant discourse of blame that caused additional tensions between health activists and doctors in the 1970s. Health activists in Canada (and the US) were looking to remove discourses of blame completely to allow women access to non-judgemental health care.

While there was not extensive discussion in any of these sources about the need for organized screening programs at the provincial level, physicians and women's groups were demanding such reforms at the provincial level. The final chapter of this thesis explores the history of three case studies of provincial screening program development: British Columbia, Ontario and Nova Scotia.

## Chapter 4 –Screening in British Columbia, Ontario, and Nova Scotia

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Even with the international medical community bettering their knowledge about cervical cancer and its risk factors, and the growing public awareness of this disease and the importance of the Pap smear in the twentieth century, ultimately the onus was on provincial governments to establish, provide, and monitor screening programs for cervical cancer. Health care decisions are a provincial responsibility, experiences and responses varied from province to province, region to region. In addition to the primary responsibilities of hospital care, health services for aboriginal peoples, and the armed forces, the federal government has several agencies that are involved in the delivery of health care, such as National Health and Welfare (Health and Welfare Canada) the Centre for Disease Control (CDC), and the Medical Research Council (MRC).<sup>1</sup> The federal government can also use its spending power to make financial contributions to certain programs that are already under provincial jurisdiction.<sup>2</sup> Provincial governments are directly responsible for “priority setting, policy selection, planning, financing, regulating, administering, resource allocation, standard setting, and delivery of any type of health service.”<sup>3</sup> Types of health services can include health promotion and education, assurance of quality care, and cancer screening programs. Provincial governments are also in charge of the allocation of responsibilities to municipal governments and the

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<sup>1</sup> Ralph Sutherland and M. Jane Fulton. *Health Care in Canada: A Description and Analysis of Canadian Health Services*. (Ottawa: The Health Group, 1988), 49.

<sup>2</sup> Odette Madore. *The Canada Health Act: Overview and Options*. (Library of Parliament, Parliamentary Research Branch: Government of Canada, 2000), 3.

<sup>3</sup> Sutherland and Fulton, 54.

negotiation of budgets and fee scales. Therefore, there are numerous variations in involvement in health care concerns in municipalities from province to province.<sup>4</sup>

The storylines are different: BC was early in their response; Nova Scotia leaned on the BC experience to institute their own rurally-based programs; and eventually Ontario responded late in the twentieth century. These provincial histories are further complicated by various influences via women's groups, women's institutes, and proactive physicians. The Vancouver Women's Health Collective played a pivotal role in the 1970s in helping to make cervical cancer public. Women's Institutes were particularly active in the mid-twentieth century in both British Columbia and Nova Scotia in helping to distribute information about cervical cancer and its prevention. By contrast, Ontario, the birthplace of Adelaide Hoodless and Women's Institutes in Canada in 1897, did not seem to offer much in terms of cancer information.<sup>5</sup> These three provinces were chosen only as illustrations of each particular region: the West Coast, Central Canada, and the East Coast. The stories do not attempt to define every province's experience in cervical cancer screening development, but rather to provide snapshots that will further help us to understand our current screening opportunities. This chapter's goal is simple – to compare and contrast three provincial governments and to demonstrate that not all preventive screening programs were developed via similar strategies.

Recognizing that the three provinces focused on in this chapter are English-speaking provinces, it is important to note that both the Women's Health Movement and

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<sup>4</sup> Ibid., 59.

<sup>5</sup> For a history of Women's Institutes in Ontario and Adelaide Hoodless, please see, Linda M. Ambrose. *For Home and Country: The Centennial History of the Women's Institutes in Ontario*. (Erin: Stoddart Publishing Co. Ltd, 1996).

cervical cancer screening program development experiences were not the same in Quebec. Quebec, Canada's only French-speaking province, has a very different history of provincial responses to women's health issues. As mentioned briefly in the introduction to this dissertation, Jacinthe Michaud has done extensive research on the development of the intricate Health Centres network in Quebec throughout much of the twentieth century. The first health centre for women, "Centre de santé des femmes du Quartier," was established in Montreal in 1975. Four more centres were opened from 1978-1982: "Centre de santé des femmes de Quebec," "Centre de santé des femmes de Sherbrooke," "Cliniques des femmes de l'Outaouais," and "Centre de santé des femmes de Lanaudière." These centres emerged in response to the lack of control women had in their own reproductive rights, mainly a result of being "denied abortions at accredited hospitals in French Quebec."<sup>6</sup>

For the most part, these Health Centres focused their efforts on abortion services and counseling. This is not to say that these centres did not offer other types of health information and counseling, however, Michaud's work focuses only on the abortion services they provided. In addition to their focus on abortion, many of the women working at these centres were focused on entering the political arena to transform "the way in which scientific medicine viewed them, specifically its view on women concerning their expected roles, and their supposed passivity, deviances and biological inferiority."<sup>7</sup> Unlike the early screening program in British Columbia, the well-women clinic network in Nova Scotia, and Ontario's impromptu approach to screening, Quebec's

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<sup>6</sup> Michaud, "Angel Makers," 14.

<sup>7</sup> Ibid., 4-5.

focus was, for the most part, on abortion services. Because women health activists in Quebec actually penetrated regional health boards and had a voice at the policy level, they were unique in their position in comparison to the three English-speaking provinces in this chapter.

As history demonstrates, increased concern for living conditions on the home front, post-war reconstruction, an increase in membership in trade unions, and a rising CCF contingent all contributed to a health insurance program on the brink of implementation early in the 1940s.<sup>8</sup> Even the preoccupation with post-war recovery did not deter many public groups from being deeply interested in some types of public health funding. For example, there were many groups focusing on the anti-TB campaign helping to create an increase in public health awareness via ways to prevent this highly contagious disease. Because it was a disease that could be particularly deadly to children, there seemed to be more public acceptance of this campaign.<sup>9</sup>

Prior to Medicare of the 1960s, post-WWII Canada did see the emergence of agencies particularly focused on cancer research and development.<sup>10</sup> The Canadian Cancer Society (CCS) was one of the most influential bodies to be established during a time of new federal funding into medical projects. The CCS was formed in 1938 with “the mandate to spread important information about the early warning signs of cancer to the Canadian public.”<sup>11</sup> Its chartered objectives included coordinating efforts to reduce

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<sup>8</sup> Naylor, *Private Practice, Public Payment*, 98-99.

<sup>9</sup> Georgina Feldberg. *Disease and Class: Tuberculosis and the Shaping of Modern North American Society*. (New Jersey: Rutgers University Press, 1995), 81-82.

<sup>10</sup> Most of the sections on CCS and the NCI were taken, whole or in part, from my MA thesis that was later published in a collection edited by Cheryl Krasnick-Warsh, *Gender, Health, and Popular Culture*.

<sup>11</sup> [www.cancer.ca/ccs/internet/standard/0.2939,3172\\_14980\\_langId-en,00.html](http://www.cancer.ca/ccs/internet/standard/0.2939,3172_14980_langId-en,00.html)

cancer mortality, disseminating information on cancer, aiding in the investigation of cancer cures, supporting research, and raising funds to meet all its objectives. The mission statement of the CCS (as updated in 1989) was “the eradication of cancer and the enhancement of quality of life of people coping with cancer.”<sup>12</sup> The CCS headed most cancer-related public health initiatives in the country. It received a considerable amount of funding from the King George V Jubilee Cancer Fund to aid in its work. Despite national support from National Health and Welfare and the CCS, each province was primarily responsible for creating its own public health education.<sup>13</sup>

For example, in 1948, the Allan Blair Report surveyed and recorded provincial cancer activities. Dr. Allan Blair started the notable phase of his career as the Associate Director of the Toronto Institute of Radiotherapy at the Toronto General Hospital, and returned to Saskatchewan in 1939 as the new Director of Cancer Services and Director of the Cancer Clinic in Regina. “His leadership was important in ensuring new cancer cases were referred to the clinics by local doctors and keeping the goodwill of doctors.” He was invited by the National Cancer Institute of Canada to conduct a national survey of cancer facilities. He died before the final report was written in 1947.<sup>14</sup> One example from this report includes Nova Scotia and the vital role Women’s Auxiliaries and various women’s organizations in Halifax and suburbs played in lay education focused on cancer.

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<sup>12</sup> *The Proceedings of Cancer 2000, April 1992. A Report on the work of a National Task Force, Cancer 2000: Strategies for Cancer Control in Canada* (Smithkline Beecham Pharma Inc.), 67.

<sup>13</sup> Official Canadian Cancer Society Website.

[www.cancer.ca/ccs/internet/standard/0,2939,3172\\_14980\\_langId-en,00.html](http://www.cancer.ca/ccs/internet/standard/0,2939,3172_14980_langId-en,00.html)

<sup>14</sup> Janet MacKenzie, Saskatchewan’s Cobalt-60 Beam therapy Unit Inaugurates a New Era in Cancer Treatment. (prepared for Winning the Prairie Gamble, Saskatchewan Western Development Museum, 2002), 4. [http://www.wdm.ca/skteacherguide/WDMResearch/Cobalt60\\_TeacherGuide.pdf](http://www.wdm.ca/skteacherguide/WDMResearch/Cobalt60_TeacherGuide.pdf) (accessed May 15, 2011)

The critical role Women's Institutes played in the distribution of cancer information will be discussed, in detail, later in this chapter. Most of the CCS's educational activities included the sending out of literature, radio talks, cancer movies, provision of speakers to home and school associations, women's institutes, rural municipalities and community clubs, streetcar placards and exhibition booths and the distribution of various different print materials on cancer for educators and students.<sup>15</sup> It was clear, right from the beginning of the CCS, that education of the lay public was their focus.

Recognizing that supporting public education on cancer is essential, another national body was created, the National Cancer Institute of Canada (NCIC). The NCIC was developed in 1947 through a joint initiative of the CCS and National Health and Welfare. The mission statement of the NCIC is "to undertake and support cancer research related programs in Canada that will lead to the reduction of the incidence, morbidity and mortality from cancer." Objectives were set in order for the Institute to achieve its mission, which included supporting cancer research through grants and other mechanisms, offering programs for training and development of personnel in cancer research, disseminating information relating to cancer research and control, facilitating and participating in activities sponsored by related agencies, and acting in concert with the CCS.<sup>16</sup> Since the beginning of the partnership between the CCS and the NCIC, the CCS has contributed more than \$800 million to cancer research.<sup>17</sup>

### **British Columbia – Early Initiatives**

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<sup>15</sup> Archives of Ontario, F4559-6, Box #24, "Allan Blair Report – 1948 – Cancer Services in Canada."

<sup>16</sup> Official National Cancer Institute of Canada Website. [www.ncic.cancer.ca](http://www.ncic.cancer.ca)

<sup>17</sup> CCS Website, updated 2004. [www.cancer.ca/ccs/](http://www.cancer.ca/ccs/)

Alongside national bodies focused on education, diagnosis, and treatment of cancer, British Columbia was the first province in Canada to develop a provincially-organized cervical cytology service focused on prevention, based out of one large central laboratory. In 1949, the government of British Columbia developed a program that began as a diagnostic laboratory and eventually branched out and focused on detecting cancer in its precancerous stages. This program expanded to full population screening in the 1960s with additional support from the CCS.<sup>18</sup> The earlier program did not, however, have components of public education, particular clinic setup, or an organized follow-up system as many of the more recently developed screening programs do. During this early period, there was an increase in the number of diagnosed cases of in-situ carcinomas from 12.3 per 100,000 in 1955 to 133.6 per 100,000 in 1985,<sup>19</sup> but British Columbia consistently had the lowest cervical cancer incidence rates in Canada until the early 1990s. Their mortality rates were also low in comparison to other provinces.<sup>20</sup> It was apparent that screening was making a difference in mortality and morbidity rates and more focus on developing organized screening programs were essential. However, it would be some time before other provinces followed BC's early initiative.

Megan Davies argues in her article, "Mapping "Region" in Canadian Medical History: The Case of British Columbia," that it is useful to look westward beyond Saskatchewan when discussing innovative provincial responses to the health care needs of their respective populations. She argues that many of the successful bureaucrats and

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<sup>18</sup> "The Walton Report," *Canadian Medical Association Journal* vol. 114 (1976), 12.

<sup>19</sup> Health Canada Website, [www.h-sc.gc.ca/hpb/lcdc/bc/updates/cervix\\_e.html](http://www.h-sc.gc.ca/hpb/lcdc/bc/updates/cervix_e.html).

<sup>20</sup> Ibid.



public health professionals began their careers in BC as early as the 1930s before focusing on the federal health policy scene.<sup>21</sup> This rich ground that allowed policy-changing health professionals to blossom additionally pushed the province to take early responsibility for the health of its female population in the 1940s by creating a successful central screening program that would prove to be inspirational for other provinces.

In addition to developing an early screening program, BC also created an atmosphere conducive to discussions of preventive health care during the early 1960s and 1970s. Various workshops, conferences, and correspondence between practicing physicians occurred under the mandate that disease, cancer in particular, was often a preventable health care crisis. A key grassroots women's organization surfaced, the Vancouver Women's Health Collective (VWHC), which would prove to be vital to the distribution of knowledge about the importance of cervical cancer screening. This group, of course, rested on the new ground of both the Women's Health Movement and the Second Wave Feminist Movement out of the United States of the early 1970s. The health activists of the VWHC often worked closely with local health care practitioners in their quest to distribute knowledge about cervical cancer. This relationship, between health activists and general practitioners, will be discussed later in this chapter.

British Columbia's history of health insurance, cancer screening program development, and community involvement in the delivery of health care education is a unique story. With an early central cytology database for cervical cancer, a rich ground of producing some of the most successful developers of federal health care policies, the

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<sup>21</sup> Megan Davies, "Mapping "Region" in Canadian Medical History: The Case of British Columbia." *CBMH/BCHM* vol. 17 (2000), 88.

beginnings of the Health Movement in the 1970s that would prove to forever change women's consumption of health care in Canada, without a doubt, British Columbia was in tune with their population's health care needs long before other provinces in the twentieth century. Some have argued that British Columbia, "in the early decades of the 20<sup>th</sup> century, was a spawning ground for a host of radical movements." Vancouver, in particular, was home to many radical women's groups, including those who started the Women's Health Movement in the early 1970s.<sup>22</sup>

Soon after the central cytology system was in place, there was a clear sense in British Columbia, even among non-feminist groups, that proper cancer screening for breast and cervical cancers would make a significant impact on mortality rates in the province. The North Vancouver Island District Board of Women's Institutes were quick to recognize the financial issues surrounding such screening and moved to pressure the Provincial Department of Health, via the provincial health minister Eric Martin, to subsidize the family doctor to make screening more accessible to "any woman." This 1963 request read as follows:

WHEREAS it has definitely been established that a smear test can detect, in advance, womb cancer formation;  
 AND WHEREAS many cases of breast cancer could be detected early by frequent self examination of the breasts; with routine examinations are often avoided or neglected;  
 AND WHEREAS the cost of an office visit to the doctors is often prohibitive;  
 THEREFORE BE IT RESOLVED that a request be made to the Provincial Department of Health, to subsidize the family doctor to make annually on any woman, the following tests, bringing the cost to the patient to a nominal fee of

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<sup>22</sup> Angus McLaren and Arlene Tigar McLaren. *The Bedroom and the State: The Changing Practices of Politics of Contraception and Abortion in Canada, 1880-1997*. (Toronto, Oxford, New York: Oxford University Press, 1997), 58 – 59.

two (or one) dollars. – A cervical examination including a smear test, a thorough breast examination, including instruction to the patient for self -examination.<sup>23</sup>

Despite what seemed like a minimal request, Mr. Martin turned it down. He argued that he was unable to meet this request because “the Department [of Health] is already engaged in contributing to prevention in this field to the maximum.”<sup>24</sup> Modern definitions of a preventive screening program were not in place at this point. These modern definitions include education programs, recall systems, and a more advanced collection and reading of smear slides. At this point in history, the BC screening program involved a central database and family doctors screening their patients at their own discretion. The feminist reaction and action at this point was focused on these missing, and most important, elements in the modern idea of a screening program.

Mr. Martin’s response to the North Vancouver Island District Board of Women’s Institutes request for funding for screening opportunities may have been representative of the general political atmosphere in regards to health matters. It is true that by the mid 1960s the BC provincial government had put into place a medical plan that insured all British Columbians, even those who could not afford to contribute to it. Shortly thereafter the federal government matched their provincial program and agreed to manage half of the annual costs to deliver such a program. However, before these programs were put into place, BC struggled to financially manage the health care costs of both the young and old. In 1949 when the BC Hospital Insurance Service was

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<sup>23</sup> British Columbia Archives. GR-0120, Box 3, File #7. Correspondence between The North Vancouver Island District Board of Women’s Institutes and Hon. Eric Martin, Minister of Health Services. May, 28, 1963.

<sup>24</sup> Ibid.

implemented it was not long before the province started to struggle financially. Collecting individual contributions was a “nightmare,” and it was soon abundantly clear that “universality seemed impossible to achieve.”<sup>25</sup> By 1952 these issues became a serious election concern, allowing the Social Credit to easily manage a victory in the same year. Their solution was to replace premiums that seemed impossible to administer with a tax hike that allowed more universal coverage. By 1957, BC was one of the five provinces to participate in a program where the federal government contributed half of all provincial hospital costs.<sup>26</sup>

With the advent of Canadian Medicare BC, as with other provinces initially involved, the provincial population was no longer responsible for bearing the costs of healthcare. Not all medical programs were focused on and properly funded. Historically, preventive programs were not funded as often as curative programs. As we have seen with the Canadian Cancer Society, its focus was primarily on raising money for treatment research and not necessarily prevention programs.<sup>27</sup> It is well known to most that drug companies were (and arguably still are) not necessarily interested in prevention of diseases from which they could potentially make a financial gain. We can easily see this through the example of cancer programs such as the breast cancer campaign (famous pink ribbon campaign), which focuses on “curing” cancer and not necessarily preventing the disease.

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<sup>25</sup> Jean Barman. *The West Beyond the West: A History of British Columbia*. (Toronto: University of Toronto Press, 2007), 316.

<sup>26</sup> Ibid.

<sup>27</sup> *The Proceedings of Cancer 2000, April 1992. A Report on the work of a National Task Force, Cancer 2000: Strategies for Cancer Control in Canada* (Smithkline Breecham Pharma Inc.), 67.

Seemingly breaking the mould, as early as the 1960s, Women's Institutes in BC recognized the need to further preventive screening opportunities in the province. While a central database was a large part of providing a foundation for a successful screening program, much more was required than just a database. In BC, screening opportunities were still via family physicians and many women were simply not utilizing them as much as they could have been. We know this by simply looking at the statistics; while the rates were declining, women were still dying from cervical cancer.<sup>28</sup> In 1963, a representative from the BC Women's Institutes submitted a request to amend a resolution to the Minister of Health Services which stated the following:

will you please give the enclosed resolution your earnest consideration...  
Be resolved that we petition, through the Federal Department of Health and Welfare, and the Provincial Department of Health Services, and the Hospital Insurance, that,  
If and when the National Health Plan is implemented in Canada, THAT STRESS be put on prevention, and the first step in this direction be, in inclusion of an available, thorough examination for the early detection of cancer of the cervix and of cancer of the breast thus avoiding prolonged suffering, costly treatment of advance cases and loss of life.  
Carried unanimously.<sup>29</sup>

Mr. Martin's responded by giving the history of cytology programs in British Columbia and its successes. He reminded her that his department, working with the BC Cancer Institute, had spent money on educational programs including brochures and films made available through the Cancer Institute on self-examination of the breast. He concluded

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<sup>28</sup> By 1983 the cervical cancer incidence rate had dropped by 45% since 1964. EJ Holowaty *et al.* "Cancer Incidence in Ontario: Trends and Regional Variations." *The Ontario Cancer Treatment and Research Foundation*, (1995): 36.

<sup>29</sup> British Columbia Archives. GR – 0120 – Box 3 File #7. Letter from Mary Raper from the British Columbia Women's Institutes to Eric Martin, Health Minister at the time. October 1963,

his response by directing Ms. Raper's "attention" to various Well Woman Clinics around the area.<sup>30</sup>

Earlier that year, The North Vancouver Island District Board of Women's Institutes held their annual conference on April 6, 1963 at Parksville, B.C. Writing a similar request, the board asked the "Provincial Department of Health to subsidize the family doctor to make annually on any woman, the following tests, brining the cost to the patient to a nominal fee of two (or one) dollars."<sup>31</sup> Eric Martin's response was not a positive one. He stated in his response, "I regret that I would not be possible to adopt such a policy of a number of reasons, but in particular, because the Department is already engaged in contributing to prevention in this field to the maximum." He went on to state the annual costs of lab fees and general cancer control debts. Again, he finished his letter by drawing Mrs. Norman's "attention" to Well Woman clinics operating in her area.<sup>32</sup>

By the 1970s there seemed to be an increase in discussion of preventive medicine within BC provincial offices. More than likely this was partially a result of the increase in the public awareness of the prevention of cancer via women's health activists' activities. Working papers, reports, and much of the correspondence that was coming out of the public health department of BC and the health minister's office focused on a new language of health management and proper lifestyle choice. For example, an avid

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<sup>30</sup> Ibid., Response to Ms. Raper, October 18, 1963.

<sup>31</sup> Ibid., Letter to Minister of Health Services from The North Vancouver Island District Board of Women's Institutes, April 6, 1963.

<sup>32</sup> Ibid., Response to The North Vancouver Island District Board of Women's Institutes from Eric Martin, Minister of Health Services,.

Canadian medical researcher, H. Rocke Robertson,<sup>33</sup> released a background study for the Science Council of Canada in March of 1973. In this report, he was particularly concerned with the distribution of energy and money on treating diseases and injuries and not on trying to prevent them. Aside from basic preventive expenditures such as vaccinations and clean water that do not rely on public cooperation, Robertson wanted to discuss the prevention of disease through analysis of overindulgences and poor lifestyle choices.<sup>34</sup> In reference to American studies, he argued,

the greatest potential for improving health of the American people is not to be found in increasing the numbers of physicians or in the forcing them into groves, or even in increasing hospital productivity, but is to be found in what people do and don't do to, and for themselves. With so much attention given to medical care and so little to health education and individual responsibility for personal health, we run the danger of pandering to the urge to buy quick solutions to a difficult problem.<sup>35</sup>

In response, Dr. D.L. Sackett<sup>36</sup> pointed out “periodic health examination programs fail to detect lethal disease in about half the cases, that when a disease is discovered it is by no means certain that the patient particularly if he is without symptoms, will modify his health behavior for a prolonged period.” He further warned that labeling someone as “diseased or high-risk” might discourage many from seeking periodic health

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<sup>33</sup> Dr. H. Rocke Robertson had an extensive medical career in Canada. After returning from serving in the Second World War as the Commander of the Second Canadian Field Surgical Unit, Dr. Robertson was one of the key organizers of the medical school at the University of British Columbia. In 1959 he moved to Montreal to work both as the Surgeon-in-Chief at the Montreal General Hospital and the Chairman of the Department of Surgery at McGill University. He retired in 1969 with many honours, including the Order of Canada. He continued to research and publish in academic circles long after his retirement.

<sup>34</sup> British Columbia Archives. GR-0089, Box 5, file #17. “Health Care in Canada: A Commentary.” Prepared and written by H. Rock Robertson, (March 1973): page 201.

<sup>35</sup> *Ibid.*, 203.

<sup>36</sup> Dr. David L. Sackett was inducted into the Canadian Medical Hall of Fame in 2000. He is the founder of Canada's first department of clinic epidemiology at McMaster University. He is particularly known for his contributions to how we measure the presence of disease in populations and how we assess treatment for disease.

examinations. Recognizing that Robertson had some strong points to his argument, Sackett focused more on the importance of studying the effectiveness of screening programs. He believed that, without a doubt, evidence would suggest that “mass screening will prove to be worthwhile.”<sup>37</sup>

Robertson proposed a general increase in public health to encourage a direct ownership of one’s health upon the individual. This new individual responsibility would require less reliance on an already tapped health care system and budget. At the time of this report, 1973, Robertson believed that no successful public health education program existed that focused on individual responsibility for one’s health. In this case, being responsible for one’s own health could be defined as participating in preventive screening. He also argued that his search of appropriate Canadian and American journals failed to “produce a single study on just how these important procedures might be made more effective in Canada.”<sup>38</sup>

Robertson was positive about the successes of screening for disease and saw it as a vital to prevention. He believed “the concept of discovering a disease in its early stages and curing it before it can spread and do harm, or even kill, is firmly entrenched in most people’s minds.” He used the early detection of pulmonary tuberculosis as an example and felt that its general screening success had allowed for a marked interest in the screening populations for a variety of reasons.<sup>39</sup>

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<sup>37</sup> “Health Care in Canada: A Commentary,” 208.

<sup>38</sup> *Ibid.*, 203-204.

<sup>39</sup> *Ibid.*, 207.



Another example of preventive health discussions is a working paper prepared by Linton L. Kulak<sup>40</sup> and David Chisholm<sup>41</sup> in July of 1973, in which they stated that “the continually escalating cost of health care delivery in British Columbia, as in all of Canada, was generating profound concern over our future ability to meet these monetary requirements. Because of this critical situation, serious consideration must be given to accelerated efforts in the area of clinical preventive medicine, particularly with regard to lifestyle.” Kulak and Chisholm focused on the concept of health maintenance and were hoping to pressure the government to change their distribution of monies to a more preventive style health care system.<sup>42</sup> This particular report further discussed the definitions of preventive medicine and its defined stages.<sup>43</sup>

These clearly defined stages of preventive medicine fit remarkably well with the prevention of cervical cancer. The first stage, “Predisease Stage,” deals with the “various risk factors which make an individual more or less at risk for developing a given illness. Efforts directed at reducing risk factors prior to the development of disease are termed primary prevention.”<sup>44</sup> As has been discussed earlier, prevention of cervical cancer often relies on lifestyle choice and the elimination of risk factors, such as sexual activity and HPV, in order to allow for the primary prevention of the disease. However, this is the

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<sup>40</sup> In the 1990s Dr. Kulak was the Director of Health, Safety and the Environment for Shell Canada. He has published on a variety of environmental issues.

<sup>41</sup> Dr. David Chisholm is a practicing OBGyn in Arizona. He graduated from the University of Sask. in 1964.

<sup>42</sup> British Columbia Archives. GR-0089, Box 2, cont. #880056-0207. “Working Paper XX – The Potential Role of Preventive Medicine in British Columbia.” – prepared by Linton L. Kulak and David M. Chisholm (1973): page 1.

<sup>43</sup> Ibid., page 2.

<sup>44</sup> Ibid.

most problematic stage, as this is often when the medical community places blame on the victims and their lack of responsibility in terms of their sexual choices.<sup>45</sup>

The second stage, the “presymptomatic or preclinical stage,” was often assumed to be more important in regards to the prevention of cervical cancer because screening for disease fits quite nicely in this stage. This early stage allows for a clear detection by special diagnostic procedures, such as the Pap test. As Kulak and Chisholm stated in their report, “the strategy here is to detect the earliest possible presence of disease in the hope that this will offer the greatest opportunity for cure or at least limitation of the disease process.”<sup>46</sup>

Once Kulak and Chisholm finished their discussion of the importance of a preventive approach to health care and its benefits, they more clearly discussed the status of screening for cervical cancer in the province. They both recognized the fact that British Columbia was “internationally known for its pioneer efforts in large scale cervical cancer screening.” They believed that interval Pap smear recommendations were carried out by “virtually all B.C. physicians” and that there was a history of excellent follow-up of abnormal results and that there was no direct cost, at all, to the patients.<sup>47</sup>

Only a month after Kulak and Chisholm’s report was released, another report was released on a workshop that had been organized in July 1973, focusing on the health care

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<sup>45</sup> Another example of this stereotyping as a disincentive to treatment would be the epidemiology of AIDS. Steven Epstein. *Impure Science: AIDS, Activism, and the Politics of Knowledge* (Berkeley: University of California Press, 1998). Epstein argues that “faced with a ‘gay disease,’ epidemiologists immediately fastened upon the most sensational markers of homosexual difference, trumpeting the cases of men with histories of thousands of sexual partners, while ignoring the cases, also reported by clinicians from the very beginning, of gay men who were monogamous or who engaged in relatively modest amounts of sexual experimentation.” 49.

<sup>46</sup> Ibid.

<sup>47</sup> Ibid., page 23.

problems of women. The men and women involved in this workshop represented many points of view which included: “the professions of medicine, nursing, social work, teaching and such consumer-oriented groups as the Indian Homemaker service and the Vancouver Women’s Health Co-operative.”<sup>48</sup> The unsettling part of this report is that cervical cancer was not clearly mentioned at all, considering Kulak and Chisholm’s report was released in the same month this workshop took place. The workshop’s only listed concerns were family planning, abortion and sterilization, maternity facilities, child battering, handicapped children, breast cancer, Indians (sic), transients, home care, nurses, paramedics and lay people, and doctors. One can only speculate as to why breast cancer made the agenda before cervical cancer.

However, despite published reports such as Kulak and Chisholm’s, Roberston’s, and even an organized conference on prevention, not everyone at this time was pro-screening. In response to Robertson’s background study in 1973, D.L. Sackett voiced his concerns about the public health system’s new reliance on screening. He argued “periodic health examination programs fail to detect lethal disease in about half the cases; that when a disease is discovered it is by no means certain that the patients, particularly if he [sic] is without symptoms, will modify his health behaviour for a prolonged period.” He also argued that the process of labeling an individual as diseased or at high-risk of developing disease might not actually help anybody, “least of all the individual, unless, of course, the disease can be cured or risk reduced – which is usually not the case.”<sup>49</sup> He

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<sup>48</sup> British Columbia Archives. GR-0089, Box 2, cont. #880056-0207. “Working Paper XXVII – Health Care Problems of Women.” (August, 1973): page 1-2.

<sup>49</sup> *Ibid.*, 208-209.

firmly believed that mass population screening programs were useless and did nothing more than cost the health care system too much money. In order for “prescriptive” screening to work, it had to be focused on high-risk groups only. He strongly believed that “existing screening and period health examination programs carry no clear promise of improving or even maintaining the health of the general population and should not, therefore, be generally applied at this time.”<sup>50</sup>

During the mid-1970s, there is evidence that individual women in BC were still pressuring the provincial government to better existing screening programs and to establish a breast-screening program. While not specifically about cervical cancer, this example demonstrates the fact that British Columbian women were intensely aware, and quite vocal, about their health care needs. For example, in 1974 a nurse and breast cancer victim Margaret Trumen, wrote in pleading terms,

From my own experience both as a nurse and as a breast cancer victim I am very much aware of how this program [breast screening program] could help. In my own case, diagnosis of cancer was not made for two years after I had first sought medical advice. Had a breast screening program been in effect it might have saved me from radical surgery and radiation treatments with the resulting disability which I shall have to the end of my life. The cost of delayed diagnosis both in pain and in personal cost and governmental cost through longer medical treatment and hospitalization is great. These are the reasons for this letter which I hope that you will give your consideration.<sup>51</sup>

Scott Wallace responded promptly to Mrs. Trumen with the following letter:

Thank you very much for your letter of December 15<sup>th</sup>, expressing the need for more adequate screening programs to detect breast cancer. I agree entirely with you that such programmes must be set up. The technology is certainly available

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<sup>50</sup> Ibid.

<sup>51</sup> British Columbia Archives. MSS 1163, Box 609, “George Scott Wallace Papers,” file #44. Correspondence re: Breast Cancer Screening programs. Margaret Trumen correspondence, December 15, 1974.

and the frightening statistics that one in every 15 women in British Columbia will develop breast cancer must surely be reason enough to launch an intensive preventive programme of breast screening. I have made this statement publicly in support of the request by the B.C. Medical Association and you can be assure that at the Spring Session of the Legislature I will be giving this matter a great deal of mention when we are discussing affairs relating to the problem of health. I do appreciate that you took the trouble to write to me and most certainly I will do all that I can to bring about the kind of comprehensive and readily available programme which the medical profession is seeking.<sup>52</sup>

In addition to Mrs. Trumen's letter, the Status of Women Action Group (SWAG) also wrote a letter to Hon. Wallace endorsing the need for a breast cancer screening clinic in British Columbia. Dorothy Maxwell, secretary of the SWAG at the time, reinforced their request by mentioning the successes in the U.S., "surely, the twenty-seven breast cancer screening centers in the United States have proved that this preventive medicine practice is a wise expenditure."<sup>53</sup>

Fortunately, Mr. Wallace followed up with his promise to Mrs. Trumen, as the following year correspondence was received in his office thanking him for his vocal support of a breast screening program in BC.<sup>54</sup> This example is useful to note because provincial governments, particularly in BC were both aware and responsive to the health needs of their citizens. The women of BC, and not necessarily self-proclaimed health activists, were active in voicing their health care needs – and rightfully so, as their government leaders were actively involved in providing proper health care services. There is no evidence that similar requests existed for cervical cancer.

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<sup>52</sup> Ibid., response to Margaret Trumen, Scott Wallace, December 23, 1974.

<sup>53</sup> Ibid., letter to Hon. Scott Wallace from Status of Women Action Group, January, 1975.

<sup>54</sup> Ibid., S. Ferrie and E. Ferrie to Scott Wallace, January 5, 1975.

Reinforcing individual requests at the time, a report was published in 1974 by the British Columbia Cancer Treatment and Research Foundation, “The British Columbia Cancer Institute: The Care and Treatment of Patients – Present and Future,” that focused primarily on the need to improve various cancers treatments, diagnosis, and long-term care in the province.<sup>55</sup> What is particularly intriguing about this report is that it always seemed to make it clear to the reader that improvements were not actually needed in the way of their cervical cytology program, and it was the breast screening program that was in desperate need of help. This lack of concern for improvement in regards to cervical cancer surely did not encourage the medical community to invest any more time in advancing any current screening opportunities. Also, this report was released at the peak of grassroots organizations and their focus on an increase in access to preventive health care options. As this next section will demonstrate, professional development with regard to preventive health care solutions was running parallel to the development of the Vancouver Women’s Health Collective.

Amidst all the formal and informal discussions of prevention, screening, and health care costs in British Columbia in the 1970s, a group was emerging in Vancouver, the Vancouver Women’s Health Collective (VWHC), which would prove to be instrumental in improving the health of the province’s women. The VWHC mantra was simple; they were a “feminist organization which provide[d] education and preventive health care to women.” By emphasizing the sharing of health information and providing

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<sup>55</sup> British Columbia Archives. GR-0089, Box 11, file “Cancer.” – “The British Columbia Cancer Institute: The Care And Treatment of Patients – Present and Future.” The British Columbia Cancer Treatment and Research Foundation, July 1974.

a space where women could feel in control of their own health, the self-health approach to health care flourished early in the Collective's existence. Some of their services still include a health information phone line, an abortion counseling service, a diaphragm fitting service, public education programs and a self-help gynecological clinic. During the 1970s, Collective members were also highly involved with political activities relating to women and health care.<sup>56</sup> Clearly, the VWHC was a result of both the Women's Health Movement, and the Women's Movement of the 1970s.

In the fall of 1971, a woman was so upset with the health care she was receiving that she put an ad in the local newspaper calling out for other women who might have felt the same way. As a result, a group of women met to discuss the current status of the health care system in their province and what they could do to further provide women with much needed health care education and programs. Key concerns that the women discussed were: birth control, vaginal infections, abortion, and counseling services. This Collective worked within a provincially funded health care system, which paid for most medical costs they would incur. However, as most know, there were serious gaps within this system that certain aspects of preventive health care were (and are) not covered. Responding to these shortcomings, the Health Collective created very specific services that encouraged a promotion of health and prevention, as opposed to illness and treatment. The Collective argued that as a result of this illness-approach to health care, "a bureaucratic medical system [is created], geared towards efficiency and productivity,

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<sup>56</sup> Linda Light and Nancy Kleiber. *Caring for Ourselves: An Alternative Structure for Health Care (Report on the Vancouver Women's Health Collective)*. (Vancouver: UBC – Press Gang, 1978), 14.

and sadly lacking in attention to education and human satisfaction.”<sup>57</sup> The Collective also believed, and continues to believe, that this health care system fails to recognize the precise needs of women as patients.

By the spring of 1972, the health group (not yet called the VWHC) was starting to get more organized, and they moved to a house they called “A Woman’s Place.” It was here that the health group met, organized, and established more services solely for women. By the summer of that year the women had already organized their first self-help clinic which was run by women who had apprenticed at a free clinic in Seattle. That summer of 1972 was also a turning point for the health group, as they received their first government grant (OFY) to fund the distribution of a questionnaire about doctors to a large number of women in the Vancouver area. The Collective argued that this particular project had three purposes: “to collect information on doctors; to share information [they] had learned with the women [they] spoke to; and, to get a broader picture of women’s experience with and expectations of doctors.”<sup>58</sup>

It was not until March of 1973 that the health group was officially named the Vancouver Women’s Health Collective. Also during the spring of this year, the Collective was moved to a new location. They believed that, “by having a location that is strictly for health activities we hoped to integrate the various aspects of the Collective – hoped that each of us would become more aware of what the other women were doing, that there would be more sharing of responsibilities.” With the naming of the Collective, there were five very distinctive services established: 1) the Health Information phone

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<sup>57</sup> Ibid., 15.

<sup>58</sup> Ibid., 20-21.



line; 2) Abortion counseling and referral; 3) Health Education Groups; 4) The Women's Self-Help Clinic and training for staff; and 5) Public Presentations for community groups.<sup>59</sup>

The Collective's initial concern was that "in our society, health care has been arranged so that doctors and nurses work in offices and clinics and hospitals where people come with their illness; the healthy person stays home." This separation "divorces the person from the health care of his or her own body while the exclusive power to treat illness enhances the authority of the health professional." This separation further creates a dependency of the average person on their health care provider and limits self-knowledge about disease and prevention. The VWHC also believed that this dependency did not pressure the health care provider to communicate health information in treating illness and preventive programs. As history has shown, women's bodies have been particularly oppressed by society and were often quickly associated with sickness and disease. This collective further believed that "although female physiology naturally and necessarily implies menstruation, contraception, pregnancy, childbirth, and menopause, a woman regularly deals with any or all of these functions in the office of her doctors who is often a specialist in female problems. According to this model women are often classified by herself, her medical plan, and her doctor as 'ill.' If a woman chooses to stay home (not considering herself to be 'ill'), she may fail to recognize the signs of authentic

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<sup>59</sup> Ibid., 21.

female illnesses such as breast cancer, cervical and uterine cancer, pelvic disease, ectopic pregnancy, or venereal disease.”<sup>60</sup>

It was this creation of separation that the VWHC responded to directly. They focused on allowing women to take control of their own health through education and informed decision-making. They quickly organized self-educational health groups and counseling services and they offered general referral services and eventually, in December of 1972, operated a weekly women’s self-help clinic.<sup>61</sup> The clinic setting was a particularly valuable service because the VWHC hoped it would further “enhance personal responsibility and emphasize prevention as well as medical treatment.”<sup>62</sup> The clinic had 3 key components that included:

1. Lay women in a clinic setting are effective in extending knowledge and building trust with the woman-patient, as opposed to the model of authority and dependence of the existing health care system. The woman, who is, after all, the primary sensor of her own well-being, is valued as an information-giver and can learn to use her information for her own health care.
2. Lay women trained to detect sign of health and illness, such as Pap tests for cervical cancer and vaginal smears for venereal disease, involved the woman-patient in understanding the importance of these routine aspects of her health care.
3. As health consultants who are involved in diagnosis and treatment, the health professionals can expand their roles beyond the clinic situation to research, training and community development.<sup>63</sup>

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<sup>60</sup> British Columbia Archives. GR-0089, Box 10, “Women and Family – Vancouver’s Women’s Health Collective.” Page 2.

<sup>61</sup> Ibid.

<sup>62</sup> Ibid., page 3.

<sup>63</sup> Ibid.

However, many of these services were hindered because of financial issues. The VWHC was under constant pressure to find monies to cover all they were trying to offer to all women.

Funding for the Collective was often rough and was not always reliable after the first few years of the Collective's existence. In 1972, the Collective obtained funds for two salaries from the Company of Young Canadians.<sup>64</sup> In February of 1974, the Collective received a grant from the Department of Health and Welfare of the Canadian government. This grant also funded two researchers who were to describe and evaluate the Collective's structure and services. In order to obtain the grant, the Collective agreed to accept the presence of the researchers. The grant further provided funds for rent, supplies, and two more salaries and the Collective chose to divide the salary money into extremely small salaries for six members. A number of volunteers continued to participate in the Collective. The federal grant continued to provide the same number of salaries through 1975. In 1976, the Collective received only six months funding from the federal government, but salaries were doubled, bringing them to a more reasonable level.<sup>65</sup>

The years 1974 through to 1977 were key years for the Collective focusing on breast and cervical cancer services and education. All their public presentations were restricted to breast and cervical self-examination clinics. In their 1978 report, the Collective explained "this re-evaluation came about because of a shortage of staff,

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<sup>64</sup> Light and Kleiber, 21.

<sup>65</sup> Ibid.

members' dissatisfaction with the way they were spending much of their time, and a concern with the impact of the Collective on the women it spoke to." After several meetings and much discussion, the Collective then decided to restrict their public presentations to teaching women how to do breast and cervical self-examination.<sup>66</sup> This policy was re-evaluated in early 1977, and the Collective decided to no longer focus solely on breast and cervical self-examination, and they encouraged their Collective members to once again start speaking to groups about a range of health care topics.<sup>67</sup>

The public presentation of cervical self-examination involved a live demonstration from one of the Collective members. This experience was particularly powerful for those who attended. Many of these women had no idea what a cervix looked like, let alone their own. The presentation started out with a woman lying on the table, and she, or one of the other Collective members, pointed out different features of the external genitals and talked about different abnormalities to watch for. The woman on the table would then insert a speculum into her own vagina. Once the speculum was in place, using a flashlight and a mirror, the woman then inspected her cervix. The other Collective members present then explained and described the vaginal walls, cervix and os, and answered any questions from the participating women in the group. The Collective was adamant about documenting many of their workshops. Several photo albums still exist in the Collective's archives.<sup>68</sup>

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<sup>66</sup> Ibid., 106-107.

<sup>67</sup> Ibid., 108-109.

<sup>68</sup> For privacy purposes, photos could not be reproduced for this dissertation. The collection of photos that still exist at the VWHC included photos of their new office in 1975 above Marginal Market, body image photos, the Collective clinic on 4<sup>th</sup> Pine Tree, and several photos of self-examination workshops from the 1970s of women observing other women examining themselves.

The Collective again applied for funding directly through the BC Minister of Health of the provincial government. In August, when the federal funding was terminated, the Collective received funding from the province, half of which came from the federal government as part of a cost-sharing program. In April 1977, the Collective's application for continuation of provincial funding was approved.<sup>69</sup>

In 1980, the Collective also published a wall calendar depicting many Collective activities throughout the 1970s. As is stated in the introduction to the calendar, the "pages reflect our anger at a system that causes ill-health and then profits from it. Other pages of the calendar express our confidence and joy in the strength of women to challenge the system and create alternatives to replace it." In other words, this calendar was both a challenge to the medical community and a celebration of women's health. The women who designed this calendar recognized that the politics of health cannot be separated from one's personal life and used this calendar to encourage women to record their own relevant health information in addition to recognizing noteworthy dates in health history that highlight experiences and contributions of others. The 1980 calendar was the 9<sup>th</sup> annual edition from Vancouver, written and designed by the Collective and then published by Press Gang, an anti-capitalist, feminist printing and publishing group.<sup>70</sup>

The Vancouver Women's Health Collective was not unique in its west coast existence and experience as they blossomed out of much larger movement occurring simultaneously in the United States. As the existing health geography literature argues, space and place matter with regard to access to health care options and general medical

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<sup>69</sup> Ibid.

<sup>70</sup> Vancouver Women's Health Collective, "1980 Women and Health Wall Calendar," cover page.

knowledge. The Los Angeles Feminist Women's Health Center was the birthplace of both the first self-help group and the technique of self-examination. Carol Downer and Lorraine Rothman were not only the first to examine their own cervixes, but they also started to publish articles and travel to other communities spreading knowledge about self-help and self-examination. Despite being charged for practicing medicine without a license in 1973, both Downer and Rothman would prove that ideas did cross borders and further promote change.<sup>71</sup> As Sheryl Ruzek argues in her book, *The Women's Health Movement: Feminist Alternatives to Medical Control*, women were establishing their own centres for health care all up the western seaboard with clinics emerging in Berkeley, Seattle, and Baltimore as early as 1971.<sup>72</sup> Often women from the VWHC would travel down to Seattle to participate in workshops and information sessions on abortion, self-help, and self-examination to further provide health care to women in Vancouver.<sup>73</sup>

While the VWHC surfaced out of a much larger array of social movements in the 1960s, one could also argue that it was the proximity to ideas about revolutionizing women's access to health care that sparked change in Vancouver. This health movement, coupled with early screening initiatives via the provincial government, defines BC as a Canadian frontrunner in facing the perils of cervical cancer head-on. BC demonstrated that it was not just about learning how to talk about this cancer, it was also about providing women with equal access to the tools to prevent it. As will be discussed in the

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<sup>71</sup> Sandra Morgan. *Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990*. (New Jersey: Rutgers University Press, 2002), 23.

<sup>72</sup> Sheryl Burt Ruzek, *The Women's Health Movement: Feminist Alternatives to Medical Control*. (New York: Praeger Publishers, 1978), 61.

<sup>73</sup> Kleiber and Light, 21. (By the summer of 1972 the women in the original health group – pre-VWHC days – had visited several clinics in Seattle to help in the setting up and management of their own clinics in Vancouver.)

next sub-section, Nova Scotia, a province located on the opposite end of Canada from BC, was quick to lean on the BC example and eventually designed a program that would work best for their population.

### **Nova Scotia – Collaboration or Conflict?**

Archival records show that from 1933 the Women's Institutes in Nova Scotia had a successful working relationship with the province's public health nurses. Public health nurses were encouraged to contact the women's institutes in their communities and to make their public health work more effective in their area. Also, women's institutes often printed lists of District nurses in issues of "Home and Country" so that the Institutes could invite their District Nurse to take part in their Institute.<sup>74</sup> This collegial relationship was also an important factor in distributing knowledge about cancer. For example, in 1977 through a contact with the National Film Board, the provincial executive was asked to view a slide presentation and then was asked their opinion on it. These women felt that a film should be made from these slides to further help educate the province's women on the dangers of ignoring early signs of cancer. The film that was eventually produced, "Women and Cancer," promoted Well Women's Clinics and the importance of cervical and breast cancer screening, and distributed information about screening opportunities provided by various organizations in the province.<sup>75</sup> One example of a positive response to this film at the time was the Cobequid Women's Institute establishing and supporting a Well Women's Clinic in their district, causing more to be

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<sup>74</sup> Yarmouth Archives. YMS 3 106 1994:47 File #1 – "Through the Years: The Women's Institute Story: A History of the W.I.N.S. 1913-1979," pg. 13.

<sup>75</sup> *Ibid.*, pg 43.

initiated around the province. As a result of all of the clinics that were established after the release of the film and the spread of cancer awareness, a manual, “Well Women’s Clinic Report and Organizational Manual”, was written.<sup>76</sup>

One of the most notable roles the Women’s Institutes had in regards to health and welfare was their constant support of their local well women’s clinics. Minutes of meetings held through the 1970s in many different districts in Nova Scotia show evidence of constant fundraising in order to keep local clinics running. The Arcadia, Bear River, Deerfield and Pleasant Valley, Smiths Cover, Joggins Bridge, and Rossway Women’s Institutes were all avid fundraisers for their local clinics. Toy drives, bake sales, fresh produce sales, and personal donations all contributed to the successful operation of clinics.<sup>77</sup>

It was not just the volunteers and Women’s Institutes in Nova Scotia who were helping to screen the province’s population. Using British Columbia as an example of a screening program that worked, physicians and researchers in Nova Scotia pushed themselves to figure out a program that would also work for their province’s women. In the 1960s, cancer statistics in Nova Scotia were not looking particularly good, and it was clear that something had to be done.<sup>78</sup> Early pilot projects were proposed and carried out

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<sup>76</sup> Ibid.

<sup>77</sup> Yarmouth Archives, YMS 3 106 1994:47 files 1,2,8, YMS 3 86, Admiral Digby Museum and Archives, 2002-20-19, 2002-20-24.

<sup>78</sup> Even as late as the 1990s, women in Nova Scotia (mainland and Cape Breton Island) were generally under-screened. This prompted the Population Health Fund of Health Canada to launch a unique program called, “Pap Screening for Life.” Using mainland women as the control group, Cape Breton Island women were targeted as they had the highest rates of cervical cancer coupled by the lowest rates of screening participation. They were sent letters to inform about the importance of screening and were encouraged to take a more active role in their preventive health care. Please see, Grace M. Johnston et al, “Community-based Cultural Predictors of Pap Smear Screening in Nova Scotia.” *Canadian Journal of Public Health* vol. 95/2 (2004): 95-98.



in Nova Scotia that would drastically change cervical cancer incidence rates in the province. While the screening programs were initially focused on Halifax and Halifax County, they quickly spread throughout the province to encourage all women to be screened. By the 1990s, Nova Scotia was one of the top three provinces in the country to have the highest numbers of women being screened on a regular basis. It was during this decade that Nova Scotia proved to be one of the most proactive provinces towards cervical cancer screening. They instituted a “letters to doctors” program in 1996 to ensure that follow-ups to abnormal smears were happening; they created “Pap Test Awareness Week” in 1997, and eventually commissioned a program to train nurses to do Pap smears in 1999.<sup>79</sup> But in order for pilot programs to be launched in 1960, there had to be an atmosphere conducive to this kind of thinking. While it is easy to recognize that Nova Scotia was active in its cancer prevention in the 1990s, they were also active in this preventive discourse as early as the 1950s.

In 1950, the Cancer Committee developed by the province through Dalhousie University medical school provided a report to the Nova Scotia Medical Society discussing their survey findings of 844 cases of malignancy. The five main categories included in the survey were: site of lesion, stage of lesion, confirmation of diagnosis by biopsy, age of patient, and interval between onset and consultation.<sup>80</sup> Attention was paid both to breast and cervical cancer cases, education regarding these types of cancers, and sources of information. While the doctors writing this report demonstrated only a “slight

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<sup>79</sup> G. Walsh, et al. *A Portrait of Gynaecological Cancer and Cervical Screening in Nova Scotia for the Period Ending 2001*. (Gynaecological Cancer Screening Program, Surveillance and Epidemiology Unit: Cancer Care Ontario, 2003), 41.

<sup>80</sup> Dalhousie University Archives. UA12, file# 198.6 – Faculty of Medicine. Correspondence between Cancer Committee and the Nova Scotia Medical Society, August 31, 1950. “Report on Cancer,” page 2.

increase” in numbers of cases of breast and cervical cancer, they argued that there was not enough general education regarding the prevention of these cancers. In 90% of the breast cancer cases women found a growth by accident and professionals believed that women needed to be encouraged to continually palpate their breasts at regular intervals so that earlier lesions could then be found.<sup>81</sup> They did not mention screening for cervical cancer, and its importance, despite the Pap smear being well-known at this point, and being used more regularly in physicians’ offices.

The conclusion of the report focused on the importance of cancer education in order to further decrease incidence rates in the province. They interrogated a large number of the patients in order to “determine the value of different methods of Cancer education and to ascertain the reasons which prevented patients from seeking earlier advice.” The results were that people within this group felt that both radio and public addresses add little to no value in “Cancer Propoganda [sic].” Patients were more willing to read articles in papers and magazines on cancer. The cancer committee members attributed this form of cancer education to the increasing number of early cases diagnosed and to the “shortening of the interval between onset and consultation.” They also credited the medical profession with paying more attention to the “cancer problem” and to addressing their concerns to their patients.<sup>82</sup>

The report also addressed why patients did not seek medical treatment sooner. They argued that both economic and “family matters” still hindered people from seeking medical treatment before a potential cancer reached advanced stages. Parents,

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<sup>81</sup> Ibid., 2.

<sup>82</sup> Ibid., 5.

particularly women, found it difficult to leave their families “without additional help in the household” and felt that productive time would be lost going to a physician. This was especially true when people were not experiencing any symptoms. The report noted that all too often advanced cancers were found only after symptoms appeared and that general cancer education was simply not successful at convincing patients to obtain preventative screening. The authors of the report argued that once a lesion was clinically found, it was often pathologically too late.<sup>83</sup>

Later in 1952, another report was submitted to the Nova Scotia Branch of the Canadian Medical Association reiterating concern about poor cancer education in the province. They argued that “cancer education is obviously not reaching the groups of mouth, lip and skin lesions and great efforts should be made to appeal to these patients.” While they were focusing on cancer of the mouth, lip and skin, their concern was still quite valid for other cancers. They felt that the medical profession should be playing a larger role in cancer education. They believed “the personal and intimate association between patient and doctor which is possible with our small population could be used with great effect in cancer propaganda. Interrogation of more than eight hundred patients on this point shows that information given by their own physician has greater influence than when obtained from any other source.”<sup>84</sup>

Nova Scotia was one Maritime province that also benefited from the successes on the West Coast. The knowledge about creating awareness and program development

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<sup>83</sup> Ibid., 5-6.

<sup>84</sup> Dalhousie University Archives. UA12 file# 198.9 Faculty of Medicine. Report sent to the Nova Scotia Branch of the Canadian Medical Association, August 25<sup>th</sup>, 1952. page 5.

traveled from B.C. and was ‘translated’ into a pilot project in Nova Scotia that would prove to be fundamental in the province’s battle against cervical cancer. At this point, it was already understood that the battle against cervical cancer was only going to be won by developing an organized screening program. Early in the 1960s, using the BC model, doctors in Nova Scotia developed their own program that would work best for their province. This distribution of knowledge, while fundamentally similar, was, using Kathy Davis’ terminology, “translated” to further suit the new geography. This geography was not confined to definitions of land, but also to population distribution and diversities of women throughout the province. For example, one of the larger municipalities in the province, Sydney (Cape Breton), had cancer incidence rates 50% higher than Nova Scotia as a whole.<sup>85</sup> Issues of socioeconomic status, rural accessibility to health care options, and various environmental pollutants are all part of large medical studies attempting to identify epidemiological explanations for these staggering statistics.<sup>86</sup>

During the early twentieth century, Nova Scotia was much more rural in its geography in comparison to BC, therefore forcing adaptation of new ideas about screening programs. Unlike BC and its strong urban feminist action, Nova Scotia had a strong and flourishing rural women’s society system. Nova Scotia’s unique Well Women Clinic system successfully responded to rural challenges in terms of the delivery of health care options. Well Women Clinics were places where women could access such health

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<sup>85</sup> Paul J. Veugelers and Judith Read Guernsey. “Health Deficiencies in Cape Breton County, Nova Scotia, Canada, 1950-1999,” *Epidemiology* vol., 10/5 (1999): 495.

<sup>86</sup> For example, see Judith Read Guernsey et al., “Incidence of Cancer in Sydney and Cape Breton County, Nova Scotia 1979-1997.” *Canadian Journal of Public Health* vol. 91/4 (2000): 285-292.

provisions as screening and birth control in addition to general health information. While each clinic was surely different, all were built with the same knowledge foundation.

On July 14<sup>th</sup>, 1960, Dr. Charles Tupper chaired a meeting to discuss a program that the province of Nova Scotia had never seen before. After he was re-elected as the chairman of the Cancer Committee of the Medical Society of Nova Scotia, Dr. Tupper called a meeting at the Victoria General Hospital with the purpose of exploring the possibility of setting up a project for the early diagnosis of cancer of the cervix. Dr. Robinson was already the head of the Uterine Detection program, but was looking to launch a program within this broader agenda, focusing particularly on cervical cancer.<sup>87</sup> Other doctors present included: Drs. N.H. Gosse, W.A. Taylor, J.S. Robertson (Deputy Minister), S.C. Robinson, Mr. Rudolph of the Federal-Provincial Grants, Department of Public Health. The pilot study was proposed for Halifax County, Nova Scotia, and estimated cost for running this project until December 1962 was approximately \$50,000.

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<sup>87</sup> In a newspaper article, in *Our Herald* February 18, 1961, the author (Beverly Day) made it sound as though the Uterine Cancer Detection Program of Nova Scotia and the program for the detection of cervical cancer were two different entities. It also appears as though the Uterine Cancer Detection Program was in place by Dr. Robinson (director) as the proposal for the cervical cancer detection program was proposed. Talks that were highlighted were discussions on the detection of cancer of the cervix and the establishment of a new province-wide program of detection. Dr. W. Carl Tupper and Dr. S.C. Robinson were both considered key speakers. Dr. Robinson was the director of the uterine cancer detection program of the Medical Society of Nova Scotia at the time. "Dr. Robinson [was] working on a program, under the instructions of the Cancer Committee of the Medical Society of Nova Scotia, which [was] aimed at early detection of female genital cancer...The program [was] initiated in Halifax city and county. The aim [was] to have all married women and those over 20 submit to an examination of the pelvis, including the simple test for cancer." Dr. Robinson believed that, "This can be done by one's own physician. The provincial pathology laboratories are ready to handle the increased volume of the detection slides. The problem is twofold: To induce every doctor to examine the women and to induce the women to come to their offices for this examination on their own, he said." Beverly Day. "Time means Matter of life or death." *Our Herald*, February 18, 1961.

This total included everything from clinic supplies, staffing, tools, mailings, and any unforeseen expenses.<sup>88</sup>

Recognizing that the results of the treatment of cervical cancer had not improved in Nova Scotia in five years, Dr. S.C. Robinson and associates suggested that the only solution would be to launch an early detection program in the province. They based this belief on the fact that this type of program had been successful in cities elsewhere; e.g. Royal Victoria Hospital, Montreal; San Diego, Memphis; and the province-wide program in British Columbia. British Columbia was particularly influential because they had demonstrated that the cost of finding one new case of cervical cancer is \$300, and the cost of one smear slide was only \$1.20.<sup>89</sup> The other examples, San Diego for example, had concrete numbers that clearly demonstrated the purposes of their proposed example. For example, according to one proposal, between 1950 and 1955, 33,750 women were screened in private practices in San Diego. Of this group, 774 women had results that suggested malignancy. In addition to these cases of malignancy, 45 cases of dysplasia, 259 cases of carcinoma in situ, 77 cases of invasive carcinoma of the cervix, and 14 cases of carcinoma of fundus were also found. This study also found that women over the age of 60 had much higher rates of incidence of cervical cancer, thus concluding that this particular age group was not as responsive as younger groups to screening programs.<sup>90</sup>

The proposal was also abundantly clear about the groups on which the pilot study wanted to focus. These groups included all married women and all other women over the

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<sup>88</sup> *Dalhousie University Archives*. UA12 file# 198.7 Faculty of Medicine. "Application for Research Grant – An Early Detection Program for Pelvic Cancer – Province of Nova Scotia." Pages 1-3.

<sup>89</sup> *Ibid.*, "Outline for Proposed Early Detection Programme," page 2.

<sup>90</sup> *Ibid.*, "The Proposed Cytological Smear Programme in Halifax", 2.

age twenty.<sup>91</sup> These groups coincided with the medical understandings of risk factors of cervical cancer at the time, which included multiple births and sexual activity. The projected number of women to be screened was around 50,000.<sup>92</sup>

How would these women be contacted? The proposal suggested that suitable advertising such as communication from family physicians, a “traveling free clinic” for the poor and fixed clinics located at various hospital out-patient departments would be sufficient. Comprehensive education programs would also be launched simultaneously with the clinics and advertising programs. The plan was to have constant descriptive releases in the daily and weekly papers, have local doctors and nurses organize meetings and give active assistance to the clinic directors and nurses, have local announcements regarding the details of arrangements at clinics via radio, press, TV, and notices, and publish progress reports every two months with findings and numbers examined in all areas.<sup>93</sup> The idea was that with proper education, women would then report any abnormal signs, such as abnormal bleeding and discharge, to their physicians in addition to subjecting themselves to yearly Pap smears.<sup>94</sup>

The proposed outcomes of this pilot project were clear. Dr. Robinson and his associates wanted to increase both lay and professional education, increase numbers of cases found, improve research, set precedents for other programs to be developed in other parts of the province, and improve both the provincial cure rate and early case finding. They also believed that while these objectives were being met, costs to run the program

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<sup>91</sup> Ibid.

<sup>92</sup> Ibid., 3.

<sup>93</sup> Ibid., 4.

<sup>94</sup> “Cancer Detection in Women.” *Canadian Cancer Society – Nova Scotia Division*, newsletter, Issue no. 23, April 1961, page 1.

would begin to decrease in subsequent years.<sup>95</sup> Using the British Columbia example as precedent, Dr. Robinson and his group of researchers wanted to be sure that adequate staff were in place before a program was publicly announced in Halifax County. In BC, Drs. Fidler and Boyes restricted the Vancouver study to only selected participants to ensure that they were organized and prepared before a public announcement was made. With these known results and concerns, Robinson proposed that a “trial run” program be conducted in Halifax using only out-patients or another “acceptable group” to ensure that all the proper staffing was in place.<sup>96</sup>

After the program was approved by the Cancer Committee of the Medical Society of Nova Scotia, a letter was sent to all practicing physicians in the province. It was clearly stated in the letter that in order for this program to have success, it was imperative “doctors who see women make it a habit to always do a cytology smear at the time of pelvic examination.”<sup>97</sup> Dr. Robinson encouraged physicians to re-organize their offices so that the tools to perform such examinations and to take specimens were readily available and to further train their secretaries to prepare slides for mailing. Dr. Robinson praised the existing cytology service in Nova Scotia, and if used, he believed that all physicians would recognize that it was quick and exceptionally convenient. He believed that as of 1960 there were approximately 4,300 unsuspected cases of “actual or incipient

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<sup>95</sup> Ibid., 5.

<sup>96</sup> Ibid., 2.

<sup>97</sup> Dalhousie University Archives, UA12 file# 198.8. Generic letter to all physicians in Nova Scotia from Dr. S.C. Robinson, 1961, page 2.



uterine cancer in Nova Scotia.” He wanted to find them and to keep a close count of numbers in order to see change over time.<sup>98</sup>

Shortly after the program was launched in 1960, researchers involved realized that convincing practicing physicians to cooperate was not going to be as easy as they had hoped. In a letter to Dr. John J. Stanton of the Halifax Department of Public Health, Dr. Robinson was not afraid to describe the grim reality of so few doctors using cytology services in the department. A survey of the cytology material submitted in 1960 was conducted, and the results were staggering. According to the findings, as of 1960 75% of Nova Scotia doctors had not submitted slides. And, as Dr. Robinson stated, “those rarely using the test are apparently using it to diagnose ‘suspicious lesions’,” thus not using the test as a screening procedure at all.<sup>99</sup> Recognizing that the situation was even worse than he could have expected, Robinson reiterated the importance of educating and communicating with physicians about the importance of cytology as a “useful, accurate, and simple technique.” He argued that the only way to reach all doctors immediately was through mail-outs of letters and information booklets. Also, personal contact and interviews and local meetings were all important techniques to further encourage physicians to use cytology services in the province.<sup>100</sup> While Robinson was thoroughly convinced of the potential success of this program, he was equally concerned with the participation of Nova Scotia’s doctors.

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<sup>98</sup> Dalhousie University Archives, UA12 file# 198.8. Generic letter to all physicians in Nova Scotia from Dr. S.C. Robinson, 1961, page 2.

<sup>99</sup> Dalhousie University Archives, UA12 file# 198.8. Letter to Dr. John J. Stanton, Halifax Department of Public Health, from Dr. S.C. Robinson, April 11, 1961, page 1.

<sup>100</sup> *Ibid.*, page 2.

Two years after the program was launched key issues started to surface. One of the main problems this program encountered was the sharp increase in numbers of slides to be read by trained technicians. While an increase in slides indicated more women were being screened, by not having the proper system in place to manage them all the work seemed futile. While earlier concerns about making sure enough staff were in place before launching the program seemed valid, such concerns had not been addressed. Nova Scotia cytology labs experienced numbers of slides that they could simply not keep up. During a meeting in January of 1961 at the Victoria General Hospital regarding the Cancer Detection Program, Dr. Tupper and others further discussed how to remedy the lack of trained staff to read smears. There was discussion of using people who are “deaf and dumb” or paraplegics to help staff cytology labs. This was not an easy and cost-effective solution, as it would take six months to a year to train people who did not have their grade twelve education. Up to this point in Nova Scotia, “deaf and dumb” students were only educated up to grade eleven.<sup>101</sup> Another solution suggested by Dr. Gosse to slow down the volume of slides was to slow down the publicity on the program. However, the other doctors present at the meeting argued that reducing public announcements would not cause a significant drop in the volume of slides being sent to provincial cytology labs. Most doctors strongly believed in the public education programs and did not want to see them slowed at all. One positive solution was to simply add to the existing public education programs by suggesting that young women, in

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<sup>101</sup> Dalhousie University Archives, UA12 file# 198.8 Minutes of a meeting held at the Victoria General Hospital on January 11<sup>th</sup>, 1962. “Cancer Detection Program.” Page, 2.

addition to getting screened on a regular basis, also consider an active career in cytology and lab work.<sup>102</sup>

One of the key aspects of the success of Dr. Robinson's proposed cervical cancer detection program was the reliance on a consistent reporting system. All physicians in Halifax County were asked to report all diagnosed and suspected cases of cervical cancer within their practices. However, as existing correspondence indicates, by 1962 Dr. Robinson had trouble convincing practicing physicians to supply him with information on the numbers of women screened and suspected cases. In a letter to Dr. James N. Park of Aberdeen Hospital, New Glasgow, Nova Scotia, Dr. Robinson pleaded with him to properly supply such imperative information. As he so firmly stated, "I am sure your program is getting along reasonably well, but until we can work out some way of supplying me with information as to the total number of slides examined and the relative facts concerning positive cases, we are working in the dark."<sup>103</sup>

By the 1990s, and in some cases even earlier, well-women clinics were being established across Nova Scotia. Many of the earlier examples of Well Women Clinics were a direct result of the work of various district Women's Institutes. Many of these late twentieth century clinics were provided through local women's centres via local and university communities. These clinics were reaching rural women, lower class women, and women who simply did not have access to screening opportunities, not to mention education about the importance of screening. They focused not only on providing

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<sup>102</sup> Ibid., 2.

<sup>103</sup> Dalhousie University Archives, UA12 file# 198.8. Correspondence between Dr. James N. Park and Dr. S.C. Robinson, March 6<sup>th</sup>, 1962.

screening services, but also on free education and counseling services. The idea was to screen, educate, and assist through all different types of test results. For the most part, volunteer physicians, nurses, and lay people staffed, and continue to staff, all of these clinics.

By the turn of the 21<sup>st</sup> century there were seven main women's centres across the province. The Dalhousie Women's Centre first opened its doors in 1993 and was a "critical component of the Dalhousie [University] and Halifax community." While this centre was volunteer driven, it was funded through student funds and continues to be a prominent place not only to learn about cervical cancer screening, but also to offer resources around social justice issues. The Centre provides referrals to other services in Halifax, sponsors events celebrating the diversity of women, and provides a diverse library of videos, books, and journals.<sup>104</sup>

Another women's centre located in a university setting is Acadia University's women's centre. Similar to Dalhousie's women's centre, it offers a small library, referrals to services available in the area in regards to health and well-being and hosts women-centred events such as the stage performance of the *Vagina Monologues*, or various information sessions. From what I have found, the Acadia women's centre was opened in 2002 and is still a tremendously significant part of campus life for women in Nova Scotia.<sup>105</sup>

The Second Story Women's Centre located in Lunenburg County, N.S., offers services similar to the Dalhousie and Acadia Universities Women's Centres. While it is

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<sup>104</sup> [www.dalwomenscentre.ca](http://www.dalwomenscentre.ca) "The Women's Centre was created to:"

<sup>105</sup> [www.womencentre.acadiau.ca](http://www.womencentre.acadiau.ca) "Executive."

not located on a university campus, it also provides workshops on prevention, education, and public awareness of a variety of health and social issues to the greater local community. They also provide, similar to the Dal centre, resource referrals to help women in crisis and provide a small library of information.<sup>106</sup> It is not clear from their website what year they opened.

The Antigonish Women's Centre was opened in 1983 and reaches both Antigonish and Guysborough counties. It is one of the many women's centres in Nova Scotia that are committed to providing "collaborative women-centred primary health care programs and services for women and adolescent girls" via their Lindsay's Health Centre for Women. This health centre currently provides mental health services, addictions services, Public Health Services, the Women's Centre, a physician and a nurse practitioner. There are also a variety of programs offered through each calendar year. The Women's Centre, going beyond just health care issues and similar to many of the women's centres in Nova Scotia, focuses on promoting the general well-being of women through "community development and community education initiatives," and often extends services to other family members as part of crisis support.<sup>107</sup>

Opened in 2002, the Tri-County Women's Centre focuses on reaching women of the Yarmouth, Shelbourne, and Digby counties. It is a volunteer, community-based organization that works towards offering "women and adolescent girls who are at risk of poverty and struggling to achieve success in their education and work environment" a

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<sup>106</sup> [www.secstory.com](http://www.secstory.com) "What we do."

<sup>107</sup> [www.antigonishwomenscentre.com](http://www.antigonishwomenscentre.com) "Lindsay's Health Centre for Women," and "What we do."

place to seek information and help.<sup>108</sup> Health is among many of the issues with which they help women and adolescent girls. By providing a place for women to come with questions about health and sexuality, the Tri-County women's centre further provides services via Public Health works that often visit the centre and meet these women on a community level.<sup>109</sup>

The Pictou County Women's Centre operates similar to the other women's centres in Nova Scotia. They offer referral services for women and their families in relation to housing, equality and health issues.<sup>110</sup> In addition to a small library available to all who drop in, this centre also provides scheduled information and education sessions, referral services, and support via one-on-one counseling.<sup>111</sup> There is generally no cost associated with a visit to this women's centre, but if there is a cost recommended, it is on the basis of what the woman can afford. This centre prides itself on never turning any woman away because of monetary issues.

The unfortunate reality, however, is that the concept of well-women clinics was not always a welcome one in Nova Scotia. The 1960s screening program discussed earlier by Dr. S.C. Robinson was highly critical of setting up specialty clinics focused on only screening services. At the time, he believed that "nothing would damage this project more than anything which would undermine the support of practising physicians." In the early stages of setting up the screening program he headed there was mention of the possibility of setting up traveling free clinics for the poor. By 1961, he argued "there is

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<sup>108</sup> [www.tricountywomenscentre.org](http://www.tricountywomenscentre.org) "opening page"

<sup>109</sup> Ibid., "About us."

<sup>110</sup> <http://www.povnet.org/node/1581>

<sup>111</sup> [http://www.pcha.nshealth.ca/mentalhealthservices/communityresources/service\\_pcwomenscentre.htm](http://www.pcha.nshealth.ca/mentalhealthservices/communityresources/service_pcwomenscentre.htm)

no need for setting up clinics of this kind as yet. The established public clinics in Halifax and the public wards in the hospitals are using cytological screening regularly.” What is compelling about this point is that in the same letter, he rants about how so few doctors (75% to be exact) were using cytology services in the province.<sup>112</sup> The type of clinic that Dr. Robinson was discussing in this letter, as mentioned earlier in this section, was not without its problems. Provincially-funded programs often run into staffing issues and the ability to maintain specially-trained technicians to read the influx of smear slides.

Finally in 1991, arguably one of Canada’s first organized cervical cancer screening programs was developed in Nova Scotia. The Cervical Cancer Prevention Program (CCPP) was developed by the Department of Health and eventually integrated with Cancer Care Nova in 2002. The CCPP consists of physicians, nurses, laboratories and many other groups and organizations in Nova Scotia working together towards creating a “comprehensive and equitable model in prevention and early detection of cervical cancer.”<sup>113</sup> The program mandate was as follows:

- public and professional education;
- the establishment and ongoing evaluation of province-wide standards in cytology,
- histopathology, and colposcopy;
- a provincial cytology/colposcopy monitoring system; and
- research.<sup>114</sup>

These mandate specifics are distributed to the greater public through over 100 volunteers who work closely with the program staff in the area of public education. Their goal is not

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<sup>112</sup> Dalhousie University Archives, UA12 file# 198.8. Letter to Dr. John J. Stanton, Halifax Department of Public Health, from Dr. S.C. Robinson, April 11, 1961, page 2.

<sup>113</sup> Cancer Care Nova Scotia website. “The Cervical Cancer Prevention Program – Program Overview.” [www.cancercare.ns.ca/inside.asp?cmPageID=167](http://www.cancercare.ns.ca/inside.asp?cmPageID=167)

<sup>114</sup> Ibid.

only to raise awareness about the importance of regular Pap tests, but also to conquer existing mortality and morbidity rates. The program is also an active member of the Cervical Cancer Prevention and Control Network. This network is a part of the national committee of the Public Health Agency of Canada whose main focus is to “facilitate the continued education in the incidence, morbidity and mortality of cervical cancer in Canada.”<sup>115</sup>

A Regional Resource Network was set up in 1994 in conjunction with the CCPP. Its focus was to organize a group of women from various communities across the province to liaise with the Program and other women in their communities about Pap test screening demographics and particular concerns from either group. Twice a year this group meets to discuss both successes and challenges and to receive updates on new technologies and news within each group. This group is similar to the CCPP, as it is composed of doctors, nurses, and various women’s groups such as the Women’s Institutes of Nova Scotia. This group acts as a “friendly, trusted resource to local women and other health professionals.”<sup>116</sup> These new committees, more than likely, are a direct result of overcoming hostilities between doctors and well women clinics.

This type of network speaks to the unique regional experience in Nova Scotia. While this model may not work in other regions, such as British Columbia, the multiple municipality and resource sharing that occurs in this province allows for a successful program that actively reaches women from across the province. British Columbia has unique regional definitions both physically and theoretically. As Megan Davies’ study

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<sup>115</sup> Ibid.

<sup>116</sup> Ibid., “Regional Resource Network.”



on the aging in British Columbia demonstrates, the constant moving of the seasonally-based population, the rough terrain, and the island dynamic all define the province unlike any other. A resource network such as the one established in a more rural province such as Nova Scotia probably would not have as much success in urban British Columbia as in Nova Scotia for these reasons.

As a follow-up to the Regional Resource Network in 1994, in 1997 the government of Nova Scotia and its department of health, in partnership with the Nova Scotia Gynaecological Cancer Screening Programme and the Nova Scotia Division of the Canadian Cancer Society, launched the first Pap Test Awareness Week the East Coast of Canada had seen up to this point. The goal of this week was to increase the public's awareness of the importance of the Pap test and its role in the early detection and treatment of cervical cancer. In response to the second annual Pap Test week in Nova Scotia, Health Minister Jim Smith commented, "Nova Scotia has unacceptably high rates of cervical cancer, the need to educate women about the importance of having regular Pap tests has never been so great."<sup>117</sup> Many activities, including well woman's clinics, displays and information booths at various locations, and several women's health information sessions at area schools, were organized throughout the Awareness week.<sup>118</sup>

While it is clear that Nova Scotia developed a screening program decidedly different from that in British Columbia, there is no doubt that they relied on BC as a model. The early 1960s pilot screening project headed by Dr. Robinson was one

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<sup>117</sup> [www.gov.ns.ca/news/details.asp?id=199810260001](http://www.gov.ns.ca/news/details.asp?id=199810260001) Department of Health, "Pap Test Awareness Week in Nova Scotia, Oct. 25-31."

<sup>118</sup> Ibid.

mirrored on the British Columbia early 1950s screening program. Building on that earlier model, Nova Scotia further developed their program to include public education via newspapers, radio, and television, in addition to more comprehensive recall and follow-up systems. The province of Ontario, while mostly urban after the Second World War, has a very different history from both Nova Scotia and British Columbia in regards to how they developed cervical cancer screening opportunities.

### **Ontario – Impromptu Approach to Screening**

During the first half of the twentieth century, Ontario was a pluralistic health culture that involved influences and interpretations of laity, alternative healers, and the medical profession.<sup>119</sup> In her book, *Negotiating Disease*, Barbara Clow argues that early attempts to battle cancer were complicated and involved many different groups that seldom agreed on how to best launch such a battle.<sup>120</sup> While a patient might have viewed their disease in a particular way, doctors have had “radically different” solutions for a cancer diagnosis.<sup>121</sup> During this period in Ontario, health policy was very much influenced by popular and medical understandings of disease. The early twentieth century was a time of medical uncertainty, particularly with regard to cancer, and Ontarians, much like other Canadians at the time, were searching for successful treatment options. This pre-1950s era in Ontario marked a new and active role for the government in the provision of cancer care and cancer control programs. But most importantly, it has to be noted that cancer care during this period remained diversified. A notion that carried

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<sup>119</sup> Clow. *Negotiating Disease.*, xiv.

<sup>120</sup> Ibid.

<sup>121</sup> Ibid.

well into the 1950s, as Clow argues in her book, was the idea that “definitions of health and illness, experiences with medical care and personnel, and convictions about social responsibility and personal autonomy profoundly influenced health care choices and policy.”<sup>122</sup> However, unlike BC and Nova Scotia, Ontario was less likely to respond to local-level requests for screening opportunities, as the provincial government remained focused on investing in top-notch treatment facilities well into the later twentieth century.

After the 1950s, the period this dissertation focuses on, key treatment innovations such as chemotherapy and health insurance programs caused a substantial shift towards the all-knowing conventional medical model. Medical authority began to assert itself during the second half of the twentieth century, priding itself on its scientific successes in cancer treatment. Prevention, as post-1950 Ontario also demonstrates, was often low on the priority list, much below treatment and diagnostic advances. Ontario was slow in its campaign to prevent cervical cancer, even with an active Women’s Institute network and doctors showing interest in a mass screening program.

Unlike British Columbia and Nova Scotia, Ontario’s Women’s Institutes distributed little information about cervical cancer. While health information was clearly on the minds of members of various Women’s Institutes across Ontario, most of the focus was on child and maternal health. In the later 1940s and early 1950s Women’s Institutes in Ontario successfully organized health insurance plans for members and their families – resulting in a sharp increase in membership during this period. This was not surprising, as rural women were having their babies more and more in hospitals and needed

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<sup>122</sup> Ibid.

insurance to help cover the costs.<sup>123</sup> It seems as though most of the pressure to create an organized cervical cancer screening program in Ontario was via medical professionals and municipal representatives.

In the 1960s, Ontario was proud of its top-notch cancer treatment options. In 1963, M.B. Dymond, Minister of Health for Ontario, prided himself on the fact that people traveled to Ontario for cancer treatment because of its high quality. Unfortunately, he showed little, if any, interest in cancer prevention. This lack of interest on the part of the Ontario Health Minister was reflected in Ontario's lack of investment into cervical cancer screening programs. However, while there was little interest from the provincial level of government in Ontario during the mid-twentieth century, there is some evidence that there were groups pressuring local governments for screening programs. A proposal was put together by a physician in 1963 for an organized screening program; however, nothing actually came to fruition in terms of an actual organized program until the late 1990s. As Ontario has a large population and is home to the Nation's capital, one could assume that the province would be interested in responding to a movement for better access to health care for women, especially during the Women's Health Movement of the 1970s. This, unfortunately, was not the case.

In the 1960s the Ontario provincial government was not as focused on organized cancer prevention as either BC or Nova Scotia. The Conservative Premier at the time, John Robarts, focused much of his efforts on education, a new Constitution and the avoidance of Quebec separatism. Ontario did, however, establish a cancer clinic in a

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<sup>123</sup> Ambrose, 157-8.

highly populated part of the province. In 1948, Ontario opened a cancer detection clinic in Toronto located at the Women's College Hospital. The idea was to examine "well women" in order to detect cancer. Although the idea of the clinic was the diagnosis of cancer and not necessarily prevention, it was an essential part of Ontario's early attempt at cancer control. The clinic was originally opened with the support of a provincial grant and later funded by the Ontario Cancer Research and Treatment Foundation (OCRTF).<sup>124</sup> Within two decades of its establishment, asymptomatic and symptomatic women and men were being examined and treated at the clinic.<sup>125</sup> All patients had to be referred to the clinic by their own physicians; the clinic simply did not "take patients off the street." At this time, the onus was still on the primary care physician to recommend such examinations.<sup>126</sup> The OCRTF could no longer subsidize the clinic after a short while, and fees were required of all patients. Eventually the cost per patient reached as high as \$19.13. This fee included the doctors' fees, x-ray, laboratory fees, a nurse, supplies, and administration.<sup>127</sup> This clinic was reaching only a small portion of Ontario's female population – those who happened to live in the Toronto area and had the funds to pay for such a health service.

Ontario was not alone, as many provinces during the mid-twentieth century were slow in their response to the rising national cervical cancer problem. However, Ontario did have some pressure from various municipal governments (despite the negative responses from the provincial government) for an organized cervical cancer screening

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<sup>124</sup> Women's College Hospital Archives. N4-Container 45, "History of the Cancer Detection Clinic."

<sup>125</sup> *Ibid.*

<sup>126</sup> Women's College Hospital Archives. N4-Container 59, File #1, "History of the Cancer Detection Clinic – Women's College Hospital."

<sup>127</sup> *Ibid.*

program. Women pressured their local municipalities because they felt that they were being underserved in terms of their health care needs. For example, in the early 1960s a proposal was sent to the provincial government on behalf of the Municipality of Kitchener-Waterloo requesting financial assistance in support of such a program. M.B. Dymond, Minister of Health in 1963, responded negatively to the request, stating that he was “becoming steadily and increasingly befuddled about the place and function of municipal government.”<sup>128</sup> There were several other municipalities across Ontario who supported such a proposal, but Dymond continued to respond to the heap of letters being sent to his office by writing to J.W. Spooner, Minister of Municipal Affairs,

Commenting on the resolution, I would say that city councils know nothing about this. Historically, Ontario has done more in this field than all the rest of Canada put together, and, indeed, when people need the latest treatment for cancer, they come to Ontario. I don't know if you ever have an opportunity to tell municipal councils in a kindly but firm way to “tend to their knitting”, but it seems to me they need to be told this, and soon, I realize it is a difficult matter but, then, I never underestimate your powers!<sup>129</sup>

It appears by Mr. Dymond's response that, because Ontario had a prestigious cancer clinic, the Cancer Clinic in Toronto at the Women's College Hospital, there was no real cancer problem. He did not seem to realize that the availability of screening was very limited, hence the outcry from municipalities across the province. The municipalities were not asking for an increase in cancer treatment services; they were focusing on services dealing with prevention.

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<sup>128</sup> Archives of Ontario. RG 10, File # 1-1-3.40. Personal letter addressed to Hon. J.W. Spooner from M.B. Dymond, Minister of Health., December 23, 1963.

<sup>129</sup> Ibid.

In addition to the municipalities in Ontario pressuring the government, there is evidence that professionals were also making organized efforts to convince the province to establish organized screening. In 1965, Dr. Erwin A. Crawford submitted a proposal entitled, “A Cytology Screening Programme For Cancer of the Cervix in the Province of Ontario.” It is unclear where this proposal was submitted, or how it was received, but this draft proposal is significant for a number of reasons. The proposal includes an extensive analysis of statistical data regarding mortality and morbidity rates and the state of cervical cancer screening procedures in Ontario up to 1965. It is noted on the first page of the proposal that in Ontario there were 1,244,000 women between the ages 25-54. Assuming that about one sixth of these women had a hysterectomy, the study isolated only about 1 million women susceptible to cervical cancer in Ontario between the ages 25-54 who should be screened. Around 2.2% of this group would develop carcinoma of the cervix and half of those would die if they developed invasive cancer of the cervix.<sup>130</sup> The proposal then clearly stated that “If all of these cases could be detected in the stage 1 cancer of the cervix, 80% could be cured, but if they all could be detected in the pre-invasive stage and treated, the deaths from cancer of the cervix could virtually be reduced to a zero quantity.”<sup>131</sup> This proposal demonstrates that there was still a need, during the 1960s, to pressure the provincial government to aid in the development of organized screening.

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<sup>130</sup> Archives of Ontario. RG 10, File # 71-4-5. “A Cytology Screening Programme For Cancer of the Cervix in the Province of Ontario,” Draft 1965.

<sup>131</sup> Ibid.

A revolutionary approach to screening was attempted in Ontario between January 1984 and August 1985. A van travelled to 12 Toronto garment factories and conducted information sessions in six different languages (English, Chinese, Italian, Spanish, Portuguese, and Vietnamese). This project was created in 1981 as a result of a “one-time grant” of \$189,000 from the federal Department of Health and Welfare. The City of Toronto also contributed funds soon after its establishment. The story of this mobile unit losing its funds hit the pages of the *Globe and Mail* in April of 1986. Clearly, according to the story’s writer, this mobile unit was reaching women who were less likely to have regular Pap smears or even to visit their physicians on a regular basis and who were generally unhappy with the care they received from their doctors. The targeted garment factories, largely staffed by immigrant women, allowed the study to reach out to a high-risk group and to evaluate how successful a mobile unit could be. The study found that 84% of the sample of women studied felt rushed when they visited their physician, only 20% would see another doctor for a second opinion and 82% of women who attended information sessions on their lunch breaks “said they now feel more confident in questioning their physicians.”<sup>132</sup> Although this mobile unit was only reaching a very select group of women in the City of Toronto, it proved that waiting for women to seek screening themselves was often unsuccessful.

Further regional differences posed challenges to consciousness-raising campaigns and the importance of organized screening programs throughout much of Canada. For example, in Ontario a formal study was carried out in Thunder Bay in 1988 to evaluate

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<sup>132</sup> “Immigrant working women may lose mobile health unit.” *The Globe and Mail*, April 18, 1986, A 11.



the effectiveness of cervical cancer screening in Northwestern Ontario. Northwestern Ontario is an excellent location to carry out such a study because it is remote and surrounding communities have little access to medical services that provide screening. The study was done by Drs. Jaro Kotalik, Eric J. Holloway, Nicolas G. Escott, Van C. Nguyen, and Jan Large and Virginia Hunter. The study was funded by the Ontario Cancer Treatment and Research Foundation along with additional support from the Thunder Bay Regional Cancer Centre.<sup>133</sup>

It was known that invasive cervical cancer (ICC) rates were much higher in Northwestern Ontario (NW) as compared to the rest of the province's regions during the late 1970s to the mid 1980s. For example, "for NW, over the period of 1974 to 1986, the standardized incidence ratio ICC was 1.15 (p=0.04) and the standardized mortality ratio was 1.27 (p=0.03), compared to the province as a whole."<sup>134</sup> With these striking statistics, the medical team proposed that the "sub-optimal performance"<sup>135</sup> of screening programs in this particular area were a large contributing factor in high morbidity and mortality rates. Through preliminary statistical analysis, the study report stated that "the risk of developing invasive cervical cancer for never screened women was three times higher than for ever screened women. 41% of all ICC in the region [Thunder Bay and area] was attributable to the failure of women to ever be screened."<sup>136</sup> It appeared that although screening was a common practice within the physician's office, Northwestern Ontario had additional problems preventing the success of a screening program. Up until 1988, it

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<sup>133</sup> Kotalik *et al.*, "The Effectiveness of Cervical Cancer Screening in Northwestern Ontario." Draft of report. From Dr. J. Kotalik's personal files that were gathered during the study in the late 1980s: 1.

<sup>134</sup> *Ibid.*, 3.

<sup>135</sup> *Ibid.*

<sup>136</sup> *Ibid.*, 2.

was impossible to evaluate the state of cervical cancer screening activity because “pap smear records [were] scattered among several sources and [were] incomplete.” Despite this major shortcoming of statistical data, the study’s conclusions were not very different from the studies executed during the decades prior to this study. Conclusions of the study were as follows:

1. There is an appreciable risk of ICC associated with inadequate performance of the cervical cancer screening programme in North-Western Ontario;
2. There is no good evidence that this performance is improving over time;
3. It is difficult to evaluate the existing programme - the databases are difficult to access and incomplete.<sup>137</sup>

As clear as these conclusions appeared to be, it was some time before a consistent effort was shown in the establishment of a funded program to remedy the issues demonstrated in the Thunder Bay study. It has to be noted that aboriginal women, and women living in remote areas of the Thunder Bay District, were not included in their survey and study. In correspondence with Anthony Miller, Professor and Chairman of the Department of Medicine and Biostatistics at University of Toronto at the time, Dr. Kotalik believed that until “there is a significant proportion of elderly, native or immigrant women, who do not and will not have access to medical practitioners,” there was no need to engage supplementary screening networks in the public health community.<sup>138</sup>

During the mid to late twentieth century, screening in Ontario commonly occurred when women visited their family physicians for unrelated problems. Even with this unorganized approach to screening, there was a recorded 46% decrease in cervical cancer

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<sup>137</sup> Dr. J. Kotalik. “A Case-Control Study of the Effectiveness of Cervical Cytology Screening in North-Western Ontario.” (1993) Presentation notes found amongst Dr. Kotalik’s personal collection of files.

<sup>138</sup> Letter to Anthony Miller from Dr. Kotalik dated September 7, 1993. Found in Dr. Kotalik’s personal files.

incidence rates between 1971 and 1999. This was probably a result of the increase in the regular use of the Pap smear in physicians' offices. There may have been an increase in the regular use of the Pap smear, but it must be kept in mind that the Pap smear was not formally introduced to Ontario and regularly used in physicians' offices until the 1960s.<sup>139</sup> The decrease in the incidence of cervical cancer was hindered by the different incidence trends according to the morphologic type of cervical cancer. For example, "declines are restricted to invasive squamous cell carcinoma. Incidence of the other major morphologic types, adenocarcinoma and adenosquamous carcinoma, increased by 5.8% per year."<sup>140</sup> Although the decrease in incidence rates was considered a success, the Ontario provincial government finally realized in the late 1990s that a more organized approach to screening for cervical cancer was needed in order to continue this declining trend.

Cancer Care Ontario (CCO) was the major organization responsible for creating and launching an organized cervical cancer screening program in Ontario. Premier Harris and the Deputy Minister of Health announced the creation of Cancer Care Ontario in late April of 1997. The Provincial Cancer Network (PCN) that reviewed the status of cancer services during the mid-1990s in Ontario developed CCO from several recommendations. Their conclusion was that "while individual services are excellent, the cancer care system is not well organized. Patients are required to navigate the complex patchwork of cancer care services on their own, and are often unaware of various options

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<sup>139</sup> Loraine D. Marrett et al. *Cervical Cancer in Ontario: 1971-1996*. (Cancer Care Ontario – Surveillance Unit and the Ontario Screening Program Division of Preventive Oncology: 1999), 2.

<sup>140</sup> *Ibid.*, iii.

for treatment and support services that are available.” The PCN believed that with the creation of a single, central agency these challenges would be overcome. The PCN submitted their report in January of 1997 and CCO was announced only three months later.<sup>141</sup>

Early in its existence, CCO received approved funding from the Ministry of Health and Long-Term Care to develop an organized screening program in Ontario.<sup>142</sup> It took three years of planning and organizing to create a program that was ready to launch. In June of 2000, CCO launched a province-wide cervical screening program to which all women living in Ontario would have access. Cancer Care Ontario was expecting to build on already existing services to provide leadership to initiate a coordinated approach to cervical screening in Ontario.<sup>143</sup> There were five key components to the Ontario Cervical Screening Program (OCSP) plan: education and communication, recruitment of women, provincial cervical screening information system, recall and follow-up, and quality assurance and improvement.

The first two components, “Education and Communications” and “Recruitment of Women,” focused mainly on educating women about the importance of screening in order to decrease the percentage of women who had never been screened. The second component, “Recruitment of Women,” focused on increasing “the coverage of the target population of women by identifying and recruiting populations not currently being screened.” This component was developed as a result of Canada’s 1996-97 National

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<sup>141</sup> Cancer Care Ontario. “Building an integrated cancer care system: How Cancer Care Ontario is Taking Shape.” CCO newsletter, Fall, 1997.

<sup>142</sup> “Ontario Cervical Screening Program: Program Report 1997-2000.” *Cancer Care Ontario*, 6.

<sup>143</sup> “Ontario Cervical Screening Program: Strategic Plan.” *Division of Preventive Oncology Cancer Care Ontario*: 1999, 1.

Population Health Survey indicating that approximately 11% of women had never been screened. Also, it was found that the majority of the women who made up the 11% of unscreened or under-screened women consisted of “disadvantaged, less educated, and older” women. The OCSP aimed to improve the quality of information that was available to the general public about the importance of screening for cervical cancer. They also aimed to reach the professionals involved in cancer screening in order to create an increase in knowledge and awareness of screening practice guidelines, such as the follow-up and management of women with abnormal smears.<sup>144</sup>

The third component in the OCSP plan, “Provincial Cervical Screening Information System”, aimed to create a population-based information system in order to maintain the key components of the OCSP. It had been shown that, in order for a comprehensive screening program to be successful, a population-based information system was necessary. With such a system in place, the “follow-up and timely recall of women; quality assurance; monitoring, evaluation and research activities; tracking of program utilization; identification of unscreened and under-screened women and compliance with established protocols” could be assured.<sup>145</sup>

The fourth and fifth components of the OCSP focused on quality assurance and improvement and a commitment to constant evaluation and research by medical officials and health educators. The OCSP believed that by assuring quality and improvement across all laboratories in Ontario, an organized screening program would flourish. In addition to the request for a Laboratory Proficiency Testing Program (LPTP),

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<sup>144</sup> Ibid., 2.

<sup>145</sup> Ibid.

“monitoring and evaluating the OCSP will serve a number of functions, such as, to inform policy decisions; to assess program effectiveness and efficiencies; and to continuously review quality and standards of service delivery and to support revision of standards, if necessary.”<sup>146</sup>

The Ontario Cervical Screening Collaborative Group (OCSCG) serves as an advisory committee to the CCO and any other organizations that are represented in its membership. Both public and private sector organizations fund the OCSCG. These organizations include “health professional associations, consumer representatives, researchers, CCS, and the Ontario Ministry of Health.” In addition to private interest groups, the Ministry of Health has provided \$700,000 in annual funding to CCO since April, 1997. It was estimated that approximately \$3 million in annual funding would be necessary to fully support this initiative and to ensure that all key components were operational by April, 2002.<sup>147</sup> The main goal of the OCSGG was to reduce the incidence and mortality rates from cervical cancer by 50 percent by the year 2005.<sup>148</sup>

As of 2000, the OCSP had experienced both successes and setbacks. A key success was demonstrated through analysis of OHIP data that an organized approach to screening was more successful at decreasing the number of diagnosed cervical cancer cases each year. Even at its genesis, while recognizing the benefits and successes of their new program, the OCSP realized its limitations and set goals for future direction. For example, recruitment of women to be screened was still on a much lower scale than the

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<sup>146</sup> Ibid., 3.

<sup>147</sup> Ibid., 5.

<sup>148</sup> Ibid.

program would have liked to have seen. In order to break access barriers to the general population and target specific at-risk populations the OCSP needed to identify and resolve such barriers. As the report states, “effective promotion of cervical screening requires a broad-based general population approach, augmented by a community development process and specific messages targeted to risk groups.”<sup>149</sup> Even with the OCSP’s increase in public service announcements, better distribution of posters and brochures, packages for public health units, a resource catalogue, and a more comprehensive website, the OCSP still did not have an increase in numbers of women being screened.<sup>150</sup> Other challenges that the OCSP faced were the inability to develop a comprehensive information system/registry that was stable and cost-effective. Currently, “technical, systemic, and legislative barriers continue to impede data collection, follow-up and recall.”<sup>151</sup> These barriers are what maintain the black cloud over the potential success of this type of preventive health program. Ontario clearly needs to keep addressing these issues, especially in the face of the new HPV vaccination debate of the 21<sup>st</sup> century.

## **Conclusion**

Region does matter when discussing cervical cancer program development in Canada. While health care is a provincial responsibility, not all women experience the same access to health care programs. Davies’, Davis’, and Friessen’s work have all shown that as historians of health, we are required to further challenge notions of region

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<sup>149</sup> “Ontario Cervical Screening Program: Program Report 1997-2000.” *Cancer Care Ontario*, 8.

<sup>150</sup> *Ibid.*

<sup>151</sup> *Ibid.*, 9.

by evaluating issues of diversity, identity, and spatial geography. Space and place matter when discussing cervical cancer screening programs. This chapter has shown that screening development was unique in British Columbia, Nova Scotia, and Ontario. While each province was aware of the problem rising cervical cancer rates were becoming, each provincial government responded differently.

British Columbia was innovative in their early attempts to create a central cytology database to further monitor and encourage cervical cancer screening. By the 1970s they also had a grassroots women's organization, the VWHC, pushing for a more comprehensive approach to cervical cancer screening and public distribution of cancer knowledge. While the Women's Health Movement began in the US, it had a powerful influence in Canada. Extensive feminist health literature and women communicating with other women about their health and health care needs became a powerful force throughout much of the 1970s and well into the 1980s.

Claiming to have one of Canada's earliest organized cervical cancer screening programs, Nova Scotia used the BC model to develop a program unique to their province. This sharing of medical knowledge was critical in Nova Scotia's development, and they recognized that without the BC model, they would have floundered. What is unique about the Nova Scotia story is that Women's Institutes played a pivotal role in not only distributing cancer information, but also in funding and maintaining local well-women clinics. These well-women clinics were vital to continuing to screen the population for cervical cancer, as they often offered a non-judgmental, "safe," place for women to seek out a Pap smear.



Ontario did not respond as quickly as BC or Nova Scotia. Even though Women's Institutes in Canada were birthed in Ontario, Women's Institutes in Ontario focused most of their work on infant and maternal health and continued to be an integral part of maintaining local histories. Early pressure from physicians in the 1960s made the Ontario government aware that something had to be done. There were snapshots of attempts in Ontario to sort out how to reach high-risk groups such as immigrant garment workers in Toronto in the mid-1980s and women living in Northwestern Ontario. Studies were done to evaluate what approach to screening might work in these specific areas, and often conclusions were hard-hitting. However, the reality in Ontario was that it was not until the year 2000 that the province launched an organized screening program, even though they were clearly not ignorant as to what was happening elsewhere. The Ontario story is unique as it is one that developed without women's health activists being part of its development, as was witnessed in B.C.

Even today, provincial governments still struggle to figure out how to screen under-screened populations of women all over Canada. How do we achieve a zero cervical cancer rate? Is it possible? Why do women still avoid being screened when it is clear that screening actually works in preventing cervical cancer? These questions are still being addressed today, both by medical professionals and by women's health activists.

## **Conclusion: Where are we now?**

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This thesis originally started under the assumption that Canadian doctors were/are simply not doing enough to educate Canadian women about cervical cancer and the importance of the Pap smear. After years of research, I realized that this assumption was incorrect. While I am sure there are doctors who probably need to talk to their female patients more about this type of cancer, historically Canadian doctors have done a considerable amount in terms of educating women about cervical cancer and pressuring their respective provinces to create more sustainable, organized, and monitored screening programs. In addition to Canadian doctors, there were many other groups, particularly women's health activists, who also contributed to educating Canadian women about cervical cancer. Women's Health Movement activists of the 1970s worked to make cervical cancer more public than ever before. Women's Institutes, particularly in Nova Scotia, and arguably more conservative and family-focused than the Women's Health Movement activists, were also doing their part to spread the word about cervical cancer. This thesis tracked more than the changing medical understandings of cervical cancer; it also tracked this disease's path through public awareness campaigns and provincial program development. It explored when, how and why Canadian doctors, women and other interested parties overcame reticence to discuss the private parts of women's bodies and engaged in a public dialogue about the causes of cervical cancer and the means for its prevention.

This dissertation argues that both Canadian medical professionals and Canadian women wanted to talk about cervical cancer in the twentieth century. Research revealed that various groups were invested in educating Canadian women about cervical cancer: medical professionals, medical educators, women's health activists, women's organizations, newspapers,

women's press, individual women and support groups, and the state (provincial and federal). More specifically, it was found that many of these groups worked collaboratively, but not without tension, to encourage women to get yearly Pap smears and wanted organized screening programs with proper data collection and recall systems. Making cervical cancer public in Canada during the 1950s through to the 1980s was the goal of both physicians and women's health activists. But, there was a level of fragility to this collaboration, as not all doctors worked together as a unified group, and neither did feminists. While their objectives were simple: to teach women about the importance of the Pap smear and general information about the prevention of cancer – their approaches were often different. Physicians wrote articles and weekly columns in a variety of newspapers across Canada maintaining their medical expertise and asserting that women should always consult their doctors. Films were doing the same, providing women with basic knowledge about the disease, all the while suggesting they consult their doctors on a regular basis for screening.

At the same time as physicians were ultimately distributing knowledge to women about their bodies, it was within the boundaries of them being the experts and women needing to consult them. Especially by the early 1970s with Medicare in place in Canada, doctors were trying to reassert their professionalism in various public arenas. This paternalistic approach was often reflected in government educational print material such as posters to encourage women to get a Pap smear. In the 1980s a series of anti-cancer posters were printed and distributed, most of them with a focus on quitting smoking. The following example from 1978, "They depend on you," was the only one I discovered which focused on cervical and breast cancer, most of the others in the series focused on anti-smoking messages.

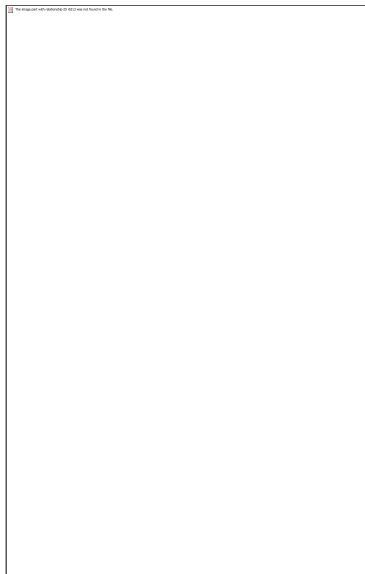


Figure 1 - Canadian Cancer Society Fonds. Library and Archives Canada. R9308-0-6-E, Box 05842 – 1978-029 60

The message is clear; women (especially mothers) have a responsibility to stay healthy for their families' sake, in addition to their own. In assigning responsibility, though, this poster – like the screening campaigns more generally – did not link women's cancers to sexual activity. Indeed, in pushing for equal access to screening for all Canadian women, health activists and their medical allies appeared to be no longer concerned with promiscuity, and its role in cervical cancer development. In advocating for annual Pap smears for all adult women, medical experts did not invoke particular policies for high risk groups. Policy makers and health activists thus defined cervical cancer as a risk all women faced and in the process shifted emphasis away from sexual behavior and history. In this context the Women's Health Movement appeared to be successful in delinking moral judgment of one's sexuality from health care provisions.

After first tracking the changing understandings of cervical cancer in the twentieth century, this dissertation first revealed that Canadian medical professionals actively participated in studying the epidemiology of cancer, but also how to prevent it. Debates about the role the Pap smear could/would play in the cervical cancer prevention were evident not just in the *CMAJ*, but also in newspapers such as the *Globe and Mail* and the *Toronto Star*. Canadian doctors

seemed to argue for simplicity in terms of a screening program for cervical cancer. This reflected a real concern for autonomy, particularly during the 1960s when there was threat of external control via a Canadian health insurance program. Some physicians argued that questionable statistics and classification and private payment were reason enough to rely on family physicians to do the screening. However, screening on an *ad hoc* basis was not proving effective, particularly in terms of reliable data collection, recall systems, and a maintained and quality-controlled lab system to read the smears. Doctors were also concerned with the question of how to educate Canadian women about this disease. Canadian doctors were often openly supportive of posters, pamphlets, films, and print articles that focussed on what cervical cancer was and how it could be prevented.

Using the *CMAJ*, various cancer conferences, and formal reports (such as the Walton Report), it was clear that Canadian doctors were talking about cervical cancer and its prevention in professional arenas. They also discussed how to better screen Canadian women. Was it more important to focus on public education? Were organized, provincially-funded, screening programs the answer? Open discussions attempting to find a solution to both of these questions were heated and demonstrated that Canadian physicians felt strongly about how to manage the cervical health of their female patients.

*Chatelaine*, a known feminist Canadian periodical, was one place that Canadian doctors could distribute information about cervical cancer. Throughout much of the 1950s through to the 1980s, most of the articles written about cervical cancer were not only informing the reader about the disease, but also recommending they seek further information from their family doctors. The approach to information changed slightly in the 1980s and into the 1990s. In these decades, directly a result of the Women's Health Movement of the decade before, physicians

were now writing about the information that women needed to know to become an integral part of the management of their own health. For example, women were starting to be told how to avoid cervical cancer, and how to take part in regular preventive screening programs. These doctors wrote without using any language of blame, as the feminist editors at the time would most likely not publish their articles otherwise. While the voice of the cervical cancer patient was not present, physicians were finally either responding to the demands of the Women's Health Movement, or simply willing to collaborate and cooperate with women's health activists in their quest to educate women about their bodies.

It was not just Canadian doctors who were responsible for educating women about this disease; women themselves took ownership of this knowledge, and worked to educate other women about this disease through various avenues. Women's health activists during the 1970s used a very different model for promotion of awareness. Some women's health activists were looking to replace the physician completely, allowing women to maintain their own health and well-being. One particularly active women's health group in Canada during the twentieth century was the Vancouver Women's Health Collective. Although much of their agenda was to provide health information to women, they also provided actual services, such as professionally staffed clinics. The Collective successfully provided women with a cost-free health clinic, one that was free of any moral judgement. Cervical cancer was very much on their radar throughout the 1970s and 1980s as they even arranged various self-examination workshops and the distributed information-based pamphlets in a variety of languages. The Collective was aware that there was not only a need for services, but that there was also a real need to *talk* about this disease in a public forum. It was vital to inform women that it was within their power to prevent this disease.

Beyond print, films were also used as a powerful means to educate women about cervical cancer. While earlier films by the Canadian Cancer Society and some produced by the NFB were more focussed on the nation's *war* against cancer in general, by the 1970s films profiling specific cancers started to appear. Particularly notable was Cheryl Wright's film, *Women and Cancer*, that details cervical cancer, often quite graphically, and the Pap smear. Her goal was to erase the fears of cervical cancer and the Pap smear. This dissertation also took the evaluation of public discussions of cervical cancer in Canada one step further – to the development of organized and provincially-funded screening programs. Three case studies/provinces were researched, British Columbia, Ontario, and Nova Scotia. Initially, these three provinces were chosen because of their regional location, hoping to provide an efficient way of capturing the Canadian approach to preventing this cancer. However, as Canadians know all too well, healthcare services are provincially defined and allocated, and these three provinces' screening programs developed very differently from each other.

In the late 1940s, in British Columbia, one of Canada's earliest central databases was created. This has often been referred to as a "program", however, the database's primary function was to collect cervical cancer morbidity and mortality rates. Regardless, this central database set the foundation for more complex approaches to cervical cancer screening programs across the country. Primary care physicians were in charge of actually screening the province's women, and the central database managed the results and, eventually, the recall protocols. But this system was not considered perfect, particularly by one feminist health group in the 1970s who were convinced that the system that was in place was simply not enough to successfully prevent British Columbian women from developing this disease. Its primary job was to collect and manage data, not necessarily prevent disease.

Nova Scotia, alongside British Columbia, claims to be one of the earliest provinces in Canada to have an organized cervical cancer screening program. Albeit differently established than British Columbia, screening in Nova Scotia surely can be deemed successful in providing women in their province with screening options. A very intricate well-women clinic system and an early central database have contributed to screening successes in this province. Early pilot projects in the 1960s helped Nova Scotia public health officials design a screening program that was efficient and reached most parts of the province. These early programs encouraged doctors and nurses to take part in community informational meetings, utilized various TV, radio, and newspapers, and attempted to reach high-risk women – all contributing factors to its success. By the 1990s, Nova Scotia was one of the top provinces in the country with high rates of women being regularly screened for cervical cancer.

Also contributing to successful, organized screening programs in Nova Scotia, were provincial public health nurses and local Women's Institutes. These two groups, consisting primarily of women, developed an important role in public education about cervical cancer, and helped to fund local screening clinics. After reading reports and meeting minutes from various branches of Women's Institutes, my research revealed that many well-women clinics would not have existed without the support of these women. Bake sales, toy drives, and personal donations helped to maintain clinic supplies and staff, in addition to promotional material that was made available. While they probably did not identify themselves as health activists, their agendas were similar; they wanted more of a focus on women's health.

The late twentieth century, and into the early years of the twenty-first century saw an explosion of women's centres in Nova Scotia. Some of the notable women's centres were located on the campuses of Dalhousie and Acadia Universities; however some were located in



local community centres. These were rich places for women to access information about cervical cancer and the various screening options located in the area. Small libraries, counselling, and other resources were made available, at no charge, to women in the province interested in managing their health care needs.

Ontario's cervical cancer screening program history, however, is not as glamorous as British Columbia and Nova Scotia's. Evidence revealed that Ontario did not have a key Women's Health group working to educate the public about cervical cancer, and most Women's Institutes in this province focused on infant and maternal health for much of the twentieth century. Even without the feminist health activist push we saw in B.C., there was some evidence that doctors in the 1960s in Ontario were attempting to organize a more comprehensive and provincially-funded screening program for this disease, but no evidence shows that such a proposal amounted to much. There was, however, some glimmer of hope in the 1980s.

In the 1980s the federal Department of Health and Welfare funded a project that sent a screening van to various working-class, immigrant communities in Toronto. In 1986, within two years of its establishment, the story of the mobile unit hit the newspapers. While it was clear that this van was successfully screening women for cervical cancer who would not normally be screened, or visit a physician on regular basis, funding was not made available, either by the federal government or the City of Toronto. The successes of the mobile unit can be measured beyond actually screening women for cervical cancer. It was demonstrated that 82% of women felt they were more confident to ask their doctors questions about their health – this is clearly an important result of this van.<sup>630</sup>

Only a few short years after the mobile unit project in Toronto, a medical doctor and researcher, Dr. Jaro Kotalik was attempting to understand high rates of cervical cancer in

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<sup>630</sup> "Immigrant working women may lose mobile health unit." *The Globe and Mail*, April 18, 1986, A11.

Thunder Bay. Attempting to gauge the effectiveness of screening for this disease in Ontario's north, this project benefited from funding by the Ontario Cancer Treatment and Research Foundation and the Thunder Bay Regional Cancer Centre. What was found was that data collection was sporadic and incomplete and that the screening program in place was inadequate and did not show any improvement over time. Calling screening at this time a "program" was troublesome, as it was not until the later 1990s in Ontario that funding was provided for adequate program details such as data collection, recall systems, and regulatory systems to manage Pap results. After several years of planning in the late 1990s, finally, in June 2000 Cancer Care Ontario launched a province-wide cervical screening program.

This dissertation fits nicely into three key sets of literature: gender history, history of medicine, and disease history. Upon first glance, this work seems to fit the most within gender history because of several concerns. The Women's Health Movement and its role in bringing more of a focus on women's health needs; the ways in which cervical cancer and its prevention require close consideration of needs particular to women; and the close association between sexual activity, socially constructed gender norms and cancer are gendered aspects of this work. This fits with Mitchinson's broader discussions of relationships between women, their health and their male doctors in the twentieth century, albeit that this dissertation shows more collaboration between women, women's health activists, and the medical profession than Mitchinson found in her work focused on the early twentieth century period.

My work also holds a place in both the history of medicine and disease history. Cervical cancer, as a disease, and changing medical understandings of the disease mark key points in the development of biomedicine, particularly in the post-World War II period. This study also highlights a change in public health initiatives as previous community concerns such as clean

water, quarantine, and vaccines were superceded by a more individual approach to public health and screening that most often diagnosed a disease rather than preventing it.

It has to be recognized that while more Canadian doctors and women were talking about cervical cancer, and some screening programs were in place, it is not safe to assume that all women in Canada were being screened. Not all women were treated equally within the Canadian health care system, it was not realistic to think all women actually received the printed information about the disease, and assumptions of promiscuity remained consistent within the medical language of risk. Even in the twenty-first century, with current understandings of the role HPV plays in cervical cancer development, assumptions of heterosexual promiscuity still percolate through public and professional discussions. For example, research has shown that lesbians (even those with a history of heterosexual intercourse) are less likely than heterosexual women to undergo regular screening for cervical cancer. Often health care professionals assume that if a woman is partnered with another woman, they are less likely to require birth control or prenatal care, and fail to recommend regular screening.<sup>631</sup> With cervical cancer being labelled as the second most common cancer in women, both heterosexual and homosexual, worldwide, and with HPV being implicated in 99% of these cancers, it is clear we need to keep talking about how to prevent this disease.<sup>632</sup>

Debates about Gardasil and Cervarix, vaccines to prevent HPV, are currently heated in medical and public arenas. Even though these vaccines are made available via public funding, and are even provided within some Canadian schools, there are still concerns about how vaccination may affect sexual behaviour. Most of the concern is via religious institutes, such as

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<sup>631</sup> Elizabeth Rankow. "Breast and Cervical Cancer among Lesbians." *Women's Health Institute* vol. 5/3 (1995): 125

<sup>632</sup> Nili Kaplan-Myrth and Janet Dollin. "Cervical cancer awareness and HPV prevention in Canada." *Canadian Family Physician* vol. 53 (April 2007): 693.

the Canadian Catholic Bioethics Institute at the University of Toronto. They argue that a vaccine for a sexually transmitted disease “gives the clear message that we think sexual activity is ok at any age and they will be protected.”<sup>633</sup> However, most recently, the Calgary Catholic School district is the first Catholic board to reconsider its ban on students receiving the HPV vaccine. As a result of recent medical studies, the board has considered offering Grade 5 girls the vaccine, after consultation with their parents. Several other publically-funded Catholic boards in Canada have banned the vaccine.<sup>634</sup>

It was estimated that in 2011, there would be 1300 new deaths as a result of cervical cancer in Canada.<sup>635</sup> This estimate was raised to 1350 new deaths in 2012.<sup>636</sup> It was also estimated in 2008 that more than 85% of all deaths from cervical cancer occur in developing countries. For example, India accounts for 27% of total worldwide cervical cancer deaths. These high numbers of deaths are a result of disproportionately large populations who are medically underserved and a simple lack of screening.<sup>637</sup> Women still feel that Pap screening is considered low priority by our health care system and that there is a real lack of public discussion of this disease.<sup>638</sup> Despite the fact that this dissertation has demonstrated that Canadian women wanted to talk about cervical cancer, and Canadian doctors were interested in taking part in this growing public dialogue in the 20<sup>th</sup> century, women *still* need to learn more about the prevention of this disease.

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<sup>633</sup> Pauline Comeau. “Debate begins over public funding for HPV vaccine.” *CMAJ* vol. 176/7 (2007): 914.

<sup>634</sup> “Calgary Catholic Schools review policy against HPV vaccinations.” [www.ctvnews.ca](http://www.ctvnews.ca) October, 26, 2012. (accessed October 30<sup>th</sup>, 2012).

<sup>635</sup> *Canadian Cancer Statistics: 2011*. (Toronto: Canadian Cancer Society, Statistics Canada, 2011), 16.

<sup>636</sup> *Canadian Cancer Statistics: 2012*. (Toronto: Canadian Cancer Society, Statistics Canada, 2012), 8.

<sup>637</sup> Ahmedin Jemal, et al. “Global Cancer Statistics.” *CA: Cancer Journal for Clinicians* vol. 61 (2011): 11-12.

<sup>638</sup> Linda Van Til, et al. “Understanding the Barriers to Cervical Cancer Screening Among Older Women.” *Qualitative Health Research* vol. 13/8 (2003): 1128

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