Feminism and Canadian History

The Impact of Feminism on the Research and Writing of Medical History: A Personal View[1]

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ABSTRACT

Using my own research on the Canadian medical profession and its treatment of women in the first half of the twentieth century, I illustrate four ways in which feminist theory and action has influenced historical scholarship: first, the recognition of women as a socially constructed gender; second, concerns about the increasing medical intervention in women's bodies; third, the recent sensitivity with regards to women's agency; and fourth, the feminist critique of science itself. In turn, I argue that historical research can help nuance our view of the present and where we want to go in the future.

RÉSUMÉ

En me servant de ma propre recherche sur la profession médicale au Canada et sur la manière dont elle a traité les femmes dans la première moitié du vingtième siècle, j'illustre quatre façons par lesquelles la théorie et l'action féministe ont influencé l'érudité historique : premièrement la reconnaissance que les femmes sont un sexe qui est construit socialement, deuxièmement, les inquiétudes au sujet de la hausse des interventions médicales sur le corps des femmes; troisièmement, la sensibilité à l'égard de l'agence féminine; et quatrièmement, la critique de la science elle même. À partir de cela, je dénote que la recherche historique peut aider à nuancer notre vue du présent et où nous voulons nous diriger dans l'avenir.

Until the late 1960s, in Canada and elsewhere, medical history consisted of institutional studies, the narratives of "great" discoveries, and the biographies of individual practitioners written by physicians interested in the development of their profession (Shortt 1981; Mitchinson 1993a). The result was a carefully delineated but internal approach to the subject. With the emergence of social history, historians were attracted to the field. Social historians favoured an external view of medicine, situating the profession in the broader context of societal developments. They also introduced patients into medical history, analyzing the kind of care they received. Women patients, in particular, gained a significant amount of attention. Feminist historians, influenced by the contemporary women's movement, brought a heightened sensitivity to women as historical "subjects." Because of their work, our knowledge of the way that the medical profession has treated women patients in the past is considerable, indeed greater than our knowledge of the treatment of male patients (Roland 1984; Roland and Bernier 2000).

More significant than the quantitative leap in scholarship on women as patients has been the interpretive lens feminism has provided. Using my own research on the Canadian medical profession and its treatment of women in the first half of the twentieth century, I want to illustrate four aspects of this feminist focus: first, the concept of women as a socially constructed gender; second, concerns about the interventionist nature of medical treatment of women; third, the recent sensitivity to women's agency; and fourth, the feminist critique of science. From this analysis, it will become clear that if contemporary feminist concerns and theory can help illuminate the past, historical research can nuance the way in which we, as feminists, view the present.

As Simone de Beauvoir made clear over fifty years ago, western society has tended to view woman as "other" and historical research has confirmed how entrenched such an attitude was and how far back in the past it extended. As reflected in Canadian medical literature in the first half of this century, it is clear that physicians saw the female body as something foreign or exotic. And for most physicians it was. The vast majority of physicians, who were male, could not experience the normal

physiological processes of the female body. Physicians saw menstruation, childbirth, and menopause as extra "stresses" which women's bodies underwent. But they were extra only in comparison to men's bodies. The male body was the standard of comparison, the norm. Practitioners saw puberty as a time when the sexes became distinct, when girls took on the attributes of womanhood. The transition from girlhood to womanhood was viewed as full of danger. W. Blair Bell in *The Principles of Gynaecology* described how the changes during puberty "spread their shadow over the whole range" of a woman's life (Bell 1907, 68).[2] If puberty posed problems for women so too did the end of "womanhood" - menopause. Physicians linked menopause to disease and associated it with a change of life that signified loss - loss of reproduction, youth, femininity, and purpose. It is next to impossible to find a positive description of menopause in the medical literature even though physicians admitted that menopause posed few problems for the majority of women. While some women experienced difficulties, they did not all experience the same difficulties. However, the medical literature listed all the "potential" problems or various "symptoms" of pathology and, over time, the list became longer so that any medical student could only conclude that menopause was a major disruption of women's health despite medical disclaimers to the contrary.

While the feminist insight of women being "other" was an exciting one, more significant were the attempts to explain it. In this, the concept of social construction was crucial. In the late 1960s and early 1970s social historians had begun to examine the history of medicine. Unlike physicians studying their own profession, social historians of medicine did not privilege medicine. They argued that practitioners in the past were very much influenced by the mores and values of their own time period. Medicine was part of culture and as such constrained by the norms of culture. For feminist critics that was the point. The norms of our culture restrained, defined, and limited women and medicine could not help but do the same. Part of the focus on social construction was the feminist distinction between sex and gender. Sex was and is still often depicted as biologically immutable, a constant in an ever changing world. Gender, as feminists pointed out, was socially constructed. The separation of the two at a theoretical level was significant - in recognizing gender women became historical subjects.

Certainly the distinction between sex and gender enabled a more sophisticated analysis of the past. Again using puberty as an example, physicians did not necessarily describe the physical changes occurring in young women in a straightforward way. According to the author of one 1907 text, puberty was when a girl "takes on the lines and curves that distinguish the mature female from the male. The increased development of bust and hips and general fullness of contour add greatly to her attractiveness, and proclaim her readiness for motherhood" (Gilliam 1907, 62). The changes delineated were not neutral ones (linked to sex) but rather imbued with cultural meaning, specifically attractiveness, and thus linked to the construction of gender. The medical construction of gender is perhaps most apparent when physicians addressed issues beyond the physiological nature of the body. For example, the authors of several texts used in Canadian medical schools considered that marriage was "the manifest destiny of women" and "the normal state of living in modern society" (Eden and Lockyer 1917, 402; Stoddart 1919, 232). So central were children to a marriage that some doctors encouraged women whose health could not stand up to childbearing not to marry. The result of such attitudes was to see women's bodies as centred on their reproductive system. Dr. H.B. Atlee, head of Gynaecology at Dalhousie Medical College, pointed out in the November 1931 *Canadian Home Journal*: "A woman's physical upbringing from her earliest years must have childbearing as its aim and end....It means that woman must carve out a feminine way of life, a way that differs from the male as her destiny differs from his" (83). Women's bodies determined their social roles and defined who or what women were. In such descriptions the view of women as "other" is easy to see but the concept of social construction and awareness of it adds a layer of complexity. Such views on marriage were medical only to the degree that physicians held and expressed them and provided them with an aura of medical rationality. They were views physicians shared with the rest of society and more significantly the men and women who made up that society. The United Church of Canada maintained that no marriage "built on the refusal to bear

children [was] a complete marriage" (Dobson 5). Childless marriages were unhappy marriages. One of Canada's leading advocates for women's rights, Emily Murphy, told her women readers in *Chatelaine* that without children a marriage was no more than "an agreement between a flirt and a philanderer" (McLaren 1990, 82). Only by placing physicians in the broader context of the society in which they worked and lived can their attitudes be understood. Physicians reflected societal values through a medical lens and in doing so gave "scientific" legitimacy to them. With respect to Atlee's quotation, a biological potential - childbearing - became a biological imperative.

A more recent understanding of the way that society constructs women has been the feminist critique of "essentialism," the tendency of society to see women as undifferentiated. The modern women's movement has been particularly sensitive to this insight, given accusations that for too long it remained a white, middle-class, heterosexual movement unwilling to embrace the diversity of women and their needs. Perhaps no-one has been more concerned about the dangers of the concept of undifferentiated "woman" than Denise Riley who has argued that within feminist thought the concept of gender has been embraced to such an extent that an individual woman has become little else but gender and as a result her class and racial identities have been marginalized. In some respects, Riley's concern mirrors early attempts of modern feminism to dismiss the specificity of the female body. Shulamith Firestone in *The Dialectic of Sex* (1970) looked forward to the day when test tube babies would free women from the burden of reproduction. But rejecting the specificity of the term woman or the specificity of women's bodies has never been the only feminist alternative. Critics of Riley warn against women trying to separate themselves from the biological (Fox-Genovese 1991, 160). Recent feminist scholarship on the new reproductive technologies certainly does not embrace them but rather emphasizes, in addition to having some say in the direction of their continued development, the need for women to exert choice with respect to such technologies. Modern feminism has also extended our view of health beyond the concentration on reproduction to include issues such as women as medical research subjects, women and specific health concerns (cancer, osteoporosis, and heart disease), and the health problems of specific groups of women. To date, the historical literature has not reflected this broadening to any great extent.

Historians have written more books on the history of childbirth than any other aspect of women's health experience. The focus of historians is understandable. As Atlee's quote revealed, physicians believed women were identified by the reproductive aspect of their bodies. The normative model for a healthy woman was one who was young enough to be still menstruating and able to bear children. Physicians judged young women entering puberty by how well their bodies were approaching this ideal and older women by how much their bodies had deviated from it. Differences based on class, ethnicity, or ability were secondary. They did try to essentialize women, but they did so only to a point - too many women's bodies refused to fit the standard scenario which, after all, represented what many practitioners felt should be rather than what actually was. This is particularly evident in medical perceptions of sexuality. Physicians viewed men's sex drive as strong and relatively constant, only declining with age. If men were the norm and women their counterparts, the "other" side of the binary, then women's sexuality should be the obverse. But it was not. Physicians saw female sexuality as much more complex than men's and more varied. Dr. Marion Hilliard best epitomized the medical gaze:

> I...used to believe that if women had no fear of pregnancy they would enjoy a sex life to the same extent and in more or less the same way as men. I was wrong. A woman's reaction to sex has few points of resemblance with a man's. For one thing, her climax arises from one so slight that it is a sigh to one so profound and deep that it results in a agonizing cry. A man's emotion varies, but his physical climaxes are identical. Millions of women feel nothing, nothing at all; others are so moved that there is a small death within them and they weep. The same woman can experience a whole galaxy of climaxes, from the top to the bottom, depending on her mood. The male enjoyment of sex requires no mood except the basic desire. (1957, 64)

Hilliard believed that women were more complex beings than men. If at times she essentialized women, men, too, became one-dimensional, card-board figures. They were very much creatures whose libido was mechanistic. Indeed in using men's bodies as the norm physicians tended to essentialize them even more, a fact that feminists have not addressed to any great extent.

The point of being aware of how society essentializes women is to recognize women's diversity - not all women are the same. The recognition of class, ethnicity, sexual orientation and other forms of difference in the present has helped historians to nuance the view of the past. It is not always easy. With physicians' desire to generalize the female body (even while recognizing variations), they focused on the sex of the patient. But other identities were there and careful reading of sources reveal them. For example, not only did physicians use men as a normative model for comparative purposes, they used "primitive" women the same way. For them "primitive" women were represented by First Nations women, peasant women, or women working on the land. "Civilized" women were the urban, middle-class women who were their clientele. The former were healthy and did not need medical assistance, the latter were not and did. Physicians had little proof to substantiate their belief; rather it was conventional wisdom and "obvious." A typical reference appeared in *A Text-Book of Gynecology* edited by Charles A.L. Reed in 1901. "There is no doubt that between the women of aboriginal peoples and those who belong to the civilized races there are certain physical differences....The reproductive function can be taken as an index. Savage women, as a rule, have but little difficulty in childbed, because they have large pelves and bear children with small heads" (6). Several themes emerge from this quotation. There was a creation of a binary - the savage, aboriginal woman and the civilized, and, left unsaid, white woman. The former had little difficulty in birthing because there was little disproportion between her pelvis and the size of the child's head. Childbirth for her was a natural process. The civilized woman, on the other hand, was clearly in a different situation - a smaller pelvis and a larger child's head. The size of head was a way of saying that the brains of "civilized" children were larger than those of aboriginal children. Civilized woman was more than a reproductive machine; her very body had changed to become less efficient in that regard. As a result, childbirth for her had become a medical condition necessitating professionalized help. The physician was the rescuer and woman the rescued.

Feminism has always been more than theorizing about women. It has action and change as its end. Being aware of the artificially constructed nature of woman as "other" led to the women's health movement. Exposés on the side effects of the pill, the horrors of the Dalkon Shield, and the dangers of breast implants raised awareness that medicine literally seemed to be targeting women's bodies. Historians, in turn, have catalogued the myriad ways that physicians have prodded and explored women's bodies, the multiplicity of instruments and medicines they have inserted into the vagina, and the various parts of the reproductive system they have excised. They have detailed how pregnancy, labour, and childbirth have become monitored and supervised. At times, the intervention seemed more for the benefit of the practitioner than the patient. One physician I interviewed mentioned that when she practiced in the 1950s and 1960s physicians would induce labour in women near term just before fishing and hunting season to ensure that deliveries would not interfere with their "sporting" activities (Letter from Dr. B.R. 1993).

It is easy to catalogue the interventions of medicine in the past but less easy to understand why they occurred. Not all intervention was bad. Caesarian section, the high rates of which have been deservedly criticized in recent years, was literally a life-saver for many women and even more babies early in the century. Before it became relatively safe, doctors would resort to various dismembering operations on the foetus in cases when a woman could not give birth vaginally without endangering her life. In the October 1913 issue of the *Canadian Medical Association Journal* Dr. Frederick Fenton wrote of one patient whose C-section had enabled her to give birth to a live child rather than undergo a third embryotomy (838). Many women were more than willing to face C-section rather than the alternative. They were also behind the short spurt in popularity of twilight sleep in childbirth, the use of a scopolamine-morphine combination. The

morphine lessened the sensation of pain and induced a light sleep, the scopolamine produced amnesia. Yet, as a procedure, twilight sleep was very much hospital and doctor controlled.

The examples of C-section, twilight sleep and intervention in general raise the issue of women's agency. In early feminism the tendency was to see women as victims and, not surprisingly, feminist medical scholars wrote about women as victims of the medical establishment. Much sociological literature on the contemporary patient/doctor relationship has focused on the inequality of power between the two. But as feminist critics have pointed out, women were doubly disadvantaged in that not only were they patients, but also, as women, constrained by their inferior social status. Until very recently, women patients most often faced a male physician whose experience might make him more sympathetic to his male patients than his female. Hopes focussed on the increasing numbers of women entering the medical profession. Surely women doctors would treat women differently? But so few women physicians practised in the past, that expecting them to "buck" the system would be naive. If male practitioners were creations of societal values, so, too, were women practitioners who in the Canadian context trained alongside their male colleagues. The physician's gender was not always enough to dictate treatment. Marion Hilliard, who in the 1940s and 1950s was Canada's best-known female doctor and obstetrician and noted for her sensitivity to the needs of her patients, could still look at pregnancy as a time when women were "out of control." Concerned by the tendency of women to talk and give advice to one another, she warned them "Don't trust yourself or anyone else... Ask me instead. I'm taking over while you go through this. When the time comes, I'll give yourself back to you" (Hilliard 1957, 23-34; Hilliard 1960, 52).

Seeing women only as victims does not provide hope for change and feminism, even in its darkest hours, is optimistic that change is possible. The script of women as victims denies them roles in their own lives. Recent feminist thought has been focusing on the ways in which medicine must acknowledge and encourage patient agency among women (Sherwin 1998). As patients in the past, Canadian women did exert agency. They decided, based on their own embodied experience, if they would seek medical help and if so what kind (and they had many alternatives from which to choose - advice books, midwives, other women, wisdom passed down to them, alternative practitioners). Even patients of regular practitioners were not without agency. They decided how to tell the story of their illness, whether to comply, and how far with medical advice. If medicine failed them they did not necessarily accept that no hope existed (Mitchinson in Iacovetta and Mitchinson 1998). These examples do not refute the limits imposed on them by a medical profession which saw them in a particular way but do suggest that women's relationship with medicine and medical practitioners was more complex than first portrayed. And if women patients could exert agency does this mean that physicians experienced constraints? Analysts of medicine have acknowledged this but feminist critics have been less willing to see how such constraints might influence the treatment of women. Looking at physicians in the past has made it clear that the confident medical professional, convinced of the expertise science provided, was offset by the uncertain practitioner facing the complexities of day-to-day practice. The growing dominance of hospitals in the medical care system challenged the individual physician and although regular medicine controlled who could practice medicine, alternative forms of care and care-givers still existed. As well, the insufficient training many doctors felt they had received, competition from their own colleagues, and the very nature of medical practice meant that insecurity was part of being a medical practitioner (Mitchinson in Sherwin 1998).

The final contribution of feminist thought to historical research on medical treatment of women that I want to address is the recent focus on the nature of medicine and science itself. If in the early years the stimulus was to focus attention on women, it is now to push the feminist agenda further and to understand why and how the institutions that exist work the way they do. Using the "linguistic turn," feminists have delved into the language medicine uses and have questioned the scientific underpinnings of medicine and science by examining how they are constructed (Hubbard 1990, 12). Such work makes me more aware of the imprecise nature of the language doctors used in the past. For example, in addressing the issue of sterility, some physicians defined it as a situation

when an egg was never fertilized, but most did not, allowing them to include under sterility habitual spontaneous abortion, stillbirths, and other conditions that prevented a live birth. Some doctors referred to the inability to conceive as absolute sterility or primary sterility. Others referred to the inability to bring forth a living child as sterility, secondary sterility, or relative sterility. Still others referred to acquired sterility, a situation where a woman had given birth but was unable to conceive again. Acquired sterility, sometimes called one-child sterility, was also mentioned under the broader category of secondary sterility (Mitchinson 1993b). How scientific was a profession that could not agree on the definition of a term? How did this affect the treatment of women? At the very least the variety of definitions meant a variety of responses to whether a woman (and it was usually the woman who was the focus) was infertile.

While at times doctors' use of language was imprecise, in their use of measurements the aura of "scientific" precision was maintained. In the first half of the twentieth century, medicine increasingly depended on various tests and measurements as a way of determining what was happening in the patient's body. However, measurements necessitated a standard, the average, as a basis of comparison. The standard became the norm - how a body should behave. Measurements gave medicine the semblance of objectivity and relieved an individual physician of responsibility, since responsibility was shared with the rest of the profession which had determined what the measurements of normalcy were. The medical tests were dependable, the patient's experience was not. As a result, physicians focused on the body, not the person, and their job was to measure the body by a constructed standard of health. As childbirth became more medicalized in the first half of the twentieth century and as it increasingly occurred in hospitals, women bore the brunt of the consequences of this normalizing trend. Nowhere was this more obvious than in the induction of labour when the physician made the decision that nature was not proceeding as it should. Some inductions were clearly life saving, as when a woman was suffering from eclampsia and only a quick birth would end it. At times, however, the decision to intervene does not appear to be as necessary. For example, in the early decades of the century, physicians worried about a woman going beyond the expected term of her pregnancy. But how much beyond the expected term was too long? Given that there was little accuracy in knowing the date of conception, the estimates of term were just that, estimates. Nonetheless, some spoke out with authority. In the October issue of the 1909 *Canadian Practitioner and Review*, Adam H. Wright, Professor of Obstetrics at the University of Toronto, insisted that labour should be induced within three days "after the patient has reached term as a matter of routine in all cases" (634). He clearly believed that pregnancy had a definite term, that he knew how to calculate that term, and that each woman had to conform to it. It did not seem to matter that there was no immediate danger for either mother or child, nor that there was little obvious reason for a three day period of grace rather than one, two, four, or more. His attitude revealed a potential repercussion of standardizing the experience of pregnancy - intervention; it reflected physician belief in the "science" of medicine - that the term of pregnancy could be calculated precisely (even if that was not the case); and it indicated the, at times, arbitrary nature of where the line was drawn between pregnancies that necessitated intervention and those that did not.

The feminist contribution to research on the medical treatment of women in the past has been considerable. In looking at the Canadian situation between 1900 and 1950, the concept of woman as socially constructed "other" and her nature generalized or essentialized has been key to understanding how physicians viewed their female patients. The activist focus on medical intervention and, in particular, the issue of women's agency it raised, has broadened the scope of analysis. The recent feminist critique of science and medicine has also allowed a more complex view of how medicine worked in the past. At the same time, historical research reminds us that men's bodies too have been generalized. In being the normative side of the male/female binary, they perhaps were more essentialized. Physicians were not all powerful and we need to recognize the constraints on their agency while not ignoring the power they held. As feminists we have a vision of how we want medicine to work and physicians to practice. We want a system that is more caring and one that allows and encourages patient agency. We want

health care to go beyond "fixing" the body, to include preventative aspects which address social factors such as racism, violence, and poverty. As a historian I can trace the way in which medical practitioners have extended their sway in society, offering advice and treatment in areas that were not traditionally deemed their prerogative. Motivated by a desire to increase their status and prestige, they also met a need in society even if not trained to do so. The question for us today is who do we want to meet the expanded needs of health care we see as necessary? We must not equate health care with medical care. Medicine is what doctors practice and it certainly has its place. But instead of expanding the scope of medicine perhaps we need to address health issues through varying means, among which medicine is only one.

ENDNOTES

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2. This text and others referred to in the paper were used in Canadian medical faculties.

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