MONSTROUS BRAINS AND PUNY BODIES: THE STRUGGLE FOR FEMALE PHYSICIANS IN CANADA 1800-1950

by

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Abstract

The end result of medical education for women as said by a male medical professor in 1873 was 'monstrous brains and puny bodies.' It is obvious from this quote that the path for a woman to become a doctor was not easy and it can be said that every 19th century female doctor in Canada was a pioneer for the future of Canadian medicine. The prevailing view of women at this time was that women were the Almighty's special creations and were susceptible to a multitude of emotional and nervous disorders. The perseverance of a few dedicated women in the mid-19th century paved the way for females to be able to be educated and practice medicine in Canada. As a woman, there were many struggles and obstacles to be faced in becoming a medical doctor.

Pioneering Canadian women in the field of medicine include the first female physician in Canada, Dr. James Miranda Stuart Barry; the founders of the first medical colleges for women, Dr. Emily Stowe and Dr. Jennie Trout; and Dr. Maude Abbott, a leader in the field of research on congenital heart disease. Obstacles that these women faced included being allowed to enter into medical school and practice in Canada, social stigma from male counterparts and the general public and the way the profession was run itself posed challenges. In overcoming these struggles, these and many other women made great contributions and strides in medicine and in the feminist movement itself in Canada.

The end result of medical education for women as said by a male medical professor in 1873 was 'monstrous brains and puny bodies' (Wynn, 2000). It is obvious from this quote that the path to becoming a doctor for women was not easy and it can be said that every 19th century female doctor was a pioneer. The prevailing view of women during the 1800s was that women were the Almighty's special creations and were susceptible to a multitude of emotional and nervous disorders (Abram 1985). The resistance for women to pursue medicine is based on the male antagonist notion of sentiment and practicality. This is the notion of an idealized womanhood – that medicine was not for women because the world itself was not for them and that only

males were capable of combating its stresses. The perseverance of a few dedicated women in the mid-19th century paved the way for females to be able to be educated and practice medicine in Canada. As a woman, there were many struggles and obstacles to be faced in becoming a medical doctor. These obstacles included being allowed entry to medical school, opposition from male colleagues, their families, society and the profession itself. However, in overcoming these struggles, many women made great contributions and strides in medicine and in the feminist movement itself.

In the 19th century, a women's role in medicine was that of a patient. The prevailing view was that women were unsuited to the profession and thus were not allowed to enter medical school. It was still unusual at this time for women to go into any branch of higher education and, even after women were allowed to enroll in universities, it did not mean they were allowed to enroll in professional faculties on the same basis as males (Waugh 1992). The medical profession, however, proved more susceptible to a feminist argument because of the long history of women healers, midwives and nurses and the important notion of female guardianship in the medical and moral needs of women and children (Abram 1985). The drive to claim a place in medicine in Canada began with the efforts of several women. By the 1850s, Canadian women began to demand the opportunity to be admitted to medical school but it wasn't until 1883 that women were allowed to do so (Kelen 2000). Surprisingly, there had previously been a female physician in Canada, Dr. James Miranda Stuart Barry, who practiced medicine disguised as a man in Canada in 1812. It wasn't until her death forty-six years later that it was revealed she was a woman and had disguised her identity (Waugh 1992).

Prior to the acceptance of women into medicine there were female doctors practicing in Canada. In the 1870s, Dr. Emily Stowe was practicing in Toronto along with her contemporary, Dr. Jennie Trout (Hacker 1974). This was because women could complete their medical education in the United States and return to practice in Canada. Stowe was forced to enter the New York Medical College for Women in the U.S. after being denied entry into any Canadian medical school (Mount Allison University). In 1867, Stowe set up a medical practice where she found many patients willing to be treated by a woman; however, she was refused a license from the College of Physicians and Surgeons of Ontario. It took more than ten years to be granted an Ontario medical license in 1880 (Mount Allison University). Stowe broke down many boundaries inside and out of the medical profession. She helped found the Toronto Women's Literary Guild, Canada's first suffragette group aimed at fighting for women's rights. She put immense pressure on the University of Toronto to allow acceptance of women into the faculty of medicine. As a result, her daughter, Augusta Stowe-Gullen, was the first woman to graduate from a Canadian medical school in 1883 (Library and Archives Canada).

Jennie Trout, a physician practicing in Canada at the same time as Emily Stowe, is credited as the first woman physician licensed to practice in Canada. This was due to

the fact that Dr. Stowe practiced illegally using her American medical degree while Jennie took the examinations of the Ontario College of Physicians and Surgeons. Dr. Trout was also the catalyst in the founding of Kingston Women's Medical College in 1883 (Hacker 1974). Dr. Trout wanted not only a place for women to receive medical education but also a 'liberal' one, meaning that women would be on the staff and the board of governors. In fact, she herself was appointed as one of the trustees of the college (Hacker 1974). Emily Stowe also sponsored a women's college and was behind the making of Toronto's Medical College for Women. Both of the schools amalgamated as the Ontario Medical College for Women in Toronto in 1894 (Hacker 1974). The women's colleges were important in that they offered women advantages difficult to find elsewhere and were an encouraging environment outside the male-dominated programs.

Although women were now allowed entry into medical school, the hardships women endured were no less difficult. Emily Stowe's daughter, Augusta Stowe, the first female to graduate from medical school in Canada, endured many struggles while enrolled in the Toronto School of Medicine in 1879 (Library and Archives Canada). Despite this, Dr. Augusta Stowe-Gullen went on to hold the first faculty position in Canadian medicine and became a founding member of Women's College Hospital in Toronto (Hacker 1974). She also continued her mother's fight for women's rights. She became an active member of the Ontario College of Physicians and Surgeons, the University Women's Club and the Toronto Board of Education. She was also one of the founders of the National Council of Women and went on to be awarded the Order of the British Empire (Mount Allison University).

Once women began entering medical school, they were still surrounded with social obstacles. Most importantly, women had to persuade their families and the public that it wasn't un-womanly to be a physician. Women at this time were idealized as being fragile creatures and that the vigorous study of medicine would cause their inevitable collapse. If women were to practice medicine, it was at the cost of their sensibility and modesty. They would have to become masculinized and repulsive to be successful (Shortt 1981). In an era where most doctors were general practitioners and were responsible for the entire range of medical practice including surgery, it was considered outside the realm of womanhood to be able to engage in aspects included in the medical profession such as dissection (Gabriel 2001). Another social obstacle was a financial one that was different from the financial challenges that may have been faced by their male counterparts. Many women battled familial hostility towards their medical career and therefore the family would not support their education financially. As a result women usually entered medical school after working as a teacher or a nurse and continued to work during school to support their education (Wells 2001).

Women also were not accepted by their fellow students or the faculty and faced academic obstacles even upon entering medical school. The male students and lecturers went out of their way to shock the women and many of the professors were

reluctant to support the education and career of these women (Hacker 1974). If subjects being taught were thought to be too awkward, such as the case with obstetrics, the women were required to sit in a separate room. This was said to prevent the embarrassment of men (Hacker 1974). The daily class life for these first few women was rough and ruthless; the men tormented the women verbally, suggesting that the women could not handle the work (Vandervoort 1992). It also was not until many years later that medical schools such as McGill, Laval and Montreal would open their doors to women. Even though the women did not face overt discrimination in the school's regulations, they were hardly given any positive reinforcement. Nowhere in Canada's education system were women encouraged to consider high status profession endeavours, especially scientific (Kealey, 1979). It was only due to the ambition and struggle of these first female medical pioneers that the professional medical role for women established itself.

The medical profession itself also posed challenges to women. In the late 1800s, the practice of medicine underwent a period of professionalization. Qualifications required to study and practice medicine were increased and restrictions were placed on accreditation. Curriculum standards at medical schools were also increased. This evidently weeded out female candidates who often received less rigorous and less scientific training at every educational level (Shortt 1981). The profession also continued to change as physicians were beginning to specialize. Women began to face increased difficulty in gaining residency positions as the development of hospitals began at the beginning of the 20th century (Gabriel 2001). Internships and residencies in Canadian hospitals commonly denied qualified women and male physicians were reluctant to consult with female colleagues (Shortt 1981).

Once outside the walls of all-female colleges though, women found it difficult in a work environment dominated by males. They were faced with discrimination throughout Canada and many traveled outside to the United States and Europe to work. As well, many female graduates went into missionary work, traveling to India and China. Missionary work was considered an unparalleled and important opportunity for women physicians (Kealey 1979). This is somewhat ironic in that Protestants were unwilling to accept female preachers but would allow female teachers, nurses and doctors in the mission field. Other options for women doctors were to the service of other women and children. This was also seen as another shortcoming of their male colleagues that was filled by female doctors.

The many obstacles and challenges women faced did not mean that many did not achieve success as physicians. In the late 1800s and early 1900s, leadership roles in medicine were beginning to be occupied by women. In the late 19th century, for example, Dr. Marjorie Ward became superintendent of the Montreal Foundling and Sick Baby Hospital. As well, in 1919, Dr. Helen MacMurchy became chief of the Federal Division of Child Welfare (Shortt 1981). These higher positions reflected the trend for women to become involved with children due to what society deemed as appropriate for 'doctors in skirts.' This trend also reflected the growing demand for a

more humanistic approach to medical care. As well, some women physicians championed taboo subjects during this period such as birth control. In the early 20th century it was illegal to prescribe birth control, and the discussion of birth control was relatively non-existent; the thought was that easy access to birth control would result in sexual promiscuity and would debase marriage. Doctors such as Rowena Douglas and Elizabeth Bagshaw thought otherwise and, in 1930, Canada's first Planned Parenthood Association was formed (Shortt 1981). Female physicians also joined other women in efforts to rectify social conditions and to advance feminist causes. They joined groups such as the YWCA and local councils of women and were important in keeping women up to date in society regarding technical and scientific advice (Shortt 1981). These activities can directly be attributed to the 19th century women's medical and feminism movement – as women were seen as more capable of empathy and soothing then their male counterparts (Abram 1985).

Still, as headway was continuing to be made in the late 1800s and early 1900s there was a decline in female physicians between 1911 and 1921. In 1921, there were approximately 8,000 doctors in Canada and 98.3% of them were male (Vandervoort 1992). This was partially attributed to the closure of the Ontario Medical College for Women and a new wave of emphasis in Canada on family life and full-time mothering. The closing of the Ontario Medical College for Women in 1906 deprived women of an important stronghold of encouragement. This went hand in hand with the new wave of popular psychology, influenced by Freud, which emphasized sexuality and female irrationality. The loss of female medical graduates was also owing to the conservatism of Canada's medical profession (Shortt 1981). This loss of female physicians is contrary to Abraham Flexner's influential report on medical education in the United States and Canada in 1910 that stated that 'women's choice is free and varied' (Kealey 1979). Attitudes against women physicians is reflected in a description of medical training in the 1950s by Dr. May Cohen at the University of Toronto who stated, "we accepted without protest, sexist remarks, and our apparent invisibility when references to the class were directed only at males" (Dodd 1994).

At the turn of the 20th century scientific medicine was hardly what it is today and was only starting to play a part in education and research. A critical influence of the scientific aspect of medicine was Dr. Maude Abbott who was appointed curator of the pathology department's museum at McGill University. Here she developed a successful system of classification and cataloguing of pathological specimens and established the museum as an important teaching tool. She started unofficially offering courses of instruction, which grew in popularity until her course of demonstrations became a compulsory part of the medical curriculum, although with no remuneration until several years later (Waugh 1992). Dr. William Osler recognized her enthusiasm and determination for the museum and its specimens. He encouraged her to submit her findings for publication in the *Journal of the American Medical Association.* This launched Dr. Abbott into a worldwide audience and she went on to publish over 100 scientific articles on cardiology and the history of medicine (Waugh 1992).

Congenital heart disease was a compelling interest for Maude and her magnum opus was publishing *The Atlas of Congenital Heart Disease* which was a classification of cardiac disease based on a thousand different cases catalogued mostly by her (Waugh 1992). This work led to advances in heart disease, including diagnosis and risk factors. Her work predicted surgical interventions that the medical profession uses to this day and led to advances in cardiology including diagnosis, risk factors, the role of inheritance, the effect of diabetes and the effect of alcohol and drugs (Kelen 2000). She went on to found the Canadian Federation of Medical Women in 1924, which supported women in medical careers (Kelen 2000). Her success in the male-dominated world of medicine was based purely on her abilities, and she made a significant contribution to the world's knowledge of heart disease in the first half of the 20th century. She also paved the way for the American physician, Dr. Helen Taussig, who is considered the founder of pediatric cardiology (National Library of Medicine).

The resistance that women faced in the 19th and into the 20th centuries while pursuing medicine still continues today. Opposition towards women continues with the same attitudes as the 19th century, that women lack the physical and mental capabilities and are unsuited to a physician's life. This is especially true concerning pregnancy where it is still a risk that is considered when hiring a female resident (Wynn 2000). Women physicians continue to lag in income compared to their male colleagues and are still underrepresented in research and leadership positions. Still today women must work hard at balancing the many demands of their composite role as both a woman and a physician (More 1999). There is a marked different in the female-to-male ratio in specialties such as surgery and internal medicine. There are also fewer females selected for academic leadership positions. For example, the first female dean of a medical school in Canada appointed in 1999, Dr. Noni MacDonald of Dalhousie University, wasn't until 170 years after the first medical school opened (Cohen 1997). This is attributed to a plethora of complex factors, such as cultural stereotyping, sexism, a lack of mentors and especially family responsibilities and reflects the inflexibility of a medical system that was created many decades ago. The Canadian medical system is still lagging compared to other countries such as the United States in developing guidelines on maternity leave, childcare, sexual harassment and gender-neutral language (Cohen 1997).

Ever since women entered medical school, some have claimed that, as physicians, women differ in fundamental ways from their male counterparts in their approach to medicine. For the reason that women are described in a maternalist ideology, as more caring and humanistic than males, they are more aware of the social and psychological needs of their patients. It is, however, unwise to assume these suggestions and to accept them is to reflect the traditional stereotypes women physician pioneers struggled to overcome (Dodd 1994). Women today, like their predecessors, must still work hard at balancing the many demands of their dual role as a woman and a physician.

However, as we enter the 21st century, it can be said that women have made incredible advances in the medical profession. The establishment of a professional medical role for women was dependent on the vitality of Canadian feminism which can still be found today as women now comprise nearly half of all incoming medical students and will represent a third of all practicing physicians by the year 2010 (Wynn 2000).

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