GIVING BIRTH IN CANADA, 1900–1950

In *Giving Birth in Canada*, the first historical study of childbirth in Canada, Wendy Mitchinson has written a fascinating account of childbirth rituals in the first half of the twentieth century. Thorough and comprehensive, the work is based on a rich variety of sources, including medical textbooks, the medical periodical press, popular medical advice books, literature published in women's magazines, patient records, and interviews with women who gave birth and physicians who practised during the period.

Mitchinson follows the birthing experience from the initial diagnosis of pregnancy, through prenatal care, and childbirth – who was present and where it took place – to obstetrical intervention, postnatal care, and the definition of what constituted a normal birth, much of which changed significantly through those years. She explores physicians' responses to the needs of pregnant women, developments in medical practices, and the increasing medicalization of childbirth.

While the book focuses on conventional medical practices, the author's survey of midwifery and Aboriginal birthing practices provides a counterpoint to the approach taken by Western medicine and permits valuable discussion about the dynamics of gender and race as they relate to childbirth and, more broadly, to early-twentieth-century Canada.

(Studies in Gender and History)

WENDY MITCHINSON is a professor of history at the University of Waterloo.

STUDIES IN GENDER AND HISTORY

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GIVING BIRTH IN CANADA 1900–1950

Wendy Mitchinson

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For Frances Mitchinson
and in memory of
Cameron Mitchinson

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Preface

I always seem to be writing books I don't intend to write. Certainly this is the case for *Giving Birth in Canada, 1900–1950.* My aim was to write an overview of the medical treatment of women in early-twentieth-century Canada, a sequel to *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada.* However, during a sabbatical year it quickly became clear that if I wanted to get even a very rudimentary first draft written, I would need to narrow my focus. I was in the enviable position of having too much research data. So I decided to concentrate on childbirth, and what follows is the result. The only part of the book previously published was a somewhat shorter version of chapter 2, which appeared as 'The Sometimes Uncertain World of Canadian Obstetrics, 1900–1950,' *Canadian Bulletin of Medical History* 17, 1–2 (2000): 193–208.

Although I am the author of the book, I could not have written it without the help of many others. Funding agencies are crucial for research, and while many of us criticize what we see as the lack of funding and a sometimes eccentric decision-making process, I have certainly benefited from research support provided by the Social Sciences and Humanities Research Council of Canada (SSHRC), Associated Medical Services through the Hannah Institute for the History of Medicine, and the University of Waterloo. I was privileged during the period of researching and writing to be awarded a Thérèse Casgrain Fellowship (1993–4), to be a scholar in residence at the Rockefeller Study Center in Bellagio,

Italy, for one month in 1994, thanks to the generosity of the Rockefeller Foundation, and to spend a month as scholar in residence in southern Spain through the Danish Fundación Valparaiso in 1997.

None of the above would have been possible without the sources to research, and it is in making them available to researchers that librarians, archivists, and holders of collections are central to the process. I would like to thank Dr Badley and Lynn Molloy from the Victoria General Hospital, Halifax, the former for giving me permission to look at the hospital's records and the latter for helping me do so. Philip Hiscock, who was then at the Memorial University of Newfoundland Folklore and Language Archive, was particularly generous in sending me material on midwives from the folklore collection. I also appreciate the work of his successor, Patricia Fulton, who checked note references. The Igloolik Oral History Project was a wonderful source, and I especially wish to thank the Inuit elders involved in it, as well as their translators. For making the material available, I appreciate the generosity of the Science Institute of the Northwest Territories and the Government of the Northwest Territories, in particular John MacDonald of the Science Institute. McGill University Archives, the Public Archives of Nova Scotia, the Provincial Archives of British Columbia, Queen's University Archives, Women's College Hospital, Toronto, and the Kitchener-Waterloo Hospital were most accommodating to me, and I particularly appreciated the officials of the latter two institutions, who gave me access to their records and were generous in setting up research space for either myself or a research assistant. Kathryn Rumbold, too, made space available for photographing items from the University Health Network Artifact Collection. Susan Bellingham of the Doris Lewis Rare Book Room, Dana Porter Library, University of Waterloo, was always helpful and interested in what I was doing.

The generosity of other scholars in sharing their research has been gratifying. David Gagan and Suzann Buckley were particularly giving. David provided me with statistical runs of the patient records from his own work on the Owen Sound General

and Marine Hospital, and Suzann did the same for the Ottawa Maternity Hospital. I cannot thank them enough. Dr Charles Hayter shared his research, as did Lesley Biggs, Jill Oakes, and Janet McNaughton. Judi Albright and her family lent me their Aunt Mary How's Cottage Hospital records from Abbey, Saskatchewan, and Sheila Joel the tapes of 'Traces,' a women's project devoted to collecting the remembrances of older women. Marlene O'Brien allowed me to relate the experiences of her mother in childbirth. Drs Stuart Houston and Robert Macbeth took an interest in what I was doing and regaled me with stories of their training and practice.

Over the many years that I was working on this project (in its larger manifestation), I was fortunate to have good research help. I would like to thank Linda Ambrose, Marlene Epp, Mona Gleason, Susan Johnston, Barbara Holzmark, Megan Davies, Julia Roberts, and Mary MacDonald. These individuals helped find patient records and coded them for analysis, surveyed medical textbooks and input data. A special thanks is due to Helen Harrison, who interviewed many women about their health experiences. The women themselves are particularly deserving of gratitude. They gave of their time and they shared experiences that were not always happy. Although not named (for purposes of confidentiality), each one contributed to the making of this book, as did the several physicians I interviewed.

During the research and writing of this manuscript I was fortunate to work with a group of scholars as part of a SSHRC Strategic Research Network Grant. As participants in the Feminist Health Care Ethics Research Network, these women both stimulated and challenged me. I thank Françoise Baylis, Marilynne Bell, Maria DeKonick, Jocelyn Downie, Abby Lippman, Margaret Lock, Kathryn Morgan, Janet Mosher, Barbara Parish, Susan Sherwin, Peggy Spencer, and Ariella Pahlke. Colleagues and friends are often unaware of how they help simply by being there and showing some interest. I would like to thank Bonnie Shettler, Chris and Linda Dumbell, Alison and Jim Prentice, Franca Iacovetta, Ian Radforth, John English, Ken McLaughlin, and Patrick Harrigan. Family members, too, are central for maintain-

ing sanity and keeping life in perspective. Over the years the joy given me by Leo, Misha, Georgia, Calder, and Bustopher will not be forgotten. I can't express enough appreciation to three individuals who with good grace took on my request to read a draft of the manuscript. Drs Murray Enkin and Charles Roland explained with endless patience the medical perspective and fortunately caught some of my more egregious faux pas. Janice Dickin, in her cheerful way, kept me focused on what it was I was trying to say. I appreciated (well, not always) the comments of the anonymous readers and those of Jill McConkey of the University of Toronto Press and the encouragement given by Karen Dubinsky of the Press's Studies in Gender and History series. Until he left University of Toronto Press, Gerry Hallowell continued to express interest in the project and kept reminding me to finish it. The editorial help provided by Carlotta Lemieux and Frances Mundy made the final work on the manuscript less stressful than it might have been. Production assistance by Len Husband also smoothed the process. Connected to producing the actual manuscript, my thanks to Nancy Birss, Irene Majer, Jill Willwerth, and Vic Neglia, all of whom remained calm when computer technology made me frazzled. Arthur Sheps suggested a working title for the book, and while it did not become the final title it lifted my spirits while I was writing.

I now feel like one of those recipients of an award who has thanked everyone. Of course that is never possible, and in writing the acknowledgments I am fearful that I may have left someone out. If that is the case I am sorry, but I trust that my oversight will be forgiven. One person I have not thanked, however, has not been forgotten. The best has merely been left for last. Rex, thank you for being in my life.

GIVING BIRTH IN CANADA, 1900–1950

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Introduction

Maternalism, a belief that mothering is central to the lives of women, was an ideology that most Canadians shared with others in Western society in the first half of the twentieth century.[1] The ability to bear children was a physical act that separated women from men. It was crucial to the survival of the species and, more particularly, to the survival and strength of various national and racial groupings. But before a woman could become a mother, she had to give birth. This was and is the most fundamental of creative acts. This book is a history of that process in Canada from 1900 to 1950. These were the years in which the medicalization of childbirth, begun in the late nineteenth century, intensified. As a consequence, this book focuses on the regular medical profession and the views of its members about the nature of birthing, and, even more significant for the women concerned, on the way in which medical practitioners treated their patients. As such, the book is part of a wider historiography on the medical treatment of women, the history of childbirth, and gender and science.

The literature examining the medical treatment of women has not been particularly complimentary. Feminist activists, motivated by what they observed in the contemporary world – the problematic side effects of the pill, the dangers of breast implants, increased medical intervention in birthing, and the emergence of new reproductive technologies – concluded that medicine seemed to be targeting women's bodies.[2] In the last

decade or so, the burgeoning field of feminist medical ethics has continued the activism, suggesting that something is missing in the way in which medicine was and is practised.[3] Historians followed suit, emphasizing the alienation from their bodies that women felt as a result of medical control.[4] One of the few exceptions to this was Edward Shorter's *History of Women's Bodies*, which was a homage to the medical profession as a saviour of women from the problems of their bodies. Although Shorter's work garnered much public attention, it was not reflective of the trend away from seeing the medical profession and its practitioners as the rescuers of women.[5] It is within that context that the early historical monographs on childbirth emerged.[6] Reproduction was central to sexual differences, and the feminist concern with the changes occurring in reproductive biology and technology made it important to understand the history of the process.[7]

No book has focused on the history of childbirth in Canada, though there are numerous studies incorporating aspects of it.[8] The international literature continues to be voluminous,[9] and its criticism of the medical profession has become much more nuanced than it had been. It now reflects anthropological and sociological as well as historical concerns about the process of birthing, the role of women in it, and the way in which birthing practices have changed as a result of pressure from both women and physicians. The literature in the field of gender and science also has been influential on childbirth studies, challenging our understanding of the nature of science in all its manifestations (including medicine) and its objectivity.[10] Nevertheless, the feminist activism of the earlier period still resonates in most of the work written.[11]

Feminist scholarship has made much about the difference between gender and sex, originally arguing that gender is socially constructed while sex is biologically grounded. This distinction was a major step forward in feminist analysis, since the focus on gender allowed a historical examination of the body and its treatment.[12] While the concept of the gendered nature of the body has been useful, it has not been without controversy. Some feminist theorists have reacted against the concept of gender as

being too generalizing, not recognizing the diversity of women.[13] In addition, the stability of the sex/gender binary is somewhat illusory, as Ruth Hubbard has pointed out: 'The distinction between sex and gender ... [is] based on the implicit, but false, assumption that the effects of biology and society are discrete and separable, at least in theory if not in practice ... These effects are in fact inseparable. Every organism constantly transforms its environment while being transformed by it, and, in the case of people, the society in which we live is a major component of our environment.'[14] Nonetheless, the conceptual conceit of the gender/sex divide led to a wealth of research on the medical treatment of women. Within this literature two major issues emerged.

The first was that medicine was part of culture and, as such, was constrained by the norms of culture. Historically, the norms of our culture have defined and limited women, and medicine could not help but do the same. The second was modern Western medicine's mechanistic view of the body, which stemmed from its mechanistic view of the universe.[15] The mechanical model emphasized the body as a machine – regular, predictable – and favoured a technological response to it. But bodies are not predictable. Nevertheless, for physicians, the male body approached the mechanistic ideal better than the female did, and as a result it became the norm for what a healthy body should be. That most physicians were male also reinforced the view that the male body was the norm.

Because of the differences between a woman's body and a man's – the ability of women to menstruate, to give birth, to undergo menopause – physicians (and others) have long assumed that women are closer to and more readily identified by their bodies than men. Consequently, they saw women as closer to nature, or as not transcending nature. Men do not completely escape being body, particularly in the realm of sexuality (their sex drive is often viewed as uncontrollable or dominating). But physicians (as men) tended to view men as being outside their bodies rather than in them. Feminists have argued that in seeing women so closely aligned to and influenced by their bodies, medicine essentialized them – the woman's body became equated

with a reproductive body.[16] The normative model of a woman was one who was young enough to be still menstruating and able to bear children. Physicians judged young women entering puberty by how well their bodies were approaching this ideal, and they judged older women by how much their bodies had deviated from it. Differences based on class, ethnicity, ability, and so on were secondary. Because physicians saw women's bodies as different from men's – as foreign – they tended to see what those bodies did as problematic, even though they acknowledged that for the vast majority of women they were not.

As physicians focused on differences between men's and women's bodies, so did historians and others. Feminist scholars have been interested in studying the repercussions that this view had on women. In the early monographs, the tendency was to see women as victims of the medical establishment.[17] However, delineating the areas in which women were victimized tells us very little about the women themselves. As the field developed, so too did interest in discerning how women patients were actors – how they exerted agency within the limits they faced. And the limits were considerable. Whether male or female, patients seldom negotiated with physicians from a position of strength. First, since the late nineteenth century, the power of science in our society has been so strong that any public challenge to it has been seen as irrational. Medicine shared in that power. By going to a doctor, the patient expressed his or her belief in the medical system. Patients have refused to follow medical direction, but medical literature, until very recently, viewed this as aberrant behaviour. Second, the difference in power between the patient and the physician compromised choice for the patient. Since the late nineteenth century, the status of medical practitioners in Canada has been high. Most were middle class (and, until recently) white males, and outside of Quebec, most were of British heritage. Third, physicians obfuscated medical information in a technical language, which made it next to impossible for patients to understand and lessened their ability to make informed judgments. Even when a decision was left to the patient, that person generally worked only with the information provided by the physi-

cian. Fourth, the patient was vulnerable compared with the physician; otherwise that person, would not be a patient.

Women were doubly disadvantaged in that as well as being patients, they were women and thus were constrained by their place in society – considered different from men, usually weaker, and often inferior. The male physician they faced was part of an influential profession, and his class position represented public power. Could such a man listen to his women patients as effectually as to his men patients, or would he see in women's bodies the concrete expression of female inferiority and subordination?[18] In the interaction between male (or even female) physicians and female patients, how much choice did the patients have? How much agency could they exert? While no general answer can be given – it certainly depended on the woman and the physician – patient agency did exist. Women often controlled whether and when they would see a physician, and they sometimes supported the increased medicalization of their lives. Just as physicians were a product of their society, so were the women they treated. Many regarded medicine as the rescuer of the ill; they believed in the objectivity of medical science and often subscribed to the social conventions that determined woman's role in society.[19]

Just as women exhibited agency, physicians experienced constraints in their practice, although feminist scholars have not been quite as willing to detail them. In Canada, most physicians were general practitioners who were overwhelmed by the demands of busy and varying practices. Many travelled long distances to see their patients and were not always paid well for doing so. They worked within the context of a professional culture that demanded that they act in a certain way. If affiliated with a hospital, they needed to respond to its regulations. Legal obligations also constrained their actions, as did their personal and moral views.

Many of the themes in the wider literature are present in this study of childbirth. I argue that reproduction itself was (and is) in part socially constructed and that it tells us much about the culture in which it occurred.[20] Even the most 'natural' childbirth

had rituals surrounding it that changed greatly over the first half of the century: who was present at the birth, what constituted a normal birth, how long a woman stayed in bed after giving birth, and so on.[21] Doctors had a very specific view of pregnant women, which stemmed from the wider view of women in society. Their medical training emphasized the problematic nature of women's bodies, a reflection of the more general societal belief in the inferiority of women. Both views influenced the medical treatment of women experiencing childbirth.

As well as being partly socially constructed, childbirth is a physiological process, and an understanding of it is necessary in order to appreciate physicians' response to it. Pregnancy lasts approximately nine months, although variations from that average can be considerable. Spontaneous labour begins with one or more of the following signs: a 'show,' or passage of small quantities of blood-stained mucus from the vagina; rupture of the amniotic sac (or bag of waters); and 'true' labour contractions. Physicians tend to see this as the beginning of the first stage of labour. During this stage, the uterine muscles contract and the cervix becomes thinner and more open. The length of this process of dilation varies considerably from patient to patient. What doctors refer to as the transition to the second stage of labour is characterized in general by the woman's urge to bear down and may also be accompanied by symptoms of nausea and temperature fluctuations. The second stage is when the most intense contractions occur, the cervix is fully dilated, and the woman bears down with each contraction to help expel her child. Once the baby has been expelled, the placenta becomes detached from the uterine wall and is also expelled.[22]

In addition to emphasizing the social interpretations of birth over its physiological nature, two other themes are central to this book. First, there is the contingent meaning of words such as *science, natural, normal,* and even *body*. But to signify this by the frequent use of quotation marks would introduce a visual messiness to the page, so I have not done so. What I have done is to point out the apocalyptic language that physicians sometimes used when trying to convince pregnant women that they should

follow medical advice. Physicians' use of binaries to emphasize the value of what they had to offer – civilized as opposed to primitive birth; educated as opposed to midwife care – was an additional language stratagem. Second, as with much of the literature on childbirth, I have had to recognize how and in what ways childbirth became more medicalized in the years under study. Pregnancy itself came under close scrutiny, and this affected the relationship between a pregnant woman and her physicians and indeed created that relationship through the various prenatal visits.

As I was researching and writing, my fascination with the medical profession increased, not just with what it was doing and how it viewed childbirth but why it did so. In many respects my work is part of a continuum of studies on the medical profession in Canada. Early studies viewed the subject very much from within the profession, emphasizing the heroic aspects of early medicine, the rise of professionalization, the great medical discoveries, the histories of medical institutions, and the biographies of medical practitioners.[23] With the emergence of social history in Canada in the 1970s and 1980s, historians became more critical of the profession, and in studies on women and their contact with medicine they emphasized the way in which medicine saw and treated women. In other words, they examined medicine from without. In recent years, historians have been at pains to find women's agency.[24] In some respects my work is a reflection of the older studies that focused on the medical profession and its treatment of women. However, I do not see the profession as a monolithic group. Indeed, I am intrigued by the internal debates that took place within it. While I recognize the constraints on medical practitioners, I do so not as an apologist for them but in order to further an understanding of why they believed what they did and why they acted the way they did. As part of the research process I became aware of the diversity of doctors, the contradictory nature of some of their beliefs, and their efforts to come to some consensus. They seemed at the same time very uncertain about what they were doing and convinced that they knew best. As Gerald Grob has argued,

> As human beings we generally inhabit two different worlds simultaneously. The first is characterized by contingency, indeterminacy, and an inability to comprehend or control the numerous variables that shape our environment; our judgements, analyses, and actions often represent a pragmatic response to a seemingly intractable and partially incomprehensible universe. The second is an imaginary and idealized world – one characterized by certainty and clarity, and where pure and precise knowledge leads to a kind of understanding that enables human beings to cope with or solve perennial problems. The static nature of this idealized world fosters the illusion that the creation of a veritable utopia is within reach.[25]

Doctors sought certainty in a field in which little existed, and they did so in several ways, including the above-mentioned use of language.

In looking at childbirth, I am analysing the structure of medicine rather than the motivation of individual physicians. The treatment that physicians gave varied, depending partly on when and where they trained and where they practised.[26] Nevertheless, the physician represented the point of contact between the individual and the medical system, although he (and most physicians throughout the first half of the century were male) may not represent the contact between the individual and health care. The purpose of this book is not to blame anyone but to point out the consequences of certain types of perspectives. There were particular ways in which medical practitioners examined issues, saw problems, and described what they did. My aim, in part, is to illuminate some of these and to make the reader more aware of how doctors as a group worked. I am not suggesting that physicians in the past should have renegotiated a new type of medicine; there is no value in taking such a position; it would be redolent with historical presentism and arrogance. Rather, my purpose is to see how physicians worked in their world. Our distance from that world allows us to be aware of what they may have been unaware of. All of us have a view of life that allows us to cope with complexity, but sooner or later this view comes

against the reality of the complexity, and that is when change is possible and – in the case of medicine – when criticism of it occurs.

And it is very easy to criticize. Yet it seems to me that often historians have created a new binary with their criticism. We have juxtaposed Western medicine against a romanticized view of how we think medicine should be. With respect to childbirth, we have romanticized midwives in particular. Certainly, many of the women who assisted other women in birth were deserving of admiration. They worked long hours for little pay. They provided care, comfort, and tangible support, and they intervened in childbirth less than physicians did. But some midwives intervened considerably and dangerously. Too often we have compared the best midwives to the worst physicians.[27] Too often we have overly dichotomized (bad) intervention and surveillance and (good) natural birth.

In the introduction to *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*, I tried to address the reason for doing a study of Canadian medicine when it could be argued that Canada was part – and perhaps not a particularly important part – of the Western medical world. There is no doubt that Canadian physicians were influenced by trends elsewhere. Their reading of the international literature was considerable. Nevertheless, to see what they were doing only within an international context is, I think, a rather provincial and limited view. It ignores the importance of place, and as the narratives of many Canadian practitioners reveal, their place of practice was a crucial factor in the medical care they could offer. Yet the call to compare the Canadian situation with that of the United States and Britain refuses to disappear. For that reason I have made some effort to tell readers what was happening elsewhere. Perhaps, as a result, some future anonymous reader of a British or American study will offer the novel critique that it should go beyond its national boundaries and take Canada into consideration!

I do not consider *Giving Birth in Canada* a definitive work by any means. To understand the nature of medical and patient choice, we need to know much more about what alternatives to

medical care existed and what understanding women had of their own bodies. Rather than detailing all the variations and shifts in treatment, I have tried to illuminate some of the trends and processes underlying treatment. In examining the first half of the twentieth century, I have chosen to focus on years that most historians of childbirth have not examined. These were years of tremendous change. In medicine, the century began with a profession practising very much as it had in the latter years of the nineteenth century. However, more rigid standards in medical education were soon implemented, and expectations of the ability to deliver curative health care increased with the discovery of insulin in the 1920s and the introduction of antibiotics by the 1940s. Nevertheless, practitioners were hard-pressed to meet those expectations. The influenza epidemic at the end of the First World War revealed the weaknesses of the health system in Canada and led to the establishment of the federal Department of Health in 1919. No medical response could offset the broader attacks on health caused by the Great Depression of the 1930s or the challenges of the Second World War – which, at least for Canadian service people, was not as horrific as that of the Great War of 1914–18.

For women's lives, the changes that would come in this half-century were difficult to imagine when the twentieth century dawned. In 1900 Canadian women did not have the vote, very few married women worked in paid employment, birth control was illegal, and while birth rates were generally in decline they were still significantly higher than they later became. A woman's prestige was very much linked to her maintaining an image of moral rectitude. Her status was closely aligned to her maternal role – indeed, motherhood was deemed to be her primary purpose. Canadians believed that the urge to mother was instinctive; it was natural for women to want to be mothers. In 1911, Lucy Maud Montgomery's reaction on discovering that she was pregnant for the first time was perhaps overly romanticized, but it was one with which many Canadian women would have identified: 'I want to have a child – something to link me with the future of my race. I want to give a human soul a chance to live

this wonderful life of ours. I want something of my very own – bone of my bone, flesh of my flesh, to love and cherish.'[28] Motherhood was women's defining social role. It was the source of their prestige; and to be worthy of it, their commitment to mothering had to be total. Other aspects of their lives and experience had to either take second place or be eliminated altogether.

In the early years of the century, higher education, women's rights activism, and women's labour were all suspect.[29] For example, critics argued that education raised women's sights to something other than their maternal responsibilities. Some physicians feared not only that educated women were more likely than their uneducated sisters to reject maternity, but that education altered the experience of maternity and made it more difficult.[30] The First World War caused some, but certainly not all, to change their views about these matters. The war brought most adult Canadian women the right to vote; it even forced Canadians to accept the significant involvement of women – including many married women – in the workforce. However, the return of peace, the desire to forget the war, and the urge to make up for the lives lost in the conflict and in the influenza epidemic that followed meant that women's childbearing role was reemphasized.

Throughout the period under study, many people contined to see having children as the purpose of marriage. A 1935 medical text argued that women who made a conscious decision not to have children or could not have children should not have the right to marry.[31] Emily Murphy, one of Canada's leading advocates for women's rights, told her women readers in *Chatelaine* that without children a marriage was no more than 'an agreement between a flirt and a philanderer.'[32] The United Church of Canada believed that no marriage 'built on the refusal to bear children [was] a complete marriage.'[33] Childless marriages were unhappy marriages. When in 1947 a woman wrote an article in *Chatelaine* claiming that she did not want to have a child, readers greeted her words with consternation and then with relief when she later recanted.[34] By emphasizing the natural or instinctual aspect of motherhood, commentators aligned it with the biologi-

cal. In doing so, they removed it from women's agency. In motherhood, women became grouped, generalized, essentialized.

But such essentialism was not of concern to most Canadians. While they had learned to accept higher education for women and the desire of single women to work, they were still uneasy about the employment of married women. Statistics showed that infant mortality was higher for children whose mothers worked than for those whose mothers did not.[35] During the Depression of the 1930s, many Canadians raised the concern about women, especially married women, taking jobs away from men. And, of course, the issue of working mothers became especially cogent during the Second World War, when the government of the day recruited mothers into the war effort and expected future mothers to engage in work traditionally done by men. While Canadians acknowledged the necessity of both, they expressed concern that in order to win the war they might be squandering their future.[36] After the war, although the government as well as the opinion makers in society encouraged women to withdraw from the workforce, by the 1950s labour-force participation rates for married women were increasing.

The irony is that, at the same time, birth rates were rising, with the beginning of the baby boom. The boom was particularly obvious because birth rates had been in a continuous decline since 1900. This decline had been accentuated by the economic woes of the 1930s, to which Canadians had responded by not getting married, by delaying marriage, or by not having large families. The decline ended with the Second World War, which brought full employment and caused a psychological shift away from delaying personal gratification. The end of the war simply emphasized this trend, which was strengthened by the desire of Canadians to focus on home and family.

Despite the decline of the birth rate from 1900 to the early years of the Second World War and its subsequent rise and then explosion, the legality of controlling fertility had altered very little. True, by the interwar period a birth control movement had emerged, and it had achieved some success in the courts. But the law of the land was unchanged – birth control was illegal. Child-

birth remained a central experience for the vast majority of Canadian women.

What follows is a description of how physicians treated women in childbirth. The first chapters set the context by providing the reader with an overview of medicine and obstetrics. Because so much of the historical literature has juxtaposed midwife-directed birth and physician-directed birth, I thought that a chapter on midwives would be appropriate; it provides a comparative basis for those that focus on regular medicine. The latter follow a woman's birthing experience from the diagnosis of pregnancy, through childbirth and its complications, to the postnatal period.

My focus is on the English-speaking regular medical profession in Canada, and the sources used for this study consisted of the following: textbooks assigned to medical students in the major Canadian medical faculties; the Canadian medical periodical press; popular medical advice books written specifically for nonmedical people and read in Canada; popular medical literature published in women's magazines; the patient records of a number of hospitals; interviews with women who gave birth during the period under study; and interviews with a number of physicians who were trained or who practised medicine during these years. As with any source material, each has its strengths and weaknesses.

One characteristic of the medical textbooks is that most were not Canadian. Canadian medical schools assigned predominantly American and British texts to their students. There were few textbooks written by Canadians, and those that did exist were not always under a Canadian imprint. The textbook authors tended to assume that their readers either were or would be urban practitioners, although occasionally they recognized the specificity of rural practice. Nonetheless, the textbooks are a central source, for they represent what Canadian medical teachers chose to have their students read. Textbooks represent the orthodoxy of the medical profession. As Nelly Oudshoorn has argued, they reflect not only the latest research but also the 'representation [of] a new reality.'[37] The evidence indicates that most physicians practised according to that reality.

The articles in the Canadian medical periodical press support this evidence. They are full of communications from Canadian physicians across the country, summaries of conferences attended, editorials on the major medical issues of the day, and reviews of the latest publications, as well as articles reprinted from other medical journals which the editors believed to be of interest to their readers. Unlike the textbooks, the articles allowed the average practitioner to have his say, and it is remarkable how many physicians from rural and small town practices found the time to describe their medical beliefs and work. Nevertheless, there is little doubt that the urban medical elite, predominantly from teaching hospitals, had pride of place. Yet regardless of who the authors were, the communications provide detailed descriptions of cases, which enable the reader to compare what some practitioners were doing with what they had been taught to do, as represented by the medical textbooks. The periodical medical press was impressively energetic during the first half of the twentieth century – there were more than seventy English-language publications. Many did not last long; some were continuations of others under a different name; still others were very specialized in their perspective.[38] The value of this literature is that it was the major forum for physicians in Canada to communicate with one another and to raise issues about what concerned them. It was written by and for physicians.

The difficulty with both the medical textbooks and the medical periodical press is that they were public forums, even if the public was only other physicians. Consequently, they tended to describe the unusual case rather than the usual, to put forward new ways of doing a procedure, or to debate the old ways. It is not always easy to get a sense of what practitioners were actually doing in their practises. The cases related in the periodical press do help overcome this problem, but even more valuable are the patient records of hospitals (both large and small) and private practices. These records represent a treasure trove for the historian of medicine, for they allow her to get closer to what physicians actually did in the past, rather than relying on what they said they did or what they recommended to others. I was very

fortunate in being given access to records from several hospitals, but there is little doubt that, for some administrators, the issue of access was a difficult one. Final agreement was reached only because I made it clear that I was not interested in using the names of patients. Instead, I have invented names that reflect the patient's ethnicity, keeping the same initials. In doing so, I have maintained confidentiality without making the new mothers appear anonymous.

Another source that helped focus more attention on the patient was the popular medical literature: books written with patients in mind, and medical articles published in women's magazines. Both sources were excellent reminders of the relationship that always existed between the patient and her physician. They provided me with the opportunity to see what women were reading about pregnancy and childbirth, and how the advice was couched when they, rather than medical professionals, were the recipients of it. This literature is popular because, in the words of one historian, 'it does not have to persuade – it does not innovate– it addresses readers who are ready for it.'[39] This was particularly true for the women's periodical press. The circulation figures of the women's press was impressive. The *Canadian Home Journal*, for example, had a circulation of over 52,000 in the mid-1920s and over 250,000 in 1940. *Chatelaine*, the premier Canadian women's magazine, had a circulation of over 70,000 in its first year of publication (1928) and over 252,000 by 1940.[40]

What was particularly rewarding about doing the research for this project, compared with my previous work on the nineteenth century, was the opportunity to conduct interviews. There was no pretence of doing so in any systematic manner. Rather, what sociologists refer to as the snowball effect (using word of mouth, etc.) was the 'method' utilized. The physicians interviewed were always open about their own training and that of others. They appreciated the changes that had occurred over time and believed that most had been for the better. At times, they suggested areas where their own practice of medicine had deviated from what they had been taught, thereby emphasizing a central tension in the profession. Hearing the accounts of women about

their birthing experience was a constant reminder of the patient's view, a needed counterpoint to the medical perspective that dominated most of the published literature on birthing. The women's memories were insightful, often ironic, and sometimes funny, but always heartfelt. They reminded me, as nothing else could, of the centrality of the childbirth experience for their lives.

While my focus is on regular medical practice, I have attempted to introduce the experience of other birthing models (whether First Nations or midwifery) to remind the reader that there is always another way of doing things – even of having a baby. Physicians were aware of these models but saw them as something more than different. They created a hierarchy of birth practices, which at times they racialized. They differentiated between 'civilized' and 'primitive' women in childbirth and attached significant meaning to those differences. In doing so they too acknowledged, at least in part, the constructed nature of childbirth.

CHAPTER ONE

The Uncertain World of Medicine and Medical Practitioners

We look with condescension on mere empirical knowledge as differing in kind from scientific dicta. Actually 'science' tells us nothing, but is itself integrated from empirically established facts. It changes constantly, both in scope and content.

F.B. Exner, 1951[1]

Medicine in Canada in the first half of the twentieth century was a profession full of tension. Its practitioners aligned themselves with science in their use of a specialized language, in their increasing dependence on technology, and in their insistence on standardization. Each of these provided an element of certainty to what physicians did, and many historians of medicine have recognized them as reflections of the development of the profession, for good or ill. Less acknowledged is that some physicians questioned the emphasis on science, at least in comparison with the art and practice of medicine. Nonetheless, the tension between medicine as science and medicine as art was negligible compared with the stresses caused by the world in which physicians worked, a world that was less than scientific and full of uncertainty. It is these stresses and uncertainties that historians of medicine, especially historians of the medical care of women, have generally overlooked. Yet they are significant if we are to understand why physicians acted in the way they did, why they emphasized the certainty of what they had to offer their patients,

and why they were so categorical about their advice. In part, such behaviour was a reflection of their belief in science and its validity. In part, it was a way of overcoming their own uncertainties and the challenges facing them as practitioners.

In addition to the perennial science-versus-art debate in medicine, several other issues confronted physicians. First, the growing dominance of hospitals in the medical care system challenged the individual physician and his ability to control his practice and his status within the profession. At least in the medical literature, hospitals were becoming a focus of attention: they were where exciting medicine took place. Second, while medical history has emphasized the way in which the allopathic approach gained a monopoly over who could call himself doctor, alternative forms of health care and caregivers still existed. Their continuance was a constant reminder of competition, but it also evinced the unwillingness of Canadians to embrace Western medicine as the only acceptable health modality. Third, many doctors believed they had received insufficient training as medical students: when they entered practice they became aware of how much they did not know. Fourth, within medicine itself various practitioners were sensitive to how their own colleagues competed with them. Of particular note was the rise of specialists and the overwhelming emphasis which the published medical literature directed at them. In reading the literature, rural practitioners could easily become aware of the gap between a well-serviced urban practice and their own.

Finally, the very nature of medical practice had its own difficulties, and many practitioners believed themselves to be overworked and underpaid. The relations between physicians and patients were always challenging, and although critics of medicine have emphasized the discrepancy in power between physician and patient, patients were not without agency; in expressing it, they could appear to be rejecting what physicians had to offer them. The patient-doctor relationship was a site of contestation and negotiation. When the patient was a woman, the power of the physicians loomed even larger. Even so, some physicians were sensitive to the power their women patients held over their

practices and were aware that the women could pose a threat to their image of respectability. This chapter introduces the world of medicine and the physician in Canada – on the surface a secure world, but one that was changing, often presenting medicine's practitioners with doubts and uncertainties.

Physicians worked within two worlds. The first was the construct of science. Positivist in nature, it reduced reality in order to study it through experimentation, and it formalized knowledge into cause and effect relationships. The second consisted of the physician's medical practice, where on a day-to-day basis he faced the vagaries and contradictions of human lives.[2] D.W. Cathell preferred the former world and criticized patients, especially women, who apparently rejected it. In his turn-of-the-century book *The Physician Himself and Things That Concern His Reputation and Success*, he contended: 'The real secret why so many truly scientific physicians ... very often decidedly lack popularity, and fail to get much practice, is that cold, unemotional, impassive logic ... [is] often associated with a deficiency of the qualities of head and heart which appeal to the weak side of woman – *her emotions*.'[3] For Cathell, lack of emotion was the strength of scientific medicine. Yet there were problems. Dr D. Mackintosh from Pugwash, Nova Scotia, feared that the 'impassive logic' so esteemed by Cathell caused patients to have overly high expectations of medicine. Science endowed medicine with an aura of certainty which neither it nor its practitioners could meet. In trying to meet it, Adam H. Wright, professor of obstetrics at the University of Toronto, worried that too often the art of medicine suffered; the danger, he said, was that the science of medicine worked to the detriment of patient care.[4]

Despite such concerns, the science of medicine seemed to be winning out over the art of medicine. Medical faculties in the interwar period increased the scientific component necessary to enter medical school, and advertisers appealed to the science of medicine to sell their products.[5] Private citizens, too, recognized that they were living in a scientific age. In 1925, Lucy Maud Montgomery wrote in her diary about what she saw as the decline of the church and asked herself, 'But suppose it does die.

What matter? It has served its day as God's instrument. He is using another now – Science. Through Science the next great revelation will come.'[6]

Not everyone was happy with the way science was dominating medicine. In 1926 Dr Harold Atlee, professor of obstetrics and gynaecology at Dalhousie University, questioned the emphasis given to the theory of medicine over its practice. The practice of medicine was what doctors did, he said, yet in medical school the students seemed to shirk the practical clinics so that they could concentrate on book learning to pass their exams.[7] Atlee did not advocate teaching less theory but wanted more time devoted to the clinical side of medicine. Any suggestion to lessen theory would have appeared to be an attack on the science of medicine, which had become the watchword for progress and modernity in medical practice. F.B Exner, in his *The Nature of Medical Practice* (1951), caught the contradiction within medical science best: 'We live in a "scientific age" and we bow in abject worship at every invocation of the holy word "Science." We tend to forget that this sacred Frankenstein is a man-made and rather amorphous structure composed of all the things we think we know – and includes all the things we know that are not true.'[8] Long before the term was coined by social historians, Exner was arguing that science and thus medicine were socially constructed.

Twentieth-century medicine aligned itself with science in three ways: through language, technology, and insistence on standardization. Scholars have argued that specialized language exemplified scientific medicine in the twentieth century. It separated both the medical practitioner and his practice from the vast majority of patients who utilized health care. Medical language helped insulate physicians from the emotional world of patients, their friends, and relatives. It distanced them from the world outside medicine and helped make medicine a somewhat closed world in which contradictions were difficult to acknowledge. Patients and physicians spoke two different languages of the body. But as scholars have also suggested, even more than using a different language to explain the same thing, medical language constructed a different way of looking at and thinking about the

body; it created 'a new world altogether.'[9] Ruth Hubbard has written revealingly on how science has deleted the person, the humanness of who did science. What was observed became more real than who did the observing.[10] What the scientist observed became a subject in its own right, and this removed it from attacks of bias. At the same time, the language of medicine was (and is) very rich metaphorically. Medical writers depicted medicine as coming to the 'rescue.' Physicians engaged in a 'war against disease.' Doctors used apocalyptic images and warnings to ensure that their patients followed recommended treatment.[11]

The use of technology also distanced the medical practitioner from his patient. Expensive technology, once purchased, demanded to be used, with the result that cheaper alternatives might disappear from practice.[12] The expansion of technology in medicine is easy to track. The coming of x-ray machines to small hospitals, such as the Owen Sound General and Marine Hospital in 1918, was a major event in their histories. The use of such machines generated money for hospitals, and they were ways in which individual institutions could distinguish themselves from one another and assure their patients that they had something special to offer. The availability of technology became the measurement of a good hospital.[13] As a result of technology such as x-rays, and through procedures that allowed surgeons to explore almost every cavity of the body, physicians became more intimate with some parts of their patients' bodies than their patients themselves were. Add to this the fact that patients did not have the specialized language to explain what it was they were experiencing, and the result was, in the words of one critic, that medical science 'owned' the study of the body.[14]

Western medicine viewed the body as a machine that should run properly. When it did not, that indicated illness or an unhealthy state. Even Dr Wilfred T. Grenfell, whose missionary work in Labrador and Newfoundland was renowned, could advise his readers in his 1924 book *Yourself and Your Body*: 'Remember that it is all machinery; and it is all the machinery that you have, and if you spoil it, you can never have another set.'[15] Such a perspective left little room for emotional or spiritual aspects –

which, given Grenfell's evangelistic persuasion, was ironic. But ironic or not, it underlined how physicians argued in books designed to be medical in orientation.

Linked to the mechanistic view of the body was the belief in the ability to measure its functioning. In Western medicine, the ability to measure what the body did through instrumentation is central, and it had become key to doing science by the mid-nineteenth century. What was important was what could be measured. This was true in the wider society as well.[16] Not just anyone could take measurements. For example, Dr Frederick Fenton, an associate professor in obstetrics at the University of Toronto in 1906, warned his colleagues not to depend on the pelvic measurements of women taken by nurses. Only someone familiar with the anatomy of the pelvis and abdomen – namely, a physician – could be trusted.[17] Measurements had to be accurate; decisions about treatment depended on them. Measurement established the standards of how healthy bodies worked – the average experience. But problems could arise when the average or normal experience became equated with the healthy experience.[18]

Measurements lent an element of certainty to what physicians did. Certainty, or at the very least a sense of confidence, was crucial for their ability to function, since they often worked in a very uncertain field. Much of a physician's skill came from experience and an intuitive sense of what might ail a patient or what might work for a patient. Each individual had his or her own responses to illness and to medication. Medication might work, but the reasons why it did were not always clear. What should work might not. Faced with such uncertainty, physicians tried to create a world of certainty or at least an aura of certainty. Measurements were hard facts, concrete indicators (once there was agreement on what they indicated). They took the art (uncertainty) out of medicine. The results of monitoring the body were dependable, whereas the patient's experience was not. Measurements allowed physicians to remove the responsibility from themselves as individual practitioners and to place it with the medical collective, which had agreed on what the measurements meant.

For some physicians, measurements became a substitute for the art of medicine and a means by which to 'read' a patient. An 1934 editorial in the *Nova Scotia Medical Bulletin* expressed concern that the medical student of the day was becoming too dependent on the 'accessory aids to diagnosis – the X-ray, blood tests, bacteriological examinations,' to the detriment of 'keen observation.'[19] Such aids constrained the medical imagination. They encouraged belief in certainty. Nowhere was this expressed more explicitly than by Montreal physician Dr A.H. Gordon:

> In the pursuit of pure science absolute accuracy is our goal, and a large part of science consists in *measurement*, and measurements of form, size, colour, density, length, breadth, strength, are the processes which occupy much of our time and energy in the pre-medical and primary medical years of our apprenticeship. Normals are established, and from these judgements are formed, and in the attempt to bridge the gap between pure science and its practical application in clinical medicine and surgery we presume to establish normals for man and for his various systems, and by the methods of clinical medicine we attempt to recognize the deviations from these normals. We recognize sensations of heat and cold, colour, sound and tension through our special senses, and assemble the results and adjudicate upon them. To these are then added other impressions through the special senses, conveyed by instruments of precision, and all of these together constitute our foundation in fact.[20]

The acceptance of and dependence on measurement, medical language, and machines resulted in conformity and standardization. This was not necessarily bad – standards protect patients. But once standards of health or illness were in place, they were difficult to shift. Also, associating health with what is normal or standard may not be advantageous, since what is normal in a society may not be healthy. Also what is normal for any one person is constantly shifting.[21] Nevertheless, standardization of treatment (or its encouragement) was part of medical culture. Trained one way as a medical student, it was not always easy for

a physician to change.[22] If he did, it could call into question the treatment he had given patients in the past, resulting in heightened levels of uncertainty and insecurity.

The increasing importance of hospitals added to the push for standardization. The expansion of hospitals in the first half of the century was partly a response to the increased technological orientation of medicine – the hospitals housed the machines. Hospitals were also where the elite of the profession practised and set standards for private practice. In the nineteenth century, most hospitals had been started as charity institutions, designed to care for the poor. As a result, there were not many of them. In 1890, for all of Ontario, there were only twenty public general hospitals in fifteen communities. But by 1922 Ontario had 122 public hospitals, including 10 sanatoria for consumptives, and in 1944 it had 116 general and 25 Red Cross hospitals. In Saskatchewan before 1900 there were few hospitals except nursing homes. By 1920 the province could claim 35 hospitals, and 23 more were built by 1930. In Canada as a whole there were 481 public general hospitals in 1929; four years later the number was 589. By 1952 there were 730 (including paediatric), and the total number of hospitals of any kind was 924.[23] The hospitals also were becoming standardized. In 1921; a hospital accreditation program began. It originated with the American College of Surgeons, which defined the minimum standard to be met by all hospitals with which its members were affiliated.[24] This was a powerful incentive for Canadian hospitals to measure up. In addition, if specific hospitals wanted to maintain their ability to teach either interns or nurses, they had to conform to the interwar period's new demands for modernity and efficiency.[25]

Not only were there more hospitals, but they were increasing in size. The Royal Victoria Hospital, in Montreal, was fairly typical of a large urban hospital in its growth pattern. In 1901 it admitted 2,579 patients; in 1915, 5,421; and by 1934, 13,307. Although numbers were incredibly large in the 1930s, officers of the hospital were concerned about occupancy rates. In 1935 the hospital reported an occupancy rate of only 65 per cent, the lowest for several years. The Depression was having its effect as

potential paying patients put off hospital care, which they felt they could no longer afford. Outpatient clientele, however, had increased. The low occupancy rates ended with the Second World War, when overcrowding became a problem for many hospitals.[26]

The expansion reflected the increasing use made of hospitals by the middle classes, for hospitals had widened their appeal. They were vocal in their insistence on aseptic conditions; they basked in the reflected glory of medicine's rise in status, a result of new discoveries such as insulin. The increase in surgery, and complex surgery at that, could best be done in an institutional setting that provided both technological and personnel support. The attractiveness of hospitals also reflected the decreasing size of homes large enough to care for the sick and the decline in the percentage of families with domestic servants who could help with the care. Some analysts have also speculated that the increasing emotional intensity of the twentieth-century family meant that illness within it became a dysfunctional factor that was lessened by removal to a hospital.[27]

Linked to middle-class use of hospitals was the rise in paying patients. In 1906 the Kingston General Hospital had 886 ward patients and 457 paying patients. In 1915 the numbers were 1,500 and 1,200, respectively. By 1917 paying patients constituted the majority – 1,663 compared with 1,473 ward patients. At times, the breakdown does not give the full impact of the shift. In looking at the number of paying patient days, the annual report for 1927 noted that they had increased 20 per cent from the previous year, whereas indigent patient days had increased only by 15 per cent. The Depression years saw a reversal of the trend. In 1934 there were 42,485 public ward patient days compared with 27,476 private and semi-private ward patient days. The annual report for that year warned: 'Since 1930 the public service has increased by over 30%. At the same time the private and semi-private service has decreased by about the same proportion.'[28] With the return of economic prosperity, the situation again reversed itself, so that by 1947 there were 39,061 public ward patient days and 85,601 private and semi-private ward patient days.[29]

Hospitals were not only growing in numbers and size; they were also becoming increasing complex, as reflected in the expansion of departments and the variety of ailments for which people were being admitted. As well, the orientation of the hospital had shifted. In the early years of the century, hospital care was generally divided between medical and surgical, the former being predominant. Soon the latter became the primary focus of hospital admissions, with medical perhaps being represented increasingly by outpatient departments and services. This followed a more general and wider sensibility within the profession, both in Canada and elsewhere, which adopted the surgeon's traditional focus on external diseases such as tumours as a model for internal diseases. As Ornella Moscucci has argued, 'Efforts were made in order to render internal diseases accessible to the senses, as was the practice in surgery, and increasing emphasis was placed on instrumental and surgical interference in diagnosis and treatment.'[30] At the turn of the century, the Victoria General Hospital, Halifax, divided its eight attending physicians and surgeons equally between the medical and the surgical divisions. In 1920–1, however, there were 424 admissions to the medical division but 1,650 to the surgical. This imbalance continued and by 1938–9 there were 982 admissions to the medical division, equally divided between the sexes, whereas there were 4,210 to the surgical with women numbering 2,278.[31] Surgery had become the predominant aspect of hospital practice. A 1917 text described it as follows:

> The performance of a surgical operation resembles the conduct of a military campaign. Special knowledge and prolonged training are required on the part of the principals – the surgeon and his assistants; the implements employed must be familiar to those who use them, and must be got ready with minute and scrupulous care; the environment must, if possible, be selected to the greatest possible advantage. The actual operation demands skill, courage, prudence, and resource; the campaign is not ended with the closure of the wound, but must be pursued without slackening until the decisive result, viz. the recovery of the patient, is assured.[32]

One consequence of the increase in surgery was a decrease in time spent in hospital, because diseases were not allowed to run their course. The push toward paying patients was also a factor, as was better nursing. Montreal General Hospital patients stayed an average of 21.2 days in 1901, 17.8 days in 1920, and 16 days by 1940.[33] Public patients stayed longer than paying patients. The difference between the two reveals that the nineteenth-century charitable legacy had not been forgotten. Non-paying patients may have arrived at the hospital sicker than paying patients and thus needed more time for care. And since they did not have the same access to supervised care at home, they stayed in hospital longer to ensure their recovery.

Hospitals added to the aura of medical practitioners because it was they who determined who could be accepted as a patient. Yet the rise of hospitals and their increasing dominance could increase an individual practitioner's anxiety. Was he good enough to receive hospital-admitting privileges? Hospitals helped create a medical elite: ambitious practitioners wanted to be on the staff of teaching institutions. In a hospital setting, the daring surgeon could find the support he needed as well as patients. Despite the fact that most medical care took place in private practice, the hospital practitioner, especially in teaching hospitals, became the focus of attention. He set the standard; he could train disciples. If that was not enough to make some in private practice feel somewhat insecure, there was also competition from other health providers who offered Canadians medical advice and assistance, challenging the hegemony over health care which doctors believed was their right.

Not everyone subscribed to the Western medical paradigm of medicine. In Canada, the First Nations had their own medical system. Franz Boas found that three types of healers existed among the southern Kwakwa *Ka*'wakw (Kwakiutl) people at the turn of the century: one healer could locate disease in the body but could do little about it; another could cure patients by building up their supernatural power; the third and most important could cure individuals and actually throw off or extract the disease from them.[34] Each First Nation or group had its own arsenal

of medicine depending on where they lived and what was available. It is just as well that they did. Even though the health of First Nations people was a federal responsibility, Ottawa shirked its duty. In 1934 Ottawa's health costs spent on Native people amounted to $9.60 per capita; on non-natives, $31.00.[35]

Alternatives to regular medicine abounded in mainstream society. Folk medicine remained very popular even when regular medicine seemingly was increasing its sway. At the turn of the century, in Brigus and Brigus Gullies, Cape Breton, the local midwife, Mrs Hazel Way, recalled: 'If you wrapped a herring around your neck you could cure strep throat. The finbone of a haddock was supposed to charm away a toothache.'[36] A schoolteacher in Quebec in 1939 noted a remedy for unwanted hair: 'Have someone give you a piece of fresh pork and rub it on the part where the hairs are to be removed and bury it in the ground (where it is left to rot) and say, "Cursed hair, remove yourself just as the devil removes himself from the sight of God and never come back again, never, never, never!"'[37] People learned to cope when doctors were not available. One woman recounted the situation on the Alberta frontier:

> I can remember Homestead's little boy when he was born. He was only two pounds. Now what do you do with a premature baby back in those days? Well, this Mrs. Lind was a Swedish woman, and they lived about six miles from us. Mrs. Homestead was at her place when the baby arrived. They rolled him in oil, or maybe vaseline, and into a little white casing right up to his head. I can still see that little tiny head. They put him in a shoebox packed with blankets. Then they put him in the warming oven of the coal stove for an incubator, and kept the lid open for circulation of the air. Mom and Mrs. Lind took turns staying up at night and keeping the heat in the stove just right so that the baby's temperature wouldn't drop. They fed him with an eyedropper. They had him six weeks in that warming oven and Mrs. Lind didn't dare bake bread because the stove would get overheated. They built another stove outside with stones so they could save that one little baby. These two women working to save that little baby. And, by jingo, he a great big six-foot guy![38]

Women throughout the country treated their families with remedies proven by experience. Most homes had their medical manuals. Some were written by physicians; others not. But all emphasized that the mother was to be nurse and doctor, not only when there were no doctors nearby but even when there were. In 1932 an article in *Chatelaine* stated: 'It is of paramount importance that every woman, especially mothers, should know what remedies to use in the treatment of slight ailments – little matters for which a physician would not be consulted but which, if neglected, may lead to grave disorders.'[39] Only when the family could not care for sick members or did not know how to respond to illness was a physician called in.

Patent medicine was also readily available, advertised in newspapers, magazines, and Eaton's catalogue. A 1918 article signed 'A Medical Man' complained that for every dollar earned by a general practitioner an equal amount was spent on patent medicines or given to alternative practitioners.[40] While some physicians were concerned about the ingredients of patent medicine and their dangers (many contained cocaine, strychnine, opium, or alcohol), their popularity testified to people's belief in their efficacy. Throughout the 1920s Canadians could still purchase old standby tonics: Lydia Pinkham's Vegetable Compound, Dr Chase's Nerve Food, and Siegel's Syrup. Dr Pierce's Favourite Prescription made a special appeal to women who had 'ills peculiar to their sex.' It played on their fear of surgery by stating that women's ills could respond to 'remedies made of herbs [used] by the Indians, among whom operations are rare.' It assured them that the prescription was 'an old, reliable, reconstructive tonic.'[41] As hospital records show, doctors were well aware that their patients took such medicines. Gordon Stiles, thirty-eight years old and a married farmer, entered the Victoria General Hospital, Halifax, on 18 December 1920 complaining about poor digestion; from which he had suffered off and on for the last eight to ten years. His case record noted that he had taken 'numerous' patent medicines. Only when they seemed to fail him had he sought the help of physicians, one of whom sent him to hospital.[42] Since physicians usually saw people when the patent medicines did not work, it is not surprising that most opposed them.

Physicians were also concerned about the attraction that other healers had, especially among women. Spiritual healing, which became popular in the interwar period, directed attention away from regular practitioners.[43] In addition, more traditional alternative medical systems continued to thrive. Dr A.W. Paskins, director of the Associated Nature Cure & Physiotherapy Institute in British Columbia, wrote to the Royal Commission on State Health Insurance and Maternity Benefits (B.C.) in 1930 requesting that naturopathic medicine be covered. He reminded the commission that not everyone used allopathic medicine. To bolster his claim, he included a letter from a Mrs Byers, describing how she had gone to a physician in St Paul's in 1927 for breast lumps. The physician had provided her with ointment, but the lumps became worse, so he advised surgery. At this point Mrs Byers went to Paskins, who treated her successfully, apparently through diet. When she became pregnant with her fourth child, the physician who eventually delivered her complained that her Paskins diet was starving her child; but despite her doctor's misgivings she gave birth to a healthy 7½ lb. baby.[44] In trying to explain the allure of competing systems of medicine, regular physicians claimed that the public did not understand the rigour of science and associated medicine with 'hocus-pocus mixed with superstition' which, they said, appealed to the 'semi-educated, the credulous and superstitious.'[45]

Although supporters of regular medicine assumed that the physician should have authority, many Canadians wanted ways of improving their health without resorting to doctors. Women often relied on what they had gleaned over the years. Vera McNichol recalled being a child in Kitchener and having flu in February 1920. The doctor did not hold out much hope for her recovery, but her parents would not give up: 'I could not get my breath, so dad took the bedroom window out and mother stretched a white sheet across the opening. Mother, on her own initiative, brought the coal-stove into the hall and fried up onions, which she put into a poultice to wrap my feet in. She rubbed my chest with goose grease with a little turpentine added ... As Time went on I steadily improved until I was able to sit propped

up on pillows.'[46] Women talked and wrote to one another, and news travelled quickly if one found something that worked. The Maple Leaf Auxilliary was a formalized neighbourhood network among the wives of Toronto's machinists, who aided each other in times of sickness.[47] Midwives, too, often offered more than birthing services. These alternative caregivers were competition for physicians, especially the local healers who seldom charged anything, or charged very little.

Even nurses were competitors, though they were not necessarily offering alternative medicine. Many physicians viewed nursing as an extension of the natural female role – mothering. Medical care was learned, rational, and skilled, but nursing care was domestic, intuitive, and considered menial. The fact that, once graduated, most nurses became private-duty nurses emphasized their role as domestic adjuncts. Despite this, some physicians saw nurses' training as a threat to their own status and therefore belittled it. When the University of British Columbia proposed opening a nursing department in 1919, the College of Physicians and Surgeons of British Columbia commented that 'overtraining of nurses is not desirable and results largely in the losing of their usefulness.'[48] In 1920, Eunice Dyke, director of public health nursing for Toronto's health department, told the story of Dr Bryce, chief medical officer for the federal Department of Immigration, who felt that public health nurses were taking too much credit for the decline in infant mortality in the city: 'He insisted recently upon extracting statements from us of other possible factors resulting in the reduction. Finally he remarked, "Don't you think that the weather may account for it?"'[49] Both Bryce's attitude and Dyke's response reflect the tension that at times could exist between physician and nurse. Not that all physicians were so dismissive. Many were more than willing to recognize the knowledge that nurses had. For example, a 1930s medical text pointed out that compared with interns, nurses were much more familiar with therapy and patients' responses to it.[50]

If the mother of the home was the gatekeeper to her family, nurses often were the gatekeepers to medical care. Those working in isolated areas might be the only medical personnel avail-

able. In some of the nursing hospitals on the prairies, the women in charge sometimes performed amputations, appendectomies, stitching, and tonsil and adenoid surgery.[51] Others could decide when a physician should be called. Some physicians' concern about keeping nurses deferential, and their fear of being usurped by them, was particularly strong with respect to public health nurses. These women were the most highly trained of all nurses and were accustomed to working on their own, unlike private-duty nurses and hospital nurses, who were far more under the supervision of physicians. Certainly, some physicians felt that public health nurses were unfair competitors – they were on salary and, unlike physicians, did not have to work as 'businessmen.'[52] Even hospital nurses sometimes seemed to be encroaching on doctors' territory. One nurse working in Glace Bay in the late 1920s remembered that nurses used to deliver babies and give anaesthesia in the operating room.[53] To maintain the division of power between doctor and nurse (of any kind), physicians in the 1920s, through the College of Physicians and Surgeons, attempted to regulate nursing by defining nurses' duties and determining who could be registered as a nurse. They failed in their attempt, but not until the 1950s could nurses themselves fully regulate who could train and be certified as a nurse.[54]

Meanwhile, Canadians continued to use what they believed worked, though they incorporated scientific discoveries into their own medical treatment. Lucy Maud Montgomery, when carrying her first child, followed the exercise regime set down in a medical book for pregnant women. But at the same time she created her own positive-thinking program: 'I have ... a strong belief in the power which the subconscious mind can exert over physical functions. Every night, as I was dropping off to sleep, and frequently through the day I repeated over and over again the command to my subconscious mind "Make my child strong and healthy in mind and body and make his birth safe and painless for me."'[55]

The external challenges to the medical profession were not the only ones that physicians faced. Their own training and colleagues could add to their insecurity. Many felt that their medical