Caring and Curing

Dodd, Dianne, Gorham, Deborah

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Introduction
DIANNE DODD AND DEBORAH GORHAM

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

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

More recently historical focus has shifted to women’s agency in attempting to redefine the boundaries of medical practice by negotiating with physicians and public health authorities for medical improvements designed to ensure the health and safety of women and children. This collection contributes to and expands on this new approach by examining women as nurses, as patients, and as members of laywomen’s organizations. Medical professionalization with its attendant risks and benefits, and its frightening but liberating medical technology, knowledge, and methods, is seen here as neither a total defeat for women, nor an unqualified triumph. Although the ideology of medicine in the late nineteenth and early twentieth centuries stressed a gendered division of labour in which highly paid prestigious and autonomous male physicians “cured,” while poorly paid and subordinate female nurses “cared” for patients, women successfully built a professional niche for themselves in health care. This role was built upon an
older tradition that did not separate, or hierarchically order, curing and caring. Occasionally as pioneer women physicians, but more commonly as a professionalized model of the traditional nurse, women offered health services to other women and children.

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

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

Nurses as Health Care Professionals

Our emphasis on the history of nursing redresses an imbalance in the literature that has allowed a scholarly interest in the professionalization of medicine to obscure a similar trend occurring in nursing. This process clearly affected a much larger group of women health care workers. The three contributors who explore nursing history in this volume, Beverly Boutilier, Meryn Stuart, and Kathryn McPherson offer new perspectives on modernized, professionalized nursing and its contribution to health care in Canada. In Canada, as elsewhere, nursing moved out of the domestic to the public sphere in the nineteenth century. As yet another aspect of women's domestic work performed in the home in times of
illness and/or childbirth, nursing bestowed no particular stature, and
certainly no remuneration. Its domestic roots indeed haunted nursing
as it slowly evolved into a twentieth century profession attempting to
cloak itself in the authority of science. These three papers address, in
different ways, the complex and sometimes contradictory definitions of
the role of the nurse that emerged as nurses realigned and renegotiated
their relationship to a changing medical establishment.

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

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

It is clear from Stuart’s paper as well as several others in the
collection that in isolated areas public health nurses often did the work
of physicians, particularly in obstetrics. Admonished against suggesting
treatment or diagnosis, even against advancing opinions, these nurses
were consistently denied the recognition or autonomy they needed to effectively meet the demands of their work.

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

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

The work of Boutilier, Stuart and McPherson reveals that professionalization in nursing offered middle-class Canadian women a role in the public sphere with remuneration and some degree of publicly authorized skill and authority. However, while nurses' self-identity may have challenged mainstream medicine, nurses remained subordinate to physicians, in the hospital, as private duty nurses, and as public health
nurses. As well, their leaders' efforts to professionalize were thwarted by a gender ideology that stressed women's subordinate role in society.10

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

Mothers, Midwifery and Medicine

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

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

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

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

Such gains certainly accrued to the handful of women who became physicians. Although medical professionalization initially ensured the exclusion of women, who by custom and by law were denied entry into the universities that granted the degree necessary to practise medicine, it also inadvertently opened the doors by codifying the requirements for training. Women physicians such as MacMurchy drew upon an already established constituency and legitimacy as health workers, and gained a measure of professional recognition their domestic predecessors could not have achieved. The fact that contemporary male practitioners, forced to share their expertise and professional status, perceived women's entry into the profession not as a harmless continuation of an older traditional role, but as an intolerable incursion into male territory, is evidence in itself of the gains made by women physicians.
The career of Dr. Helen MacMurchy, the prominent Canadian public health authority, eugenicist, and educator illustrates that women physicians, like other women health care workers, often served as a bridge between the older tradition associated with the now degraded midwife, and modern professionalized health care roles. Dodd in her paper focusses on one specific venture in MacMurchy’s career as a public health physician: her plan to introduce a popular midwifery guide for women into isolated areas of Canada. Dodd’s textual analysis of the guide reveals MacMurchy’s deep ambivalence toward women’s traditional expertise when it came to birthing. On the one hand, MacMurchy was convinced that medical science would do more to save mothers and children from preventable deaths than traditional patterns. On the other hand, she recognized and even respected the skills that ordinary women could bring to this woman’s event. MacMurchy’s efforts to reduce maternal mortality in rural Canada encompassed a broader view of healing than most of her male colleagues would tolerate. Despite her middle-class reform and eugenist sympathies, and her commitment to medical professionalization, MacMurchy showed considerably more sympathy with midwifery than did the male physicians Connor describes.

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

The role of laywomen health reformers as the vital link between medical professionals and their patients, is an important but neglected aspect of the history of women and health care in Canada. This volume’s exploration of women’s advocacy of health reforms, and their promotion of the medicalization of child and maternal health highlights the origins of public health. Modern bureaucratic structures
aside, public health is merely a continuation of older folk traditions in which women played a prominent role. The emphasis on living a healthy lifestyle, religious commitment in the pre-1920s period, prevention of illness, and the focus on education within the family, make public health a modern version of women's visiting.

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

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

Receiving substantial backing—emotionally, financially and politically—from the women's movement, women professionals, particularly in public health, tried to represent the interests of middle-class women and indirectly the poor, geographically isolated women they served. They were not entirely successful. Physicians such as MacMurchy who became missionaries in underdeveloped countries, or public health workers, took the message of medicalization to the poor and isolated. They used their position as white upper middle-class professionals to overcome the disadvantages they suffered as women. Indeed their focus on professionalization denigrated traditional domestic and maternal skills, and displaced the “untrained” midwife and working-class hospital nurse. Indeed, the whole nursing movement was based on the replace-
ment of working-class "domestic drudges" with "gentlewomen" of middle-class origins. Public health nurses who were thought to require tact and diplomacy, were often of upper-class origins. Stuart's public health nurses clearly held class and ethnic loyalties that put them at a distance both from their women patients and from the rural doctors with whom they worked and whose education was not, they thought, of the highest quality.

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

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

In the Canadian context, any discussion of social medicine must take into account the factor of geographic isolation, a subtext that runs through several of the papers. It is especially important in light of the
midwifery and maternal mortality campaigns. As both Dodd's and Boutilier's papers show, middle-class women tried to provide Canadian outpost mothers with either nursing services, or alternative medical services such as midwives. Through their campaigns, which won them the active hostility of the medical profession, women reformers pointed out the stark contradictions in the public health message. The emerging medical system advocated increased medical consultations while narrowing the definition of an acceptable medical practitioner. However, in a country where the availability of recognized medical expertise was severely restricted by cost, distance and professional rivalry, inequities resulted.

Women Physicians

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

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

At the turn of the century women such as MacMurchy were relegated to the margins of medicine and confined to areas pertaining to women and children. Gorham suggests that even today sex segregation is a factor in the medical profession. Women gravitate toward family practice, pediatrics, and obstetrics and gynecology, while men continue to dominate such prestigious specialties as surgery and biomedical engineering. Women physicians still encounter role conflict in juggling
domestic and career demands. As well, Gorham points out, women physicians must struggle to balance conflicting norms for feminine behaviour on the one hand, and masculine professionalism on the other. In this regard, Gorham presents a perspective on the meaning of professionalism and its relationship to gender that differs in significant respects from that of other contributors to this volume, most notably McPherson and Stuart. In their work on nursing, they stress the efforts of nurses to feminize professionalization, whereas Gorham maintains that modern professionalization has been and continues to be so closely linked to modern conceptions of masculinity that it will take more than muted reforms to break those links and develop genuinely gender-free, egalitarian concepts of skill and achievement.

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

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

Conclusion

As health care consumers, as lay reformers and as health care workers, women have been ambivalent about the modernization of medicine throughout the period with which this volume is concerned. On the one
hand, they actively sought the improvements to health and safety that new medical science could bring to women and children. As well, middle-class women struggled to build a professional role for themselves as nurses, doctors and lay health reformers. Initially basing their claim to such work on an older tradition in which healing was part of women’s domestic role, they were forced to repudiate that tradition in favour of a professionalized model. Only by doing so could they achieve recognition within the modern health care system.

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

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

Endnotes


14. Such a modernized midwifery is now developing. See Gorham's paper in this collection.


23. See Denyse Baillargeon’s article in this collection.

24. Morantz points out the role health reformers had in making public the idea that health is a woman's responsibility. Walsh, on the other hand, links the emotional and financial support provided by the nineteenth century women's movement to the successful career of women physicians such as Marie Zakrzewska. See Regina Markell Morantz, "Making Woman Modern: Middle-Class Women and Health Reform in Nineteenth Century America," in Women and Health in America, ed. Leavitt, and Mary Roth Walsh, "Feminist Showplace," in Women and Health in America, ed. Leavitt.


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