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

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

One of the most significant achievements of the contributors to this volume is to emphasize that during the period that medical men transformed their occupation into the modern, scientific medical profession, a parallel process took place in nursing—the most important of the modern health care occupations dominated by women. Modern nursing in Canada, like modern medicine, aspired to professional status and to connecting both its training and its practice to science. But, as our contributors demonstrate, the professionalization of women’s work as healers did not take place without struggles with the medical profession. From the late nineteenth century, Canadian medical men proved willing to absorb women healers into the modern institutions they created, but only if the women would do so on the physicians’ terms. Thus, while as J. T. H. Connor correctly points out, they did not engage in any organized conspiracy, medical men nonetheless used their collective influence to banish the traditional midwife from Canada. And my reading of the contributions of Boutilier, Stuart, McPherson and Baillargeon to this volume is that modernized nursing was acceptable to physicians only if nurses remained their subordinates.
The nurses themselves, while asserting their claims to professional status, did so in a way that accommodated medicine's assumptions of primacy and accepted and even capitalized on gender difference. Thus, nursing underwent professionalization, but in a "womanly" way, and professionalization, while it raised the status of nurses, did not carry with it the same implications concerning power, authority or knowledge that were associated with the professionalization of medicine. If modern nursing became associated with curing as well as caring, as Katherine McPherson cogently argues, the medical profession nonetheless assumed that caring was subordinate to curing, and would be delegated wherever possible to the modern nurse. In sum, by the mid-twentieth century, the modernization of health care meant that caring like curing became professionalized, but the gendered nature of the distinction between caring and curing became if anything more sharply articulated than it was in earlier periods.

But what of the small minority of women who chose to become physicians? The woman physician does appear in the pages of this volume, but pioneers like Dr. Helen MacMurchy remained remarkably few in number. After their initial success in gaining the right to train, during the first three-quarters of this century, women as a group made little progress in establishing themselves as physicians in Canada and there was remarkably little visible pressure for change. During the middle years of the century, Canadian medicine was overwhelmingly dominated by white males from relatively affluent backgrounds. However, in recent years, this situation has changed radically, at least as far as gender is concerned, and in our own period we are witnessing a truly dramatic shift in the gender balance of medical students and young physicians. The statistics indicate that while the shift was not yet noticeable, it began in the middle of the 1960s. In 1959 "women accounted for 6% of Canadian medical school graduates, in 1981 for more than 38% and in 1989 for 44%." In the 1990s, the shift in gender balance has been decisive. There are annual fluctuations in the numbers of women admitted to medical schools in Canada and across North America, but we can safely assume that a drop back down to the 6% figure of the 1950s is not likely to occur. Moreover, while women by no means as yet dominate the profession—the fact that much of the increase has taken place so recently means both that most of Canada's women physicians are relatively young, and that men still comprise the majority of the profession—if present trends continue, in terms of numbers women will reach parity with men in a few decades. At the present time, women make up some 22% of the total number of practising physicians in Canada. Their number should reach 35% by the
turn of the century, and today in medical and non-medical circles observers are commenting with increasing frequency (and often with alarm) on the declining numbers of men entering the medical profession in Canada and in the United States.

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

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

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

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

By the middle decades of this century, young women medical students were not confronted with forms of hazing as outrageous as the University of Edinburgh sheep, but the biases against women, the existence of what feminists now call a "chilly climate" certainly still existed. The best that the few women who did participate in medical training could hope for was to be ignored. By this I mean that in the post-war period, the image conjured up by "medical student" within the profession itself and in the wider society, was of a young white male from a middle- or upper-class background. Those who did not fit this norm, whether they were members of minority ethnic or racial groups, or women, were accepted on sufferance, and expected to act as much as possible like the norm. Their difference was covertly assessed as a deficiency that it behooved them to hide if possible or at least to minimize.

Dr. May Cohen, recollecting her training at the University of Toronto's Faculty of Medicine in the early 1950s, says of her experience during those years: "At that time there was a 10% quota with respect to the number of women permitted to enter any class and those of us who succeeded in getting through that barrier could only feel extremely grateful for our good fortune. We were not about to make waves and so
accepted, without protest, sexist remarks, [and] our apparent invisibility when references to the class were directed only at males.”

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

While faculty and male fellow students could simply ignore the handful of women among them, for the women medical students themselves the conflict between the professional role that medical students are trained to adopt and the norms of femininity was as acute during the post-Second World War period as it was at any time during the history of the modernization of medicine. Historians of medicine and theorists of gender difference have analysed the stratified and masculine nature that medicine took on as it professionalized in the nineteenth and twentieth centuries. The extensive literature on professionalization and on the process through which neophytes become professionals indicates that elite professional status is closely identified with male gender, and membership in the dominant economic, racial and ethnic group. In contrast, the professional status attained by Canadian nurses, as documented by MacPherson, Stuart and Boutillier in this volume, while genuine and important, was a muted, feminine variety of professionalism, which underscored the nurses’ subordination as women and as workers, while at the same time affirming the benefits of their modernized training. Moreover, becoming a physician involves more than learning what there is to know about disease. Part of what the medical student learns is how to take on the role of physician. Michael Shapiro, who has written about his own experience of medical training at McGill beginning in 1969, has observed that young medical students, faced with the anxieties that accompany medical training, embrace the
role of "Doctor." "Medical students have to look for something to hang on to," Shapiro says. "And that something is provided: their new identity as 'doctor,' which becomes increasingly important as the medical years progress." As another perceptive observer put it, writing in 1979 about medical training in Britain: "The medical student, unlike students of the humanities, acquires an identity along with his education by his identification with the medical profession." Part of medical training involves the acquisition of a "professional mask."19

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

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

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

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

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

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

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

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

The implications of these responses are more complex than the respondents themselves perhaps realized at the time. The women medical students quoted above focussed on the fact that as women medical students their existence was not fully recognized. In consequence they were barred from the "men's" dressing room, and thus denied access to part of their training. But they mention the antagonism of the nurses only in passing, and avoid any attempt to analyse the fact that the sexist hierarchy that declared that nurses are women and physicians men served to weaken any bond based on a shared experience as women between the nurses and the women physicians. For the same reasons, the respondent who reports that the Chief of Obstetrics and Gynecology thought she should be a nurse assumes—correctly—that this was meant as an insult. But she was not in a position to fully explore the circumstances that would have encouraged her to accept this identification of nursing with inferiority. Faced with presumptions about gender and status that limited their opportunities to take full possession
of the status of physician, these female medical students distanced themselves from nurses. They appeared not to have understood the nurses’ difficulties as women workers whose subordinate position in the medical hierarchy was reinforced by their gender. Shapiro, a sympathetic, non-sexist male observer noted such distancing on the part of the women medical students who were members of his cohort at McGill in the early 1970s. Commenting on the tensions between medical students and nursing staff he says: “Female students were, if anything, more anxious [than males] to assume the mantle of physician and, thereby, to clarify in the minds of patients, other health workers and themselves that they were a class apart from the nurses.”

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

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

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

Campbell herself has some insightful comments to make about this tradition of humour. She observes that it stems partly from the very understandable fear and discomfort that physicians inevitably experience because they must confront the physical realities of disease and
The rituals of humour, she suggests, allow the medical student to distance himself from these fears. However, she points out that such fears can be constructively dealt with, without victimizing women, and that "students of both sexes" need such help.

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

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

As Weiss points out "all medical students and physicians are 'he' in Obstetrics and Gynecology" and moreover the text frequently suggests that the physician should assume an all-wise stance, and encourage a child-like trust in his patients. Both implicitly and explicitly the physi-
cian is encouraged to find out as much as he can about his patient's personality.

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

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

By the 1970s, physicians were not totally unresponsive to this feminist critique. The widely used Willson textbook was, for example, revised by Willson and Carrington in 1979. 41 This revision reflects an awareness that feminist criticism was being levelled at their particular text, but the authors were confused about what the feminist critics wanted from them and their efforts to add feminist content in this sixth edition can best be described as an unsuccessful attempt to "add feminism and stir." The feminism appears as congealed lumps in a version of the same old sauce. The physician is no longer referred to as "he" and the authors do list works such as the pathbreaking Boston Women's Health Collective's Our Bodies, Ourselves, and Kate Millett's Sexual Politics in their footnotes, and there are occasional references to feminism in the text. 42 However, an only slightly modified version of the older section on "The Feminine Core" remains and while there is less misogynist emphasis on women's narcissism and the need for female masochism, the sixth edition of this major textbook still contains much that is offensive from a feminist perspective. For example, in this edition as in earlier ones the physician is advised to evaluate the patient when she comes into the office in the following manner: "Character traits are expressed in her walk, her dress, her makeup, her responses to questions. . . . The observant physician can quickly make a judgment as to whether she is overcompliant, overdemanding, aggressive, passive, erotic, or infantile. . . ." 43 The authors still encourage the physician to ask intrusive questions about the sex lives of their patients, but never
about issues such as rape and incest that might relate to male sexual abuse of women.\textsuperscript{44}

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

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

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

These and other signs, like the posters advertising events for International Women's Week in 1991 at the University of Ottawa's Faculty of Health Science\textsuperscript{48} or the incredulous response of my second-year medical student respondent when I told her that in the 1970s professors had used \textit{Playboy} slides in their lectures, indicate real change. But many problems still remain and gender discrimination is still an issue for women medical students and women practising physicians, just as it is for other women in our society.\textsuperscript{49}
First of all, there are areas where overt discrimination still exists. As one might expect, they are to be found in those specialties that are still largely male-dominated. Surgery appears to be the worst offender. Data from two recent American studies clearly indicate that some of the patterns of the early 1970s persist in surgery.\textsuperscript{50} Students on clinical rotations still encounter sexist remarks and outright sexual harassment.\textsuperscript{51} Women are still sometimes excluded "from locker room discussions preceding and following surgical procedures" but fortunately this does not happen as frequently as it did in the past.\textsuperscript{52} One of my University of Ottawa respondents reported an incident that took place recently: during a clinical demonstration, the surgeon in charge asked the men students to come forward where they could see, and instructed the women students to stay in the back, "because they weren't going to go into surgery anyway."\textsuperscript{53}

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

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

It is noteworthy that the decisive shift in gender balance in medicine in Canada and throughout North America has occurred during a period when health care has been changing in a number of remarkable ways. From the rise of the health care consumer movement, which has transformed "patients" into assertive "health care consumers" to the current continent-wide "crisis" over health care costs, medicine is facing new challenges. At the beginning of the nineteenth century, North American medical practitioners were part of an occupational group with dubious social and economic status. By the middle of the twentieth century, they had become the most respected and most highly paid of all professional groups. Now, at the end of the twentieth century, although they are still powerful, still respected and still well paid, the authority of physicians both within the health care system and in the
wider society is being questioned. The physician is no longer undisputed “captain of the ship” of health care. Other professionals—including practitioners of “alternate therapies” and newly militant nurses— as well as patients and administrators of health plans are all questioning a decision-making power that a few decades ago was regarded as absolute. As I write this (in May 1993), the Ontario provincial government, in an attempt to grapple with what it perceives to be a fiscal emergency, has announced that it will restrict the possibilities for practice of newly qualifying physicians. Of the estimated 350 doctors who are expected to enter family medicine this year, only 45 new family doctors will be allowed to set up practice in Ontario, and only in areas deemed by the Ministry of Health to be suffering from shortages of such physicians.

This attack on newly qualifying family physicians on the part of the Ontario government is occurring just when the gender balance in family medicine has shifted decisively in favour of women, and as the representation of individuals from racial and ethnic minorities has begun to increase. As the President of the Professional Association of Interns and Residents of Ontario—herself a woman—put it: “More than half of us affected by this proposal are women, and many affected are from minority communities.”

The Ontario government’s attack on young family physicians, the most vulnerable members of the profession, is an indication that a pattern that has been associated with the history of women and work in our own society and cross-culturally, is now a factor in medicine. Work tends to be “gendered,” and the work of women—whatever it may be—is perceived as less valuable than the work of men, simply because women do it. Women’s entry into North American medicine in significant numbers may be as much an indication of the declining status of medicine as it is of the improved position of women.

Ever since women began entering medicine, some observers have claimed that women physicians differ in fundamental ways from their male colleagues in their approach to medical practice. Female physicians today have been described by some observers as more caring and more humanistic than their male counterparts, as more attuned to the social and psychological needs of their patients and as less likely to resort to technological fixes. From the perspective of many critics of modern medicine, women physicians appear preferable to men, thus raising the hope that this new cohort of women will be able to transform the profession, just because they are women. But is there more than anecdotal evidence to support assertions either about the woman
physician’s greater concern with caring or her more critical stance in relationship to the medical authoritarianism that has been an intrinsic part of the hierarchical nature of modern health care?

There are some measurable differences between female and male physicians. Women work in group practice with greater frequency than men, they work significantly fewer hours per week than male physicians, and they see fewer patients. Moreover, female physicians make less money than men, even when statisticians control for the above mentioned variables. The most significant difference between young women and young men physicians in Canada today concerns choice of specialization. In Canada (and the United States), while young women physicians are indeed to be found in all areas of specialization, they are gravitating to family medicine, pediatrics, obstetrics and gynecology and psychiatry. They are not, for example, becoming surgeons. As one perceptive commentator notes: “In thinking about how health professionals retain their niches...it is important to recognize one...feature of hierarchical behavior: it is rampant within medicine as well as without...Within medicine, there is a pecking order of specialties, an order that has been far from invariant over time...” In our own era, surgery has much more prestige than family medicine or obstetrics and gynecology.

The fact that female physicians spend more time with their patients than do males perhaps does reflect attitudinal differences, and it could be that women physicians choose specialties like pediatrics or family medicine rather than surgery because they enjoy dealing with people. However, there is also evidence to suggest that they select these fields both because they are discouraged from entering specialties such as surgery and because specialties such as family medicine or psychiatry make more manageable demands on a physician’s time and are therefore easier to combine with the roles of wife and mother.

Two recent studies, one Canadian and one American, indicate that there is little difference between women and men physicians or medical students when one analyses their opinions concerning issues like preserving the clinical authority of the physician, or attitudes to medicare. There is also plenty of evidence indicating that medical training “homogenizes” the attitudes of men and women physicians and encourages women to adapt to the masculine norms of the profession.

But even if it is true that women’s socialization encourages them to be more empathic physicians than men, it is dangerous both for women and for the health care system to suggest that women’s capacities as nurturers will humanize medicine and satisfy the demands of
contemporary critics. It is dangerous for women because such assumptions reflect traditional stereotypes about femininity. If it is assumed that women physicians because of their feminine nature can and should take on the task of humanizing medicine—a view implicit in statements like “women make better physicians than men because they have a greater capacity for caring”—then male physicians would be absolved of any obligation to change their ways. Male physicians need not become more caring; the women will do it for them, in the “soft” fields such as family medicine, pediatrics and obstetrics. Meanwhile, the men can get on with the more “rigorous” fields such as neurosurgery, oncology and biomedical engineering. If these patterns harden, men will continue to garner the most prestige within the profession, to make the most money, and to retain power.

In the 1980s and 1990s, as their numbers have increased, women physicians in North America are developing a heightened awareness of gender discrimination, whether or not they identify themselves as feminist. They are more able than they have been in the past to articulate their concerns about the ways in which they are affected by society’s continuing expectations of appropriate roles for women and men. Women physicians in both Canada and the United States are organizing themselves and discussing these issues with new interest. In both countries the women’s medical societies have been more open to feminist analysis than they had been previously, and this is reflected in their respective publications, the Newsletter of the Federation of Medical Women of Canada and the Journal of the American Medical Women’s Association. The Canadian organization has become during the last few years remarkably responsive to a feminist point of view, speaking out not only against sexism in the profession, but also for women as health care consumers. In its Newsletter, at conferences and in representations to federal and provincial levels of government it has taken a strong stand on such issues as the underfunding of medical research on women’s health needs, on the need for the profession to vigorously censure physicians who sexually abuse their patients, and on such wider social issues as violence against women.

One problem of concern to the organized medical women is that of the conflicts that arise when women physicians marry and have children during medical training. This happens most typically during internship and residency. The result is often described in the literature as “role strain,” that is, the conflict between what a woman is expected to achieve as a physician student, and what she is expected to do as a mother. At the present time, when the majority of women physicians
in North America are young women still in their childbearing years this role conflict represents a serious and widespread problem. The discussions of the problem by physicians—whether women or men—assume for the most part that it is inevitable that women will shoulder the major responsibility for homemaking and child care in the families they establish. It is indeed the case that male partners of female physicians, whether they themselves are physicians or not, behave much like other young men in our society. While as a group they do more household and child-care tasks than their fathers did, they still do not participate equally with their female partners in this work.\textsuperscript{71}

Although most women physicians in training and in practice do cope with the multiple demands on their time if they are combining their professional career with marriage and motherhood, it is clear that this is not an easy task. If they are in training, for example, they face stringent demands on their time: while there have been some changes in this area,\textsuperscript{72} internship and residency are extremely demanding. One of my female physician respondents, when asked about arrangements at the University of Ottawa for medical students, interns and residents commented that the school is definitely not “family friendly.” But she also pointed out that there are real difficulties involved in making residency, internship and “on call” requirements more flexible. When I asked my more senior woman physician respondent why residency could not be made more flexible she replied that “medicine is not a correspondence course.”\textsuperscript{73}

The literature indicates that women physicians frequently perceive the problems they encounter when they combine domestic with professional roles as personal dilemmas for which they must find personal solutions. For some, as we have seen, the solution is to choose to specialize in a field that will allow more rather than less flexibility. For example, to choose community medicine over surgery. While one could take the point of view that in making their selections of fields of specialization, women are simply making individual choices with no wider significance, the preference of individuals has more general implications. In the late twentieth century, the problems of combining family life and career are especially pressing for young professional workers, both male and female. The older pattern in which women sacrificed professional careers and assumed domestic responsibilities, thus allowing men to devote themselves nearly exclusively to professional life is becoming less and less common, but it is being replaced by one in which the burden imposed upon both sexes has become crushing. In North America at the present time, young professionals of all types are
simply expected to achieve too much in their personal and in their working lives during their twenties and thirties. The multiplicity of obligations imposed on young physicians is but one example of this contemporary dilemma, but it is a particularly telling one because of the tradition in medical training and in professional practice itself that encourages excessive work. As one observer puts it, medical students and physicians frequently “engage in compulsive work.” The negative effect of overwork on physicians, which is reflected for example in their higher than average rates of suicide and alcoholism, has been generally acknowledged only in recent decades.

Because women give birth, live longer than men and assume most of the responsibility for the health of children, they have more contact than men with the health care system as consumers. In Canada at the present time, “70% of visits to physicians are [by] women and children.”

In recent years, women activists have been conscious of these numbers, and conscious of the extent to which the medical profession has not served women well. Indeed, women consumers have been in the forefront of those working for changes in medical practice. The clearest articulation of the demand that medicine be less mechanistic and authoritarian and more concerned with the whole person has come from the contemporary women’s health movement. In the words of one writer on the subject:

One of the major goals of the women’s health movement has been to make information about women’s bodies and health accessible to all women in demedicalized, clear language. A medical expert is not required to tell us what is going on in our own bodies.

What is the connection between this new assertiveness on the part of women as consumers of health care and the rise in the numbers of women physicians? Are women physicians as a group responding in significantly different ways from their male colleagues to the demands of the women’s health movement? Definitive answers to this complex question cannot be given but there are indications here in Canada and in the United States both of tensions between the women’s health movement and women physicians, and of alliances between the two groups. On the question of the physician’s relationship to women’s health centres, for example, women consumer activists and women physicians sometimes have sharply differing points of view. For example, Nancy Worcester and Marianne H. Whatley, in a recent piece that examines the “co-optation” of the women’s health movement by the medical
system suggest that women physicians play a major role in such co-optation. They observe that while women practitioners represent a step forward, hiring a woman physician and women staff members for a women's health centre will not guarantee that the feminist, consumer-oriented, non-authoritarian principles of the movement will be implemented. "Having women practitioners does not guarantee a particular philosophy," they point out, and they add that "the concept of consumer control is essential to the feminist demand for health care by women for women; medical control, even if by women, undermines this goal."\(^7\) The very different perspective of some women physicians on this question is reflected in an article that appeared in the *Journal of the Medical Women of America* in 1988. The author discusses the fact that while feminist health centres prefer to hire women rather than men physicians, the organizers frequently are suspicious of all physicians; consequently, for the female physician, working in such a setting can be frustrating and unrewarding.\(^7\)

As these varying perspectives indicate, the issues posed by a feminist analysis of women and health care will not automatically be resolved simply because more of our physicians are women. In this regard, past and current controversy concerning maternity care is especially relevant. For decades, the demedicalizing of birthing has been a central concern of the women's health movement. One solution proposed by women's health advocates has been support for the prospective mother's right to choose an alternative practitioner as her birth attendant. That alternative practitioner is usually a woman who defines her occupation as "midwife." In Canada, as readers of the Connor and Dodd papers in this volume know, traditional midwives lost their right to practice before the twentieth century began. But in recent years, modern midwives and their supporters in the women's health movement have successfully organized, in spite of the opposition of physicians.\(^8\) In Ontario, new legislation will allow trained midwives to assist in home births, as well as in hospitals and in proposed new birthing centres.\(^9\) Training programs are planned at three of Ontario's universities, and there is now a new Ontario College of Midwives.\(^10\)

It seems almost certain that this new development, when coupled with the rise in the numbers of women physicians entering obstetrics, will result in the reversal of the shift in gender balance in obstetrical care that took place in the eighteenth and nineteenth centuries.\(^11\) Then, male birthing attendants gradually replaced the women who had traditionally done this work. Now, within decades it appears that women will once again dominate birthing. But this does not mean that the new
midwives will necessarily form an alliance with women physician obstetricians. There could be rivalry and competition between the two kinds of practitioners. On the other hand, the new midwives, as their numbers grow, could find themselves subsumed as subordinate members of a health care system controlled by physicians. And will the expectant mother be allowed to choose between types of attendant and styles of birthing care, or will an underfunded health care system make these decisions for women, on the basis of cost to the system? These are just a few of the open questions regarding the future of maternity care that will not be resolved simply because the majority of practitioners in this field will be women.

Women health care workers have a multiplicity of identities and form a multiplicity of alliances. Women physicians have not in the past attempted to work together with nurses (or with midwives). Nurses, in turn, have not forged alliances with nurses' aids. Obvious barriers of status within the health care system and less obvious class, ethnic and racial differences between these groups have made it difficult for them to work together, either to enhance their status as women workers, or to represent the needs of the women who make up the majority of the recipients of their care.

Conclusion

One of the lessons to be learned from the contributors to this volume is that throughout its history, health care in Canada has affected women's lives in a variety of ways. As an occupational category, health care has been a site of struggle between a majority of female workers disadvantaged because of their sex and often because of their social class and sometimes because of their race or ethnicity, and a minority of male workers whose position as physicians has garnered them power, prestige and wealth. And we learn from the growing body of work on women and health care, of which this volume forms a part, the lamentable truth that women as patients have experienced not only curing and caring from physicians and from the health care system, but also denigration, neglect and abuse.

Recently, Dr. Frances Rosenberg, who was for several years the editor of the Federation of Medical Women of Canada (FMWC) Newsletter, reflecting on the changes in gender balance in the medical profession, suggested that women physicians could either use the power of their numbers to become "change agents" in the profession or they
could remain "second class citizens within medicine." Rosenberg, like most of the activists within the FMWC, clearly hopes that women physicians will be agents of change, in a way that will benefit all women. Certainly the FMWC’s remarkable openness to women’s concerns is heartening, and perhaps the existence of a numerically strong female presence at the pinnacle of the health care pyramid will encourage change for the better for all women health care workers and for health care consumers. But it will not in itself bring about such change, nor should we expect it to do so. Resolving the moral, social and economic dilemmas confronting the Canadian health care system at the end of the twentieth century will require the collective effort of female and male practitioners across the complex spectrum of health care occupations and as well, the decision making of an informed, actively involved community of health care consumers.

Endnotes

* The quotation is taken from the title of an editorial by Dr. Frances Rosenberg, Editor, "No longer an invisible minority," Federation of the Medical Women of Canada Newsletter, October 1990, vol. IV, p. 5. This paper was first presented in the series "Gender and Medicine" offered by the Hannah Chair in the History of Medicine at the University of Ottawa in 1991. I would like to thank the following people for their help: Meryn Stuart, Diane Dodd and Toby Gelfand, who organized the series; Myra Owen and her staff at the University of Ottawa’s Health Sciences Library; the University of Ottawa archivists; my Carleton University colleague Fran Cherry, and E. Ryten, Director of the Office of Research and Information Services of the Association of Canadian Medical Colleges; and the faculty members and students at the University of Ottawa Faculty of Medicine who kindly answered my queries during the months of February and March 1991. These were two female physicians—one in the professoriate and one who was a faculty member within the last decade; one male full professor; and one second-year female medical student. Finally, I am grateful to Wendy Mitchinson for her careful reading of a version of this paper.


2. In Canada, as in the United States, progress in admissions at the end of the nineteenth century was followed by a decline in the first decades of the twentieth century. In 1955 in the United States, only 4.7% of medical students were women. See Rosenthal and Eaton, "Women MDs in America." For Canada see E. Ryten, "The changing demographics of physician supply in Canada: How did we get where we are and where are we going? Does it matter?" Unpublished paper, n.d. but 1990. I thank Ms. Ryten for giving me access to this and other papers cited here.


5. The Universities of Toronto, Western Ontario, and Ottawa, and Queen's and McMaster Universities all have schools of medicine.

6. *Canadian Medical Education Statistics* vol. 12, 1990, Table 17A, 19. There are some marked regional variations in the overall Canadian pattern. In 1988–1990 more than half the enrolment at the three Francophone schools in Quebec was female, whereas in Ontario female enrolment made up 39% of the total. At Laval University in Quebec City, women comprised 55.6% of the total enrolment.


8. "A profound lack of female physicians in academic leadership positions exists. In 1988 two (1.6%) of 127 deans, 11% of associate deans, 22% of assistant deans and 3% of chairpersons were women. Nine (13%) of these chairs were in pediatrics." "For the past 30 years, women have been more likely than men to enter academic medicine. However, they have not achieved the same success as men." Catherine DeAngelis, M.D., "Women in Medicine, Fantasies, Dreams, Myths and Realities," *American Journal of Diseases of Children* (AJDC) 145 (January 1991): 49–52.

9. Ryten, who has analysed this data, reminds us that "the cohort factor" is at work here. In her view, "just because the current output of Canadian medical schools is more than 40% female, by no means implies that the pool of qualified individuals from which medically qualified academics were recruited contained 40+% women." Ryten believes that at the present time, women are not meeting with discrimination in hirings at Canadian medical schools. Nonetheless, the fact that there are so few women in positions of power in academic medicine does contribute to continuing patterns of inequity. See the discussion of women in surgery below.


13. For this, see for example Martin Shapiro, *Getting Doctored: Critical Reflections on Becoming a Physician* (Kitchener, Ontario: Between the Lines, 1978). Shapiro, who was part of the entering medical school class at McGill in 1969, emphasizes in this excellent critical discussion of medical training, that his overwhelmingly male entering class of 135 students were from "economically privileged sectors of society" (p. 14), that there were no black
Canadians or black Americans in his class (p. 18), the only blacks being "a few Africans, all from wealthy families," and no native people. He also says that the interview process, in these years of student activism at McGill, were designed to weed out "radicals" from the medical school cohort (p. 19). The conservative, conformist, authoritarian atmosphere of medical school could be difficult for many males, of course; this is one of Shapiro's main points. But Shapiro himself emphasizes that women students faced active discrimination and denigration during these years: there was no way that they could fully conform, especially since the conservatism and conformism of the male students and staff included for the most part an acceptance of sexism and misogyny.

14. Dr. May Cohen goes on to recall that "our anatomy lab teams and our clinic groups consisted of women only—even though that meant much larger groups than the men's clinical groups." Cohen, since 1991 Associate Dean of Health Services in the Faculty of Health Sciences, McMaster University, graduated from the University of Toronto's medical school in 1955. In recent years, she has been active in promoting women's issues within the profession of medicine, and in speaking out on issues related to women and health. She has been active in the Federation of Medical Women of Canada (FMWC), serving as the organization's President in 1991–1992. The quotation is from her FMWC presidency acceptance speech, excerpts of which appear in the FMWC Newsletter, October 1991, vol. 4, p. 9. Regarding Cohen's reference to the 10% quota, affirmative action policies, especially in the United States, are sometimes said to involve "quotas," meaning that at least that many members of the targeted group must be included. The quotas of the 1950s, to which Cohen refers, were designed to limit the targeted group.

15. For Dr. Besnack, see the Report of the Dean: Faculty of Medicine, 1970–1972, which mentions her retirement after "close to 10 years," 19. Report is in the University of Ottawa Archives.

16. I read Calendars and Reports from the school's founding until the present in the University Archives. Some who were at the school do not agree: the one physician faculty member who attended the talk on which this paper is based, during the Hannah Chair's "Gender and Medicine" series in 1991, was a woman who had been at the school for many years. She insisted that there never was any gender bias at the school, but then she also insisted that in the twentieth century there never has been any bias against women in medicine anywhere.

17. On this question, as it relates to science and medicine, see Rosser, Feminism within the Science and Health Care Professions, pass., and also Glazer and Slater, Unequal Colleagues.

18. Shapiro, Getting Doctored, 27.


21. McMaster is not unique here; Shapiro's account of his McGill training makes it clear that there, too, during his training, medical students were referred to as "doctor" in their second year, when they entered the hospital setting. Shapiro, Getting Doctored, 59–67.

22. Haas and Shaffir, "Taking on the Role," 406–407. Note that while this article uses the pronouns "he" and "she" rather than the universal "he," and the authors are aware that
even in 1982 McMaster's medical school had a higher than average number of women students, the authors do not discuss gender as a factor.

23. Barbara Ehrenreich and Deirdre English, For Her Own Good: 150 Years of the Experts' Advice to Women (Garden City, N.Y.: Anchor, 1978).

24. Margaret A. Campbell, M.D., "Why Would a Girl Go into Medicine?": Medical Education in the United States: A Guide for Women (Old Westbury, N.Y.: The Feminist Press, 1973). On the inside cover we are informed that "Dr. Margaret A. Campbell is a pseudonym." This study received some recognition in the medical profession itself. For example see an article that appeared in the "Sounding Board" section of the NEJM in 1974: Mary C. Howell, M.D., Ph.D., "What medical schools teach about women," NEJM 291 (1974): 304–307. Howell, who, like Campbell, takes a feminist point of view, and believes that discrimination in medical schools was widespread, cites Campbell frequently.

25. Campbell, "Why Would a Girl Go into Medicine?" 110-111. Regarding women physicians in training and nurses' quarters, Cohen says of her experience as an intern, training at the University of Toronto medical school in the early 1950s, "As interns, we [women medical students] were forced to live in the nurses' quarters where no men were allowed to cross the threshold (even though I was already married)." FMWC Newsletter, October 1991, vol. 4, 9.


27. That the division between nurses and women physicians continues is reflected in this comment made by Dr. Frances Conley, a neurosurgeon who in 1991 resigned her professorship at Stanford University to protest the sexism of Stanford's medical school. (She has since returned to Stanford because some of her complaints have been addressed.) Conley is a feminist and an outstanding achiever in a field still overwhelmingly dominated by men, but in a speech she gave at the University of California at San Francisco she is reported as having made the following comment about nurses: "women have not responded to gender insensitivity very well... Some operating room nurses with whom I have worked put up with blatantly sexist remarks because they do not want to jeopardize their 'special' relationships with the doctors; I term this type of women 'enablers' because they enable sexism to continue." Cynthia Corwin, "Conley foresees 'no room at top' for women in Academia," Synapse 36, 12 (14 November 1991): 5. Synapse is the student-run paper at UCSF.

28. Shapiro, Getting Doctored, 70.


30. On the fact that this was not accurate, see Campbell, footnote 4, p. 102: "In 1952 and again in 1965 the modal numbers of hours of practice per week were 45 for women physicians, 50 for men physicians."

31. See Howell, op. cit.: "The men's-club atmosphere is heightened by the tradition of 'medical humor,' much of it at the expense of women. A major theme of this humor is male sexual prurience, and an underlying attitude is that any woman is an appropriate object for that prurience—any woman, including a patient, including a colleague," 306.


33. Bennet makes the same point: "So often the medical students, and junior doctors too, react with a robust kind of detachment, so that grave or gruesome matters are the subjects of jokes" (p. 148).

34. Campbell, "Why Would a Girl Go into Medicine?," 42-43.
35. By 1992, one half of the obstetricians and gynecologists in training in Canada were women, according to an article in the FMWC Newsletter, October 1992, vol. 5, no. 3: 5. And that number will likely increase rapidly: "In 1980/1981, 28% of the post-M.D. trainees in obs/gyn were women; by 1984/1985, this figure had climbed to 41%; now [1989-1990] 81% of medical students who state they wish to become obstetricians/gynaecologists are women. If these figures mean anything at all, they signify that obstetrics and gynaecology will rapidly become a female dominated field of medical practice." Ryten, "The changing demographics of physician supply," 17. Others have noted this shift in obstetrics/gynaecology. For example, an observer writing about developments in the U.S. says: "The largest recent shift has come in obstetrics and gynecology, where the number of women doubled between 1980 and 1990." Valerie Ulstad, M.D., "How women are changing medicine," JAMWA 48, 3 (May-June 1993): 75-78.


38. J. R. Willson, M.D., C. T. Beecham, M.D. and E. R. Carrington, M.D., Obstetrics and Gynecology, 4th ed. (St. Louis: The C. V. Mosby Co., 1971). Weiss reports that it was used in 1977 in 60 U.S. medical schools. For the University of Ottawa, see Calendars in the University Archives. Texts are listed under subject specialties. This textbook appears in listings throughout the 1970s and into the 1980s.

39. This is quoted in Weiss, "What Medical Students Learn," 214.

40. Edmund Novak, Jerreanna Seeger Jones and Howard W. Jones, Jr., Novak's Textbook of Gynecology, 8th ed. (Baltimore: Williams and Wilkins, 1970), 663. Another text, also listed in the University of Ottawa calendars, and like Novak et al., still available in the Gynecology section of the University's Health Sciences Library, gives the following advice about the menopause: "The menopause exaggerates the woman's anxieties and fears. It increases her dissatisfaction with her socio-economic or domestic state and brings into sharper focus vague feelings of self-pity, apprehension and depression. Traits of pettiness, irritability and excitability which were controlled or dormant in former years make their appearance. They often appear as sudden outbursts of anger, weeping or depression which are out of proportion to the situation inciting them. Insomnia, boredom, fatigue and forgetfulness are frequently among the complaints which bring the menopausal woman to her physician." John William Huffman, Gynecology and Obstetrics, 11th ed. (Philadelphia: W. B. Saunders, 1962).


42. For example in the chapter on sexuality, the authors say: "The women's liberation movement has been an important influence in altering sexual roles in a most dramatic way ... the new ideal places a woman's position as equal to that of the male ... ." Willson and Carrington, Obstetrics and Gynecology, 51.

43. Willson and Carrington, Obstetrics and Gynecology, 51.

44. This sixth edition still contains the following racist and sexist statement about the psychological effects of pelvic surgery: "Many patients believe that the source of their sexual desires is located in this area. This is a common belief of black patients, who think that it is in the uterus; white patients think that the source of their sexual desires is in the ovaries." 59.
that it is in the uterus; white patients think that the source of their sexual desires is in the ovaries," 59.

45. Neville Hacker and J. George Moore, Essentials of Obstetrics and Gynecology (Philadelphia: Saunders, 1986). This text was not listed in the University Calendar, nor had it yet appeared in the Health Sciences Library catalogue, but it was the textbook ordered by the Health Science bookstore, and according to the bookseller, it was the required text.

46. S. Jean Herriot Emans and Donald Peter Goldstein, Pediatric and Adolescent Gynecology, 2nd ed. (Boston: Little, Brown Clinical Pediatric Series, 1982).

47. Emans and Goldstein, Pediatric and Adolescent Gynecology, 540.

48. During International Women’s Week of March 1991, posters in Guindon Hall, the Health Science Building, for example, advertised study sessions on the subject “women abuse: it hurts.” This project was sponsored by the student project for preventative medicine.

49. A sense of the way in which women physicians themselves view these problems can be gained from articles in JAMWA and the FMWC Newsletter. From the latter, here are comments from Mary Donlevy, the 1990–1991 president: “I have spoken to women residents who were being sexually harassed by their male professors and mentors; to fully qualified women specialists who do not practise their specialty because of sexual discrimination; to women residents who were told not to get pregnant during residency by the program director.” Dr. Donlevy on the President’s Page, FMWC Newsletter, October 1990, vol. IV: 9.


51. From a respondent in Grant’s study, op. cit.: “I really was hassled a lot as a woman, had my ass pinched by a surgery resident, was picked on with trivial questions, was embarrassed, even brought to tears a few times. (The chief resident) just laughed and said there it was, proof that women didn’t have the stamina and what it takes for surgery.” Grant, “The Gender Climate,” 110.

52. See Ramos and Feiner, “Women Surgeons,” 24. In the Grant study, one student, for example, compared two different surgery rotations: in one, she was subjected to persistent sexism; in the next, however, “some of the [staff physicians] really encouraged women to enter surgery. The chief mentioned . . . a couple of times that surgery needed more women.” Grant, “The Gender Climate,” 110.

53. The American case of the neurosurgeon Dr. Frances Conley (see footnote 27) has given publicity to the issue of continuing discrimination against women, especially in surgery. When Conley spoke at the University of California at San Francisco medical school, she attracted a crowd of 500 people (about three-fourths women). In this talk, Conley, while generally optimistic about women’s ability to fight sexism, talked of the pervasiveness of “gender insensitivity.” See Corwin, “Conley foresees ‘no room at top’ for women.”

54. Grant found that 34% of women said they had indeed experienced gender discrimination. However, “faculty and staff physicians” are main source of “gender discrimination.” Grant, “The Gender Climate,” 118.

56. On the equitability of Canadian hiring practices, see Ryten, "Women in Academic Medicine in Canada: Are Women Subject to Discrimination?" Unpublished paper: n.d. but c. 1989. But see in contrast Cohen: "Although the number of women in medicine has increased, gender harassment and gender discrimination are still important issues for women. Sexual harassment or gender discrimination is often subtle and difficult to label and may range all the way from sexual remarks, jokes or teasing to sexual assault... Disapproval, overt or covert, of women who are pregnant, either residents or practicing physicians, is a form of gender discrimination which many in this room have experienced." Cohen's presidency acceptance speech, op. cit.

57. The articles on nursing in this volume can be seen in part as a reflection of a newly assertive nursing profession that is claiming both its own history and its right to define itself.

58. One good discussion of the question, in historical and philosophical context: Nancy M. P. King, Larry R. Churchill and Alan W. Cross, The Physician as Captain of the Ship: A Critical Reappraisal, Philosophy and Medicine series, vol. 29 (Dordrecht, Holland: D. Reidel Publishing Co., 1988). "Twenty years ago... the physician was 'captain of the ship...'." As a result of pressures from a number of diverse directions—including technological advances, the development of new health professionals, changes in health care financing and delivery, the recent emphasis on consumer choice and patients' rights—what our society expects physicians to do and to be is different now" (p. xi).

59. "The prospect of becoming Canada's first large group of unemployed doctors has shocked Ontario residents and interns... [T]he Ontario government's dramatic and unexpected proposal last week [will] limit most new family doctors and pediatricians to 25 per cent of the normal billing rate for physicians, a rate so low it would in effect bar them from practice. Only 45 new family doctors in five counties in Southern Ontario where there are 'marginal shortages' would be exempt. That would leave more than 300 of the estimated 350 doctors who are expected to enter family medicine this year without work, a situation virtually unprecedented in Canada." "New doctors aghast at limits on practice," Toronto Globe and Mail, Tuesday, 4 May 1993: A6. A month later, the provincial government was forced to modify this policy: "Ontario improves offer to doctors: Billing by new MDs would be set at 75 per cent of OHIP fee," Toronto Globe and Mail, 5 June 1993: A3.

60. "New doctors aghast at limits on practice." Comment of Dr. Lisa Moore to the press.


62. For the fact that Canadian women physicians prefer group over solo practice—only 17.8% of female physicians were in solo practice as compared with 29.2% of male physicians—see Williams, "Women in Medicine," 197.

63. "The income differences reported... persisted even after we controlled for patient visits, hours worked, age and specialization..." Williams, "Women in Medicine," 199.

64. For Canada, see Ryten, "The changing demographics of physician supply," 16, and for the U.S. see Altekruse and McDermott, "Contemporary Concerns," 72.

66. Williams et al., "Women in Medicine"; Maheux, Dufort, and Beland, "Professional and sociopolitical attitudes."

67. Maheux et al. suggest this (p. 75).

68. This statement was made by my male physician respondent.


70. See for example Marcia Angell, "Juggling the personal and the professional life," *JAMWA* 37 (1982). As one might expect, doctors marry each other: "... over half of [medical] women are married to or will marry other doctors."


72. One of the two female physician respondents from the University of Ottawa commented that when she had a child during her residency some two decades ago, she was given virtually no time off. Now a resident is guaranteed a three-month pregnancy leave.

73. Not everyone agrees that the requirements need to remain so inflexible. See DeAngelis, "Women in Medicine" for a different point of view. And for the FMWC, "shared and part-time residency options" is a change to which they are currently committed. See the article by Dr. Jean Swenerton, the organization's President in 1992–1993 in the FMWC *Newsletter*, Winter 1992–1993, vol. 5, no. 4: 4.

74. Michael Shapiro, *Getting Doctored*, 31. Shapiro goes on, "The compulsion to work ... represents also an attempt by the students to immerse themselves in and become part of something big and powerful. They readily submerge in a professional role and internalize the compulsion to work. The latter becomes integral, in fact, to their burgeoning professional identity" (p. 32).

75. For example, see the reference to "workaholic physicians" in a recent issue of the FMWC *Newsletter*: "While most workaholic physicians are men, the number of women who suffer from this problem is on the rise." January 1992, vol. 5, no. 1: 2.


77. Marianne H. Whatley, "Beyond Compliance: Towards a Feminist Health Education," in Rosser, *Feminism Within*.


80. Ontario is, as yet, the only province to have passed enabling legislation, but the issue is being discussed in Alberta, British Columbia and Quebec. For physicians' opposition see, for example, the pro-midwife editorial "Quebec is ready for midwives: Doctors should stop fighting this sensible step," Montreal *Gazette*, 14 March 1993, B2. And "Midwives complain that doctors refuse to give them support," Montreal *Gazette*, 28 January, 1993, A4. A Canadian Medical Association policy statement of May 1993, "Revisions to Recom-
mandations of CMA's "Obstetrics 87" Report," makes no mention at all of midwives, but "recommends the continued support of the existing obstetrical care system in Canada," suggests measures to "encourage physicians with obstetric/gynaecological training to practice obstetrics" and "supports the continuing involvement of family physicians in all aspects of obstetrical care in Canada." My thanks to the CMA for providing me with this document.

81. According to a Globe and Mail story that appeared in March 1993, the legislation, the Regulated Health Professions Act, which includes midwifery, is expected to be proclaimed before the end of 1993. "Midwives to operate birthing centres," Toronto Globe and Mail, 30 March 1993, A1-A2.

82. For the training programs see "Ontario midwives get a big push: three B.A. programs will start in Fall for province," Medical Post 29, 2 January 12, 1993: 40. For the College of Midwives see "Midwives to operate birthing centres," Toronto Globe and Mail, 30 March 1993, A1-A2.

83. It should be noted, however, that not all modern midwives are female. The Dutch midwife who is assisting the Quebec Ministry of Health to establish guidelines for midwife training and standards is male. See "Only 12 of 120 hopefuls pass midwives' tests," Montreal Gazette, 12 March 1993, A5.

84. I have seen no indication that women physicians are taking a position different from that of their male colleagues on the midwife issue. The FMWC Newsletter, for example, although it discusses many women's health issues in a forthright manner, and often opposes the mainstream views of the profession, has not taken up this issue.
