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"Endormez-moi!"
An Early Twentieth-Century Obstetrical Practice in the Gatineau Valley, Quebec

by Jayne Elliott, B.A.

A thesis submitted to the Faculty of Graduate Studies
in partial fulfilment of the requirements for the degree of
Master of Arts in History

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Ottawa, Ontario
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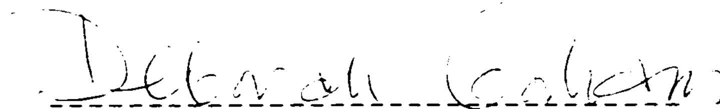
"*Endormez-moi!*"

An Early Twentieth-Century Obstetrical Practice in the Gatineau Valley, Quebec

submitted by

Jayne Elliott, B.A.

in partial fulfilment of the requirements for the degree of Master of Arts



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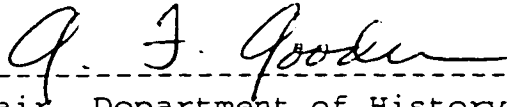

Chair, Department of History

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4 September 1997

Abstract

Following his graduation from McGill University in 1911, Dr. Harold Geggie worked as a general practitioner for fifty-five years in the rural area around the village of Wakefield, Quebec, delivering women at home until the hospital opened in 1952. This thesis is partially a study of the medical aspects of Dr. Geggie's obstetrical practice and is based primarily on his memoirs and the two thousand bedside obstetrical notes that he kept. The research moved beyond the local area to situate this one specific practice into the broader historical context with other known rural obstetrical practices of the late nineteenth and early twentieth century. A small number of oral interviews were conducted with women who were Dr. Geggie's patients, which further helps to shed light on obstetrical care and home birthing before it became almost entirely institutionalized by mid-century.

Acknowledgements

The inspiration for this study came from Harold Geggie's youngest son and daughter-in-law, Dr. Stuart Geggie and his wife, Norma. I thank them for not only providing me with such liberal access to these well-preserved records from their father's practice, but also for their patience and generosity with which they shared his life with me.

I am also grateful to the women, all patients of Dr. Harold at one time, who agreed to talk with me about the births of their children. Whether or not they believed they had anything worthwhile to say, they willingly shared their time, offering a fascinating glimpse into a era that has quickly faded away. Their stories were all valuable.

I would also like to thank Stuart Renfrew from the Queen's University Archives who first pointed out J. Howard Walmsley's papers to me, and Dr. Walmsley's daughter, Kathleen Girard, who agreed to allow me access to his patient records. There is more to be done there.

Dr. Deborah Gorham has been an advisor and mentor extraordinaire, not just for this study but throughout these last few years at Carleton. I have enjoyed sharing my research with her, and have appreciated her calm assurance that I could actually accomplish what I set out to do.

Finally, my family has been ignored but not forgotten; thank you for waiting so patiently until I finished.

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Introduction

Perched high on a hill, the new hospital in Wakefield, Quebec overlooks the village hugging the shores of the Gatineau River below. This modern medical facility replaces the old cottage hospital, a stately manor home in the centre of Wakefield, which at its conversion in 1952, was the realization of a dream for the village's long-time family physician, Dr. Harold Geggie. At the edge of the new hospital grounds the visitor can find a bronze likeness of Dr. Geggie, now sitting in quiet contemplation over the undulating hills and valleys that stretch as far as the eye can see. It was to this territory, the Gatineau Hills, that in 1911 a young Dr. Geggie arrived, and where he remained until his death fifty-five years later.

As a newly-graduated general physician from McGill, Dr. Geggie turned down the offer of a year's internship in a Montreal hospital to spend at least two years as an assistant to an older and overworked general practitioner in Wakefield, a village thirty kilometres north of Ottawa. His 'Preceptor', Dr. Hans Stevenson, died prematurely a short six months later, leaving Dr. Geggie agonizing over whether or not to remain in a community that had not yet fully accepted him. His decision to carry on, undoubtedly influenced by his romantic interest in one of Dr. Stevenson's daughters, was also made easier by his strengthening belief that his services in this rural district were greatly needed.

Other doctors came and went in areas peripheral to the Wakefield area, but until his sons joined him in practice (the first one in 1945) Dr. Geggie worked virtually alone.[1] During this time, he took only two major breaks, one for service in the First World War and the other for an eighteen month study break in England in 1931 and 1932. Dr. Harold, as he came to be known, described himself as a "simple country doctor," but at least one of his contemporaries believed he was "one of the grand old family doctors of Canada,"[2] and in 1958 the Canadian Medical Association awarded him a Senior membership "because he represented so well the physician of the rural areas.[3]

In this study, I intend to investigate in some detail the medical obstetrical care offered by Dr. Geggie. As the community hospital in Wakefield did not open until 1952, most of the births Dr. Geggie attended were conducted in the homes of the birthing women. Obstetrics, just one of the components of a general practice, was nevertheless considered by doctors to be one of the foundations upon which medical work could be built, and by the early twentieth century, rural physicians were realizing that delivering babies was an important avenue into providing medical care for the entire family. If the

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[1] As each of the three sons finished medical school, they joined their father, where they became known as Dr. Hans, Dr. David, and Dr. Stuart, respectively.

[2] William Victor Johnston, *Before the Age of Miracles: Memoirs of a Country Doctor* (Toronto: Fitzhenry and Whiteside, 1972), 159

[3] Obituary, *Canadian Medical Association Journal (CMAJ)* 94 (1966): 1285

woman were satisfied with her treatment during her confinement, the doctor might then be engaged to attend the family's other medical needs.

The national statistics show that not until the 1940s did at least half of the population of Canadian women give birth in the hospital, and the numbers varied widely among the provinces.[4] While much has been written about the interplay between midwives, male physicians and labouring women and their relationship to the development of obstetrical practice throughout the nineteenth century, there is less of an historical record on the first half of the twentieth century.[5] Much of what has been published on this latter period also

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[4] See Table 1, Appendix 2

[5] Much of this literature from the nineteenth-century will be discussed in the following chapters. Some of the most significant works include Ann Douglas Wood, "'The Fashionable Diseases': Women's Complaints and Their Treatment in Nineteenth-Century America," in *Clio's Consciousness Raised: New Perspectives on the History of Women*, eds. M.S. Hartman and L. Banner (New York: Harper and Row, 1974), 1-22; Regina Morantz, "The Lady and Her Physician," in *Clio's Consciousness Raised: New Perspectives on the History of Women*, eds. M.S. Hartman and L. Banner (New York: Harper and Row, 1974), 38-53; Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 Years of the Expert's Advice to Women* (New York: Anchor Press, 1978); (these first three citations are not necessarily about obstetrics, but provide a good perspective on some of the earliest writing on the relationship between women and doctors); Catherine M. Scholten, "'On the Importance of the Obstetrick Art': Changing Customs of Childbirth in America, 1760 to 1825," *William and Mary Quarterly* 34 (1977): 426-445; Richard W. Wertz and Dorothy C. Wertz, "*Lying-In: A History of Childbirth in America* (New York, The Free Press, 1977), especially the chapters "Midwives and Social Childbirth in Colonial America," 1-28, "The New Midwifery," 29-76, and "Modesty and Morality," 77-108; Jane Donegan, *Women and Men Midwives: Medicine, Morality and Misogyny in Early America* (Westport, Conn.: Greenwood Press, 1978); Nancy Schrom Dye, "History of Childbirth in America," *Signs: The Journal of Women in Culture and Society* 6 (1980): 97-108; Judith Walzer Leavitt, *Brought to Bed: Childbearing in America 1750 to 1950* (New York: Oxford University Press, 1986), especially chapters "'Under the Shadow of Maternity': Childbirth and Women's Lives in America," 13-35, "'Science' Enters the Birthing Room: The Impact of Physician Obstetrics," 36-63. For works by Canadian authors, see Wendy Mitchinson, "Historical Attitudes Toward Women and Childbirth," *Atlantis* 4 (1979): 13-24, Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto Press, 1991); Edward Shorter, *A History of Women's Bodies* (New York: Basic Books, 1982), especially the chapters "Traditional Births: Women Take Charge," 35-47, "The Rise of the Birth Experience," 139-176.

focuses on the transition to hospitalization for childbirth,[6] and historians have therefore paid less attention to the other half of Canadian women who were continuing to give birth at home. What also has been somewhat neglected, especially in the Canadian context, is the experience of the medical practitioner who attended these women.[7]

This thesis will first be a chronicle of Dr. Geggie's practice, a highlighting of the techniques and methods used by one rural physician in the early 1900s which were relevant to the needs of the women who chose him to help deliver their babies in their homes. I intend that the sum of this obstetrical practice be regarded from the perspective of the physician himself, from the theoretical underpinnings of his education in medical maternity care to the realities of attending labouring women in a rural environment in which

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[6] Jo Oppenheimer, "Childbirth in Ontario: The Transformation from Home to Hospital in the Early Twentieth Century," in *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries*, Katherine Arnup, Andrée Lévesque and Ruth Roach Pierson, eds. (London: Routledge, 1990), 51-74; Veronica Strong-Boag and Kathryn McPherson, "The Confinement of Women: Childbirth and Hospitalization in Vancouver, 1919-1939," *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries*, Katherine Arnup, Andrée Lévesque and Ruth Roach Pierson, eds. (London: Routledge, 1990),75-107; Neal Devitt, "The Transition from Home to Hospital Birth in the United States: 1930-1960, *Birth and the Family Journal* 4 (1977): 47-58

[7] A few examples on general practice include W.J Bishop, "The Evolution of the General Practitioner in England," *Science, Medicine and History: Essays on the Evolution of Scientific Thought and Medical Practice*, Vol. 2, E. Ashworth Underwood, ed. (London: Oxford University Press, 1953), 351-357; R.M.S. McConaghey, "The History of Rural Medical Practice," *The Evolution of Medical Practice in Britain*, F.N.L. Poynter, ed. (London: Pitman Medical Publishing, 1961), 117-143; M. Jeanne Peterson, *The Medical Profession in Mid-Victorian England* (Berkeley, University of California Press, 1978); David Woods, "The family doctor in Canada evolves," *CMAJ* 12 (1975): 92-95; S. E. D. Shortt, "'Before the Age of Miracles': The Rise, Fall and Rebirth of General Practice in Canada 1890-1940," *Health, Disease and Medicine: Essays in Canadian History*, Charles G. Roland, ed. (Toronto: Hannah Institute for the History of Medicine and Clarke Irwin, 1984), 123-152

modern amenities were often lacking.

Secondly, by fitting this practice into a context with both earlier and contemporary obstetrical practices of other rural general practitioners, an attempt will be made to add to our understanding of the development of obstetrical care. While much of the information left to us from country practices is anecdotal and in the form of physician memoirs and autobiographies, there is a growing interest by historians to explore and utilize these kinds of sources, alongside other clinical records, to reconstruct an historical framework on rural medicine from the perspective of those rank and file practitioners who actually delivered it to the bedside. Until more of these individual medical practices come to light and are studied in depth, however, any conclusions arising from comparisons between them as to what was considered normative or typical practice must remain tentative.

Thirdly, as far as possible I want to illuminate some of the voices of the parturient women themselves, those women in the communities where Dr. Geggie worked who continued to integrate childbearing into the rhythm of their lives but who also desired the services of a physician to help them through their labour and delivery. Some of these voices can only be filtered through the clinical records left by Dr. Geggie; others from oral interviews provide more direct evidence. All are important, and lend concrete support to the thesis that as long as birthing remained in the home, women continued to maintain some forms of control over how it was carried out. However, I also

argue that the circumstances in Wakefield demonstrate that this premise can be further refined. The entrenchment of medical obstetrical care in this area, even before the move to the hospital, may imply that women's 'control' over the birthing process was lessening. Within the limits of their own resources, women may have been able to choose their female attendants, or even to negotiate where they wanted the birth to take place, but they appeared to have had little choice in the actual birthing procedures themselves, as seemingly had been the case for some women in the past. At the same time, there is fairly strong evidence that women actively desired what the doctor had to offer to alleviate the pain and danger of the trials of childbirth. With a close examination of an obstetrical practice such as this, it is possible to provide a deeper historical comprehension of the profound transformation in birthing customs and traditions that had been underway since the mid-nineteenth century.

This study also seeks to address some of the issues in the writing of the social history of medicine. Developments in this field have closely paralleled those in social history more generally. Prior to the 1960s, historical scholarship in medicine was confined in the main to celebrating the achievements of 'great men' and the advances made by scientific medicine, although by that time succeeding generation of physicians were not relying so much on the knowledge of their predecessors to inform their own understanding of medical practice. This focus on documenting the lives of

doctors and institutions persists in being of interest to the writers of medical history.[8] However, over the past thirty years or so, maturing alongside this at times hagiographic tendency has been a scholarship that has sought to integrate the history of medicine into a much broader social, cultural and political context. Scholars were urged to "[view] medicine in a societal framework– [examine] its relations with other aspects of community life [and] bring into prominence its social character."[9] The history of medicine has now become a distinctive subfield within social history, and many historians have drawn on many of the new and stimulating theoretical frameworks that have developed in other related fields. As Canadian scholar Colin Howell sees it, a "new generation of professional historians . . . has since set about to investigate medicine and health as it relates to questions of class, power, ideology, and social development."[10] All part of this emerging field, the history of medicine might now more correctly be considered the history of health care,

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[8] For instance, the Hannah Institute for the History of Medicine has a long list of books yet to be published in the *Canadian Medical Lives Series*. See the introduction to Mary Beacock Fryer, *Emily Howard Stowe: Doctor and Suffragist* (Toronto: Hannah Institute and Dundurn Press, 1990) For a brief history of this writing in Canada, see S E. D. Shortt, "Antiquarians and Amateurs: Reflections on the Writing of Medical History in Canada", *Medicine in Canadian History: Historical Perspectives*, S. E. D. Shortt, ed. (Montreal: McGill-Queen's University Press, 1981) 1-17, and Shortt, "The New Social History of Medicine: Some Implications for Research", *Archivaria* 10 (1980): 5-22

[9] George Rosen, "People, Disease and Emotion: Some Newer Problems for Research in Medical History," *Bulletin of the History of Medicine* 41 (1967):8-9. Rosen (and others) continued to build on Henry E. Sigerist's prodding, delivered as early as 1940. See Judith Walzer Leavitt, "Medicine in Context: A Review Essay of the History of Medicine," *American History Review* 95 (1990): 1471, n.1

[10] Colin Howell, "Back to the Bedside: Recent Work on the History of Medicine in Canada," *Acadiensis* 17 (1988): 185

as it now incorporates such things as the history of therapeutics and diseases, with the public and private response to them, the role of medical schools, education and professionalization, the development of health care institutions and other health care workers, and the evolution of philosophies and economics contributing to public health. Multi-disciplinary influences from other specialty areas, such as anthropology and sociology, science and technology, and cultural studies and demography, have also contributed to the broadening scope of study. This increasing interest in differing aspects of medicine and health has greatly expanded (or as some would say, fragmented) the field.

Until recently, the history of medicine was sustained mainly by full-time physicians whose accounts reflected both the preoccupations and clinical experiences of those writing from inside the profession. Over the last three decades, however, the field of medical history has been entered by non-physician historians, those "whose training has brought them into contact neither with bedside nor bench."[11] These professional Ph.D. historians, who have applied recent methodology from social and cultural history, have illuminated different facets of medical history, and while their work has generally been seen as beneficial to the evolution of this history, it has occasionally met with criticism for its lack of knowledge or understanding of the more technical and clinical aspects of medicine. In other words, historians

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[11] Sherwin B. Nuland, "Doctors and Historians," *Journal of the History of Medicine and Allied Sciences* 43 (1988): 137

have sometimes been accused of "doing medical history without medicine."[12]

In this thesis I seek to find a middle ground. I am attempting to maintain a focus on the medical features of the topic at the same time as I try to contextualize the field of inquiry within its particular social and cultural milieu. Within the limits of the available sources, this is an attempt to investigate both the theory and the practice of rural obstetrical care during the early twentieth-century, while at the same time keeping in mind the communities and patients to whom this care was important.

Among Dr. Geggie's papers are sets of obstetrical case notes that he kept for all the women he attended in labour, and it is these that form the foundation of this thesis. He appears to have written these notes at the time of each delivery, and he kept them separately from his daybooks and other account books. He recorded on each account the date, the name of the patient, her age and parity (number of previous pregnancies carried to viability of the fetus), a mini history of any problems and the course and results of her labour.

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[12] See, for example, an acrimonious debate between an obstetrician/reviewer and historians who refuted his review. The books reviewed by the physician were Judy Barrett Litoff's *American Midwives: 1860 to the Present* (Westport, Conn. and London: Greenwood Press, 1978) and Richard W. Wertz and Dorothy C. Wertz, *Lying-in: A History of Childbirth in America* (New York: Free Press, 1977). The obstetrician reviewer accused the authors of the two books of bias against obstetricians in favour of midwives, gained from gleaning many of their "facts" from "newspapers in libraries". Ronald Numbers and Judith Leavitt, in reacting to this review, accused the physician of a "rambling vituperation against the alleged critics of clinical obstetrics" and angrily denounced the suggestion that lay historians could not write an accurate history of childbirth. See the review by Gordon Jones in the *Journal of the History of Medicine and Allied Sciences* 34 (1979): 112-114. For the replies by Numbers and Leavitt (and the editor) see the *Journal of the History of Medicine and the Allied Sciences* 34 (1979): 456-458. See also Leonard Wilson, "Medical History without Medicine", *Journal of the History of Medicine and Allied Sciences* 35 (1980): 5-7

It is not known when Dr. Geggie began his note-taking routine, as, with a few gaps, the extant records cover only the years between 1926 and 1949. However, combined with the reconstructed obstetrical cases from his daybooks, over 2,000 obstetrical case records have been found.[13]

To supplement the information contained in these case records, two sets of surviving daybooks have also been used, one set from the years 1919 to 1923, and the second from the years 1938 to 1944. These daybooks are much more than simply patient registers with accounts of charges and payments, as, especially in the earlier years, Dr. Geggie often included surprisingly detailed descriptions of patient symptoms and treatment rendered.[14] Although there were no bedside obstetrical notes available to match the earlier set of daybooks, it was still possible to reconstruct the obstetrical caseload, consisting of prenatal and postpartum visits as well as the actual deliveries, from the daybooks for the years 1921 to 1923. This was then matched with a similar set of data reconstructed from the daybooks and case records from the years 1941 to 1943. These more or less symmetrical data sets, two decades apart,

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[13] A total of 2058 cases were entered into the data base. These obstetrical records included full term deliveries as well as miscarriages and premature births to which Dr. Geggie was called. The records were numbered consecutively during each year, for example, 1:29 or 4:49, which would indicate the first case in 1929 or the fourth in 1949, respectively. I have kept this numbering system to identify individual case records throughout. My yearly totals may not always agree with his, since he sometimes counted false labours or threatened abortions and he did not indicate what the result had been.

[14] I am indeed grateful to Dr. Stuart Geggie and his wife, Norma, for their help with this thesis. I was allowed full access to all of these papers, and both of them searched their home for other materials that they thought might be of interest to me. They answered all of my questions, and initiated contact with some of the women whom I was able to interview, asking only that all names found in the records be kept confidential.

have enabled me to highlight significant changes and to point out the similarities in Dr. Geggie's obstetrical practice over the years.

Scholars have only recently begun to seriously consider the significance of physician case notes or patient records to the history of medicine, and it is now realized that their value reaches beyond the mere compilation of more statistical information.[15] These accounts allow us to observe a physician's daily practice from his or her own perspective and in his or her own words, and can illuminate both the medical and social contexts in which this work was carried out. Not only are specific modes of medical treatment uncovered but the matrix of social relationships between physicians and their patients can often be revealed. As Steven Stowe contends, both what doctors write and the way that they choose to do it, "suggests how the social scope of doctoring went well beyond the specifically medical professional realm."[16] Sprinkled throughout Dr. Geggie's records are apparently verbatim comments from women or members of their family that he may have found particularly appropriate to the situation, which provide fascinating glimpses not only into the social

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[15] Guenter B. Risse and John Harley Warner, "Reconstructing Clinical Activities: Patient Records in Medical History," *The Society for the Social History of Medicine* 5 (1992): 183-205; Amalie M. Kass, "'Called to Her at Three O'Clock AM': Obstetrical Practice in Physician Case Notes," *Journal of the History of Medicine and Allied Sciences* 50 (1995): 194-229; Steven M. Stowe, "Obstetrics and the Work of Doctoring in the Mid-Nineteenth Century American South," *Bulletin of the History of Medicine* 64 (1990): 540-566; Harriet Nowell-Smith, "Nineteenth-Century Narrative Case Histories: An Inquiry into Stylistics and History," *Canadian Bulletin of Medical History / Bulletin canadien d'histoire de la médecine* 12 (1995): 47-67; Julia Epstein, "Historiography, Diagnosis and Poetics," *Literature and Medicine* 11 (1992): 23-44.

[16] Stowe, 557

circumstances and conditions in the families he visited, but also reflect to some extent the values and perceptions of their doctor. When one woman refused to divulge how many previous pregnancies she had had, he noted wryly: "Je ne sais pas et elle ne veut le dire."[17] At the delivery of an unmarried young girl, her father indicated his feelings when he stated firmly: "Votre bill vous l'enverrez à [his daughter's boyfriend.][18] Consider, too, how much we can learn from the words of Dr. Geggie's eldest son, appended to the obstetrical note of one delivery of twins at which he had helped his father.

> Family has nothing–not even enough to eat. House clean and tidy tho. 10 babies now and prospects for 9 more years. Dad going to give her clothes made by ladies aid [in] Wakefield for the babies. These people were not hit by the Depression–have had continual depression since they were married 10 years ago–due to church largely.[19]

Written usually as events unfold, the obstetrical notes allow us to follow through delivery after delivery with the doctor and his patient, and despite their similarity, they often make quite compelling reading. As Amalie Kass so rightly notes in her study of nineteenth-century American physicians, "occasionally the notes resemble short stories, with the outcome of a particularly complicated case unknown until the end of five or six pages and

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[17] OBS note 74:42. While all the obstetrical case notes were written in English, Dr. Geggie would transcribe these comments in French if they were from French Canadian patients.

[18] OBS note 34:41

[19] OBS note 87:36. My other favourite quote from this son came not long after he started medical school, when his inexperience in helping his father with a frank breech delivery was obviously noticeable. As he wrote, "Things moved too damned fast for J.H.G. jr." OBS note, 94:38.

a compassionate reader [hopes] against hope that all will turn out well.[20] While the majority of Dr. Geggie's records ended with his trademark phrase "all okay" or "both okay", problems resulting in the death of an infant, or more rarely, the mother, catch the reader quite by surprise.

What is perhaps most striking is the degree of anxiety, uncertainty and honesty expressed by physicians in the privacy of these records. While this has been noted for doctors from the nineteenth century,[21] it is clear that while the modern science of obstetrics had produced new knowledge, many aspects of the birth process remained puzzling to medical attendants well into the twentieth century. It was not uncommon for Dr. Geggie during uneasy moments to query on paper whether or not he had made the correct diagnosis or had chosen the right technique for the situation.

Reading these patient records in conjunction with contemporary textbooks and journals may also offer clues as to how medical technological information was transmitted to or taken up by physicians at the bedside. Jacalyn Duffin was able to follow to some extent the time lag between the announcement of new drugs and diagnostic techniques and their introduction into James Langstaff's nineteenth-century general practice.[22] Similarly, as I discuss for Dr. Geggie, there is some evidence that as he searched for better

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[20] Kass, 198

[21] Kass, 196, 203

[22] Jacalyn Duffin, *Langstaff: A Nineteenth-Century Medical Life* (Toronto: University of Toronto Press, 1993), especially 59-91

obstetrical anaesthetic techniques for use in his rural practice, he introduced them into his practice relatively quickly after their appearance in the *Canadian Medical Association Journal*. Finally, an examination of physician behaviour at the practical level, which these sorts of records often furnish, may expose variations or discrepancies between medical theory and practice which might normally be obscured by an inquiry grounded solely in more conventional medical historical sources. As Guenter Risse and John Harley Warner express it, "[a]s a tool for opening up new avenues of historical investigation, patient records may well prove to have their greatest utility in permitting a systematic exploration of the relationship between medical ideas and medical activities, between ideology and behaviour. Through patient records the historian can discern both the use of concepts and the experiences that originally shaped ideas and expectations."[23]

It is not fully understood why private physicians kept track of their obstetrical cases, but there is evidence that many did.[24] These types of bedside case notes differ from the case histories published in medical journals and textbooks, which were meant to be used primarily as instructional tools

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[23] Guenter B.Risse and John Harley Warner, 199

[24] See particularly Kass, 194-229; Stowe, 540-566. This evidence is so far stronger for the nineteenth century than it is for the twentieth, which may be a matter of access to records or perhaps more likely, as physicians delivered more of their women in hospitals, the record keeping changed and much of this information is now kept by these institutions. I have yet to come across any early- to mid-twentieth century general practice that had records with the same breadth and depth as these of Dr. Geggie.

employing unusual or interesting medical examples.[25] It would appear that during Dr. Geggie's medical training he was supposed to keep an obstetrical casebook, but as he may have been required to attend only six confinements, it is unlikely that this became a well-ingrained habit. It has been suggested that for some doctors, obstetrical case notes served as references or memory aids, but there is no indication in Dr. Geggie's case that he referred back to them himself.[26] Quite possibly, however, these obstetrical records were a reflection of Dr. Geggie's own interests and concerns, and this was the format that he devised to allow him to obtain a statistical overview of certain factors in his obstetrical practice. In 1927, for example, he charted all his confinements for that year under such diverse headings as "nursing" [care], [maternal] "complications"and "distance travelled." We do not know if he ever created other charts for subsequent years. He also passionately believed that general practitioners should "take modern medicine to the people" especially in the "outlying areas", and he judged general practice to be an equal partner with other departments in medicine.[27] He eagerly welcomed medical students into his practice, where he felt that both he and the younger student could learn from each other, and it is possible that these obstetrical notes could also

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[25] For an informative discussion on published case histories, see Harriet Nowell-Smith, 47-67

[26] There is some evidence that James Langstaff, a nineteenth-century physician, used his obstetrical case notes as reference material for his own practice, although he kept them only for a short time. Duffin, 182-183

[27] H.J.G. Geggie, "An Address to the McGill Undergraduate Society" (February, 1950): 17

have found use as teaching supports.

In this thesis, I also rely heavily on Dr. Geggie's memoirs, which following his death were edited into book form by Norma and Stuart Geggie, his youngest son and daughter-in-law. A careful reading of this book, *The Extra Mile*, provides a rich and intriguing contextualization for the somewhat more prosaic obstetrical records.[28] I have also used autobiographies written by other early twentieth-century general practitioners to provide a broader base from which to analyse rural obstetrical practice. Biographies of 'great' physicians are a well-recognized phenomenon in the writing of medical history, but ordinary physician memoirs and autobiographies are important resources that are only beginning to be mined for what they have to offer historians about the non-elite doctor. Erwin Ackerknecht, in a now famous article, appealed to medical historians to pay more attention to "what doctors *did* in addition to what they *thought* and *wrote*", maintaining for that reason the "rank and file" doctor deserved as much attention as the elite.[29] Indeed, there has been more scholarly interest in this rank and file doctor in the past few years, helping to rescue the general practitioner from what Shortt has called their more traditional portrait as "creation[s] of popular culture."[30]

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[28] H.J.G. Geggie, *The Extra Mile: Medicine in Rural Quebec 1885-1965*, ed. Norma and Stuart Geggie (Self-published, 1987)

[29] Erwin H. Ackerknecht, "A Plea for the "Behaviourist" Approach in Writing the History of Medicine," *Journal of the History of Medicine* 22 (1967): 211-214

[30] S.E.D. Shortt, 124, also Shortt, "Approaches to the Physician's Life." *Bulletin of the History of Medicine* 55 (1981): 124-127. For examples of recent work on general practitioners, see Duffin, *Langstaff: A Nineteenth-Century Medical Life*; Charlotte Borst,

While a systematic study has yet to be undertaken, physician autobiographies and memoirs written in the late nineteenth and twentieth century seemed to have proliferated.[31] Although I have as yet come across no studies that look at these collectively as a genre of writing,[32] one author, who compared approximately forty autobiographies of women doctors with the same number of those written by male doctors, discovered that the autobiographies of both sexes were written in the "public voice" rather than the "confessional" or "self-critical" voice. (This may also help to explain why they have sometimes been referred to as "vanity autobiographies".[33]) This similarity she attributes to the success and respect the majority of these doctors found in their individual communities, a phenomenon born out by the autobiographies used in my study.[34] All of the Canadian general practitioners who wrote their

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Catching Babies: The Professionalization of Childbirth, 1870-1920 (Cambridge: Harvard University Press, 1995); Jan Coombs, "Rural Medical Practice in the 1880s: A View from Central Wisconsin," *Bulletin of the History of Medicine* 64 (1990): 35-62; Paul Berman, "The Practice of Obstetrics in Rural America, 1800-1860," *Journal of the History of Medicine and the Allied Sciences* 50 (1995): 175-193.

[31] One author, who makes no claims that hers was an exhaustive list, identified eighty-three American published and unpublished autobiographies. See Joyce Marie Butler Ray, "Women and Men in American Medicine, 1849-1925: Autobiographies as evidence," (Ph.D. Thesis, The University of Texas at Austin, 1992). I also thank Professor Donald L. Madison for sending me a sixty page annotated bibliography from the University of North Carolina at Chapel Hill, which describes many more written in this same time period. I myself found at least twenty Canadian sources, and I know there are many more.

[32] There is, however, a fair amount of work on "literary doctors" and doctors in literature. See, for example, the essays in Enid Rhodes Peschel, ed., *Medicine and Literature* (New York: Neale Watson Academic Publications, 1980)

[33] From the annotated note by Madison to Fred Lyman Adair's autobiography, *The Country Doctor and the Specialist* (Maitland, Fl: Adair Award Fund, 1968), 1

[34] Butler Ray, xiii-xiv

stories after many years of service in their towns and villages were well-respected and often revered members of their communities. They shared a common interest in wanting to preserve the past, a not-uncommon aspiration for all those who write autobiography.[35]

While this is not always explicitly stated, many physicians were also undoubtedly writing for future generations of medical students, in this way connecting themselves to a time-honoured tradition within the profession. In describing his reasons for writing his own autobiography, one physician wrote, "many of my good friends, whom I trust, tell me that the main facts of my life are such as to be of interest to others and [will] prove inspiring and stimulating to younger men."[36] The ever-quickening pace of changes in scientific medicine also contributed to a sense of urgency that the stories must be told before the medical past was completely forgotten, and I suspect that for many of those who were writing after World War II, even they must have wondered at times how they managed to practice in a world that now looked so completely different. "Might it not be of some use to one curious reader," Dr. Geggie asked in the preface to his memoirs, "wanting to know how people lived at the turn of the century, before the wars, before the wide use of

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[35] As one author states, (paraphrasing another), " the soul has a basic need to tell autobiographical stories, to historicize . . . We historicize to give the events of our lives a dignity that they cannot receive from contemporaneousness." Howard Brody, *Stories of Sickness* (New Haven, Conn.: Yale University Press, 1987), 14

[36] Edward Trudeau, as quoted by Beate Caspari-Rosen and George Rosen, "Autobiography in Medicine, or The Doctor in Search of Himself," *Journal of the History of Medicine and Allied Sciences* 1 (1946): 293

electricity, oil, internal combustion engines; before aviation, broadcasting, before X-rays, the sulfas, vitamins and antibiotics? Was medicine–rural medicine–possible at all before these things?"[37]

Duffin has claimed that, as interesting as doctors' diaries and autobiographies are, they tend to emphasize "the spectacular or the bizarre at the expense of the banal," and that the everyday work of an ordinary practitioner is obscured.[38] Many, of course, do just that, and it is only natural that over the course of a lifetime some of the more memorable and remarkable events would be foremost in one's mind. Considered as a collective, physician autobiographies and memoirs, of which *The Extra Mile* is a highly readable example, are valuable additions to an accumulating collection of clinical resource material. Along with a focus on medical practice, they also offer a compelling social portrait, albeit from the viewpoint of physicians, of both the locale and the people among whom doctors worked. As Shortt contends, these types of sources taken as a whole can "provide significant insight . . . into the lives and professional activities of a vanished generation of practitioners."[39] The field is ripe for further research.

A decade ago British medical historian Roy Porter, among others, echoed

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[37] H.J.G. Geggie, *The Extra Mile*, 7. See also the prologue to Victor Johnston's book, in which he lists among his reasons for writing his "book about medicine" the need to recall and evaluate the past, in order that in "the current climate of rapid change all about us" the past can be reassessed "with the hope it can retain the good and discard the bad." Johnston, 1

[38] Duffin, 4.

[39] Shortt, "'Before the Age of Miracles,' 124

the calls that were emanating from social historians more generally and called for a refocusing of the historical lens on the patient or "sufferer". "For it takes two to make a medical encounter," he asserted, "the sick person as well as the doctor; and for this reason, one might contend that medical history ought centrally to be about the two-way encounters between doctors and patients."[40] It could be debated that this has been heeded nowhere as closely as by historians of women's health, especially those most interested in the history of childbirth. Giving birth, arguably once the domain of a women-centred community, was perceived by earlier historians of women to have fallen victim to an all-powerful male medical elite. As increasing attention has been paid to parturient women, this persepective has been refined and altered to the point that we can now comprehend how the evolution of birthing care was often, at least for some women, a negotiated process between themselves and their sometimes less-than-confident physicians.

Although medical records reveal the physician's side of the story, even from these records we do gain illuminating, if limited, insights into the birthing experiences of individual women. To further aid in locating the patients within this study, five women, all patients of Dr. Geggie for at least some of their births, agreed to be interviewed about their home birthing

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[40] Roy Porter, "The Patient's View: Doing Medical History from Below," *Theory and Society* 14 (1985): 175 The concept of doing medical history "from the bottom up" may no longer be novel, but it nevertheless remains an important aspect, leading Wendy Mitchinson to state that she does not "necessarily expect patients to be the focus, but [she does] expect them to be there. See her "The Health of Medical History," *Acadiensis* 22 (1990): 254

experiences.[41] The small number obviously makes it impossible to claim whether or not their experiences were typical of other women in this district, and the difficulty in obtaining women to interview raises the possibility there were more women delivering in the hospitals in Ottawa and Hull, or else at home with midwives only, than once thought. There may not be too many women alive who still fit the criteria for which I was looking, and the researcher's 'outsider' status in the community, which may have made women reluctant to talk to me, may have also been a contributing factor to the small sample size. Nevertheless, the interviews that were conducted afforded a fascinating, if tantalizing, look at home birthing during this period. The diversity of experience among these women was impressive, and the contribution of these interviews to the overall representation of childbirth in this area far outweighed their small total.

In order to establish the grounding Dr. Geggie obtained in obstetrics, the next chapter will be devoted to an overview of medical education during the first decade of the twentieth century, the period during which Harold Geggie trained. Chapter Three will be devoted to an examination of the managment of parturition in his capacity as the medical birthing attendant to

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[41] It was surprisingly difficult to find women to be interviewed for this project. Although several people from different areas in Wakefield were approached, either directly or through the Historical Society, very few could remember women who had had their children at home. Three out of the five women were referred by the Geggies, but because Dr. Stuart did not start his own practice until after the hospital opened, his knowledge of these women was also limited. Even the 'snowball' method did not help; only one woman interviewed could refer me to a friend.

the women in the Wakefield area. The fourth chapter will attempt to situate this one physician's practice within the broader historical context of obstetrical care of both earlier and contemporary doctors, while Chapter Five will examine some of the measures and strategies with which the women of Wakefield organized the births of their children. Finally, Chapter Six will offer some general conclusions.

Chapter Two

Medical Education

In 1886, Harold James Gugy Geggie, the third youngest of four children of James Geggie and Leila Gugy, was born in Beauport, Quebec, three miles north of Quebec City. Brought up by hardworking and loving parents, he and his siblings absorbed a love of history along with the more traditional lessons of what constituted proper religious behaviour and decent family living. Their earliest schooling took place in a private school, attended only by their own family, and while English was the primary language in the home, the children grew up to be bilingual.[1] Harold's older brother Conrad left high school before finishing to take a job in a bank, but did eventually return to night school. While still living at home, Conrad began his studies to fulfil his dream of becoming a surgeon.[2] Described as being a "reluctant student" until he entered medicine, Harold chose to remain in school as the "lesser evil" to "going into business and meeting the public".[3] It was only after a chance trip to McGill at the end of his high school career that he began to think of university, and

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[1] C.G. Geggie, Unpublished manuscript. NAC MG 55, Box 31, Vol. 4. Conrad Geggie, elder brother of Harold, graduated from Laval Medical School and took post-graduate work to be a surgeon in France, London, Glasgow and Edinburgh. He spent most of his career as a surgeon with the Armed Forces, first serving overseas and then with the Pension Board in Edmonton. He has left an anecdotal record of his medical life and practice in the National Archives.

[2] C.G. Geggie, 2

[3] H.J.G. Geggie, *The Extra Mile: Medicine in Rural Quebec 1885-1965.* Norma and Stuart Geggie, eds. (Self-published: 1987):19

in 1906 he entered the Arts and Medicine programme at McGill, following in the steps of his elder brother who by then was well into his medical training at Laval.

In some ways the Geggie brothers were typical of many others who entered medicine in the early twentieth century. S.E.D. Shortt found in his survey of general practitioners in the 1900s that most were not sharply focused on a medical career in their early years, but were often exposed to the idea of studying medicine by a chance remark or experience.[4] Some "just drifted into medicine".[5] Dr. H. H. Hepburn, a 1910 graduate of medicine at McGill, estimated that between seventy-five and ninety percent of his 1906 class (including himself) had first been school teachers, and he claimed that teaching "was good valuable training" to help future physicians understand the social and economic conditions of family and community life that was of immeasurable importance in the making of an effective general practitioner.[6] In hindsight, Dr. Geggie felt that both he and his brother may have had their interest in medicine piqued at a young age by watching his mother. Although she was not a nurse, one of their earliest memories was of her vaccinating

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[4] S.E.D. Shortt, "'Before the Age of Miracles': The Rise, Fall and Rebirth of General Practice in Canada 1890-1940," *Health, Disease and Medicine: Essays in Canadian History,* Charles G. Roland, ed., (Toronto: Hannah Institute for the History of Medicine and Clarke Irwin, 1984), 126

[5] Victor Johnston, *Before the Age of Miracles: Memoirs of a Country Doctor*, (Toronto: Fitzhenry and Whiteside, 1972), 5

[6] H.H. Hepburn, "The Evolution of Medical Practice During One Man's Lifetime", *Alberta Medical Bulletin* 24 (1959): 128. Hans Stevenson, the doctor Dr. Geggie came to Wakefield to assist, had also been a school teacher before entering McGill.

neighbourhood women and children for smallpox; one other time, she provided "an expensive new French serum" which cured a playmate of diphtheria.[7]

The choice of medical school that Conrad and Harold Geggie each made, and the path each brother took once he finished medical school, might be considered somewhat atypical, at least within their respective Quebec medical institutions. The findings of a study undertaken by George Weisz on the geographical origins and destinations of medical graduates in Quebec from the mid-nineteenth to the mid-twentieth century suggest that, despite a generally standardized medical education within the province by the end of the 1800s, there were considerable individual differences among the medical schools in Quebec with respect to recruitment and eventual place of practice.[8] On the one hand, the school at Laval situated in Quebec City appears to have recruited mainly from rural areas, in particular eastern Quebec, and although an increasing number of its graduates began to work in the cities after the turn of the century, it nevertheless continued to provide the province with a significant body of rural general practitioners.[9] However, Conrad Geggie, who attended this largely francophone school, knew he wanted to be a surgeon before entering medicine, and apart from a few short months following graduation, spent the remainder of his days in practice outside of the province.

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[7] H.J.G. Geggie, *The Extra Mile,* 19-20

[8] George Weisz, "The Geographical Origins and Destinations of Medical Graduates in Quebec, 1834-1939", *Histoire Sociale/Social History* 19 (May 1986): 95.

[9] Weisz, 117-118

It is unclear what influenced his decision to attend Laval, although the fact that tuition was less expensive than at McGill, and that he was able to live at home while attending, suggests that financial matters may have played a hand. The resources of the family are somewhat unclear. While Conrad attests that his father was the manager of the large wholesale business,[10] Harold's account states that his father "remained at a low salary for almost sixty years until his death in 1915," although apparently other sources of income might have come from the family farm.[11]

On the other hand, McGill, as a well-established anglophone medical school in the city of Montreal, attracted the majority of its students from outside the province. As Weisz clearly demonstrates, this was not from a neglect of either the anglophone or francophone population from within the province per se, but was the result of a complex series of factors that influenced recruitment strategies and promoted access at different times for Canadian medical students from both the east and west, and for Americans from the south. Not unexpectedly then, only one-quarter of McGill's medical graduates remained to practice in Quebec. According to Weisz's study, Harold Geggie may well have been in the minority as a medical graduate from McGill, for he remained in Quebec and practised as a rural general practitioner for the length of his days. As he himself wondered in his memoirs, it is difficult to

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[10] C.G. Geggie, 2

[11] H.J.G. Geggie, *The Extra Mile*, 14

fathom how much of a person's path is determined by choice or by fate[12], but his reflections later in his life on his years in the Gatineau Valley suggest that he had obtained a goodly measure of satisfaction from his decision to remain where he did for his entire career.[13]

In this chapter I will first endeavour to outline briefly the context in which medical education was situated just after the turn of the century, during the time when Harold Geggie was immersed in his medical school training at McGill. This was also the point at which Abraham Flexner published his influential summary of the state of medical education throughout North America, which drew into sharp relief both the state of academic medicine in the training of new physicians and the conditions under which this education took place. In the nineteenth century, the development of medical education in English Canada had perhaps been influenced more by the organization of medical education in Britain than in the United States,[14] but the turmoil in the medical schools created by the release of the Flexner Report in 1910 suggests

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[12] H.J.G. Geggie, *The Extra Mile*, 35.

[13] Without tracing each member of their respective medical classes, it is impossible to determine more clearly whether or not the Geggie brothers were indeed atypical from their classmates. The differences they exhibited, in comparison with the longer term trends described by Weisz, are intriguing nonetheless.

[14] For instance, in the mid- to late 1800s, almost two-thirds of the medical elite who were instrumental in shaping the profession in Ontario had strong ties to Britain and/or had received at least part of their medical training there. See R.D. Gidney and W.P.J. Millar, *Professional Gentlemen: The Professions in Nineteenth-Century Ontario* (Toronto: University of Toronto Press, 1994), 88-90. See also A.A. Travill, *Medicine at Queen's 1854-1920: A Peculiarly Happy Relationship* (Kingston: Faculty of Medicine, Queen's University and The Hannah Institute for the History of Medicine, 1988), especially 34-58

that the American influence on teaching in medicine by that time was keenly felt.[15] In many ways Flexner's work can be seen as the culmination rather than the beginning of a transformation in medical education, because although there were distinct differences between the United States and Canada in both the organization and control of medical education, physician-educators in both countries were already integrating the changes emerging through developments in scientific medicine into their programmes.

A closer look will also be given to specific aspects of the obstetrical training of the general practitioner, that area that most likely concerned a young doctor starting out in practice. Many scholars have investigated the evolution of obstetrical care that began in earnest during the mid-nineteenth century, which included the development and implementation of antisepsis and asepsis, forceps and anaesthesia. These are all important elements implicated in the medicalization of birthing, and few aspects in the history of medicine over the past one hundred and fifty years or so have caused as much

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[15] Abraham Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching* (Boston: The Merrymount Press, 1910) Reprint edition Arno Press: 1972. Many Canadian medical schools published defensive reactions to the criticism levelled at them by the Flexner Report. For example, the editorials "Queen's and the Carnegie Report" and "The Halifax Medical College," in the *Canadian Medical Association Journal (CMAJ)* 1 (1911): 62-66; "The Vindication of Laval," *CMAJ* 1 (1911): 354-356. Flexner's particular harsh treatment of the Halifax Medical School provoked a lengthy reply by D.A. Campbell, "Medical Education in Nova Scotia", *Montreal Medical Journal* 39 (1910): 628-649, although some of the problems Flexner had complained about were quickly remedied by the following year. See the editorial "Medical Teaching in Halifax," *CMAJ* 1 (1911): 983-985. For a present day assessment of Flexner's critique of the Halifax Medical College and the results for the school, see Sheila M. Penney, "'Marked for Slaughter": The Halifax Medical College and the Wrong Kind of Reform, 1868-1910," *Acadiensis* 29 (1989): 27-51

controversy as the changes they brought about. While there also has been some work on the development of 'safer' obstetrics from the mid-twentieth century on to the present, encompassing the contribution of the 'miracle drugs' of sulfonamides and antibiotics, less attention has been paid to obstetrical care in the time period in between, to the first decades of this century.[16]

Only rarely, too, have historians attempted to investigate the correlation between obstetrical education, and its subseqent effect on practice, between the theoretical background that underpinned the medical school education and how it was applied by, in this case, a rural general practitioner at the bedside.[17] It was not until the 1900s that obstetrics appears to have become a large part of a younger general physicians's practice. As Herbert Little, professor of obstetrics at McGill during the early 1900s, noted in his quarter-century retrospective, "[t]he largest obstetric practice [had been] enjoyed by the man with the largest general practice; and the younger men, who by inclination would turn from the practice of obstetrics, were urged to undertake the work as a basis for family practice."[18] By the early twentieth century, medical

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[16] S.E.D. Shortt, "'Before the Age of Miracles': 124

[17] In Charlotte Borst's recent book, she does attempt to do this. In this exhaustive study of a group of physicians in Wisconsin, she assesses "both the education of a specific group of practicing physicians and the possible effects of educational reform on obstetrical practice." See her *Catching Babies: The Professionalization of Childbirth 1870-1920* (Cambridge: Harvard University Press, 1995): 6

[18] Herbert M. Little, "Obstetrics During the Past Twenty-Five Years," *CMAJ* 14, (1924): 903. Physicians may have been "urged" to undertake obstetrics, but it was not until more women wanted them for their deliveries that the time at maternity cases was considered both economically feasible and prestigious enough. See also Borst, 119-120.

teachers were beginning to recognize that, for better or for worse, obstetrics often would be the foundation upon which newly-minted physicians would likely build their practices. Both the quality and the quantity of obstetrical training was therefore becoming of more specific concern to those responsible for its transmission. While Dr. Geggie's practice cannot be considered typical until more of these sorts of investigations are undertaken, a focus on both the education and the obstetrical practice of one general practitioner provides at least some insight into medical obstetrical care during the early twentieth century.

From the middle of the nineteenth century onward, an increasing dependence on the rhetoric of science signalled a major shift in all aspects of the relationship between medicine and society. Doctors themselves had debated over what role science should play in delineating professional standards, and towards the end of the century, there was more general agreement amongst at least the orthodox members of the profession that health care could best be managed by the 'expert' whose knowledge was increasingly based on a scientific perspective. The nineteenth century ideal of a 'professional gentleman' with its concomitant claim to cultural authority was altered as a scientific education began to command the same respectability as a more traditionally liberal schooling.[19] The legitimacy of the doctor-patient relationship and its demarcation from that of sectarian practice no longer

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[19] R.D. Gidney and W.P.J. Millar, *Professional Gentlemen*, 367

rested solely on proper professional etiquette and the application of orthodox 'heroic' treatments. Instead, as John Harley Warner contends, "[t]he defining core of the proper physician's task became less the *exercise of judgment* and more the expert *application of knowledge*.[20] 'Doing something' did not remain the most significant declaration of authenticity for orthodox physicians; they could now claim a certain validity from the accumulation of scientific knowledge and its promise for increased efficacy of treatment.

Science did not immediately become, however, the straightforward panacea to the more secure professionalism that physicians were seeking. As Colin Howell submits in his discussion of the Halifax medical establishment, "[i]t was not enough that doctors should practice scientific medicine; it was also imperative that they were seen to be scientific by the public at large."[21] Until society in general more readily accepted scientific ideals and methods, most physicians were still torn between what appeared to be competing methodologies of contemporary therapeutic practice and new laboratory science. The discovery of anaesthesia and the germ theory of disease gave the appearance that scientific medicine was taking great practical strides forward, and the public began to have more faith in 'regular' medicine. As several

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[20] John Harley Warner, *The Therapeutic Perspective: Medical Practice, Knowledge and Identity in America, 1820-1885* (Cambridge, Massachusetts: Harvard University Press, 1986): 260. Italics in original.

[21] Colin D. Howell, "Elite Doctors and the Development of Scientific Medicine: The Halifax Medical Establishment and 19th Century Medical Professionalism", in *Health, Disease and Medicine: Essays in Canadian History*, Charles G. Roland, ed. (Toronto: The Hannah Institute for the History of Medicine and Clarke Irwin, 1984): 109

historians have pointed out, however, scientific knowledge far outstripped by several decades reliable therapeutic efficacy,[22] a fact that many contemporary physicians, recognizing this as a real threat to their hard-won prestige, realized with dismay. Despite an intense societal interest in matters of science at the turn of the century, doctors continued to face scepticism because often the "knowledge generated in the laboratory simply made no difference in actual practice".[23]

Nevertheless, the surging tide of science could not be held back. Even though the real benefits reaped at first were slim, increasing emphasis on the more complicated aspects of science in the laboratory by the "regular" doctors served to remove the practice of medicine from general public knowledge or understanding. This eventually "broke the confidence" of "common sense" ideas about medical treatment, and "helped [re]establish the cultural authority of medicine by restoring a sense of its *legitimate complexity*."[24] Heartened by this turn of events, the orthodox medical profession continued to institutionalize the ideals of a solid scientific foundation upon which medicine could build and eventually fortify its public position. In its wake both the

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[22] See, for example, Anne Digby, *Making a Medical Living: Doctors and patients in the English market for medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994): 69; Gidney and Millar, *Professional Gentlemen,* 365; S.E.D. Shortt, "'Before the Age of Miracles', 124.

[23] Warner, 254

[24] Paul Starr, *The Social Transformation of American Medicine*, (New York: Basic Books, 1982), 59. While this is perhaps more applicable to the American 'democratic' tradition, it is argued here that the general population may have felt much the same effect in both the United States and Canada.

substance and the teaching in medical education could not help but be reshaped.

The Flexner report of 1910 sharply critiqued the general state of medical education in both the United States and Canada. For the most part, however, Canadian medical education was not just "that of the United States writ small",[25]and Flexner did acknowledge this throughout his account.[26] The crucial distinction appears to rest on the regulation of medical licensing. Early in the nineteenth century, any effective overall outside regulation over the licensing of American doctors by medical schools had been rejected, both by the individual states and by the numerous medical societies that had sprung up, and therefore a graduate medical degree itself was recognized as a sufficient requirement to practice. In the two Canadas, the early formation of centralized medical boards retained the authority to set educational standards and licensing requirements even after 1867. As well, Canadian government policy generally encouraged an effective and more cordial alliance between the main professional organizations and the schools of medicine, which again, in

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[25] R.D. Gidney and W.P.J. Millar, "The Reorientation of Medical Education in Late Nineteenth-Century Ontario: The Proprietary Medical Schools and the Founding of the Faculty of Medicine at the University of Toronto", *Journal of the History of Medicine and Allied Sciences* 29 (1994):53.

[26] Comparisons to what he thought were the two best Canadian schools, McGill and Toronto, crop up periodically throughout his book (p. 15, 41) but Flexner's clearest statement about the differences between American and Canadian schools comes when he states that "[i]n Canada, conditions have never become so badly demoralized as they have in the United States. There the best features of English clinical teaching had never been wholly forgotten. Convalescence from a relatively mild over-indulgence in commercial medical schools [in Canada] set in earlier and is more nearly completed". See Flexner, 13.

contrast to the American experience, led to a somewhat more orderly growth in medical education in this country.[27] The differences in the organization of medical education between the two nations have been linked to the context of their wider social and political philosophies, with the results that to Americans, "[m]edical insitutions seemed out of step with triumphant egalitarianism; [whereas] in Canada they appeared to be guarantors of triumphant paternalism."[28]

One of the results of this American "triumphant egalitarianism" was the proliferation of proprietary medical schools with their widely varying educational standards. This rapid growth was particularly evident in the United States, for while Canadian proprietary or commercial schools did exist after 1850 for a time, the provincial medical councils prohibited them from granting medical degrees on their own, and their need to establish a university affiliation necessarily limited their growth.[29] Flexner was particulary incensed over these schools, which he accused existed primarily for the profit of the individual doctors who had organized them and which, he also argued,

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[27] Joseph F. Kett, "American and Canadian Medical Institutions, 1800-1870", *Medicine in Canadian Society: Historical Perspectives*, S.E.D. Shortt, ed. (Montreal: McGill-Queen's University Press, 1981): 203

[28] Kett, 195

[29] Kett, 199. For example, the Laval medical school (developed from courses at the Marine Hospital in Quebec City) could not grant a degree until it became affiliated with Laval university in 1852. (See Weisz, 95) However, Flexner condemned the three Canadian medical schools who were the closest to the proprietary model. At London, he believed conditions were "as bad as anything that can be found on this side of the line" and both Halifax Medical College and the Laval school (at Montreal) he found as "feeble". Flexner, 325-326

commericialized medical education to the great detriment of both the graduates and the unsuspecting public on which they were released. One of his great concerns arose out of the inability of the majority of the schools to provide a medical education securely grounded in the basic sciences, which he believed was beyond the interests and financial capabilities of schools totally dependent upon student fees. His ideal was to be found in the "organic" schools, those securely connected or enfolded within universities who could supervise a young student's education in the increasingly important fields of the pre-clinical and laboratory sciences.[30]

At least one historian has called the contribution of Flexner's report on the quality of North American medical education more of a "catalyst to an already evolving process" rather than a completely "revolutionary" change. Reform initiatives in the education of doctors, while admittedly unevenly distributed, had already begun before the Carnegie Foundation ever decided to commission Abraham Flexner.[31] During the late nineteenth and early

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[30] Flexner, especially 28-89

[31] Robert P. Hudson, "Abraham Flexner in Perspective: American Medical Eudcation 1865-1910," in *Sickness and Health in America: Readings in the History of Medicine and Public Health*, Judith Walzer Leavitt and Ronald L. Numbers, eds. (Madison: University of Wisconsin Press, 1978), 105-115. In a comprehensive review of the historiography on Flexner, Thomas Bonner shows how both Flexner's ideals and his reputation came in for considerable criticism during the 1970s when he was accused by some historians of making medical education elitist, overly standardized and antihumanistic. Although Bonner agrees that Hudson's assessment is reasonable, he suggests that other historians may be suffering from presentism, and believes that Flexner's writings have been oversimplified and largely misunderstood As Bonner argues, too, "the decline and fall of Flexner's reputation and [subsequent] recent mild revival" during the late 1980s may have more to do with the shifts in historical writing that have taken place over the past thirty years. See Thomas Neville Bonner, "Abraham Flexner and the Historians," *Journal of the History of Medicine and Allied Sciences* 45 (1990): 3-10.

twentieth centuries, Canadian medical schools were contributing to this transformation as one by one they became more completely integrated into the university system, continually expanding both their curricula with the addition of a wider variety of the non-applied sciences, and the buildings in which to house increasingly sophisticated laboratory equipment.[32] In the early part of this century, for example, Queen's was undertaking to expand its medical school facilities by erecting new buildings and introducing new courses "because the new faculty men understood the importance of the new laboratory sciences."[33] The gradual separation of professional identity from therapeutic practice opened up the potential for positions that involved only research and teaching,[34]although it was several decades before medical school professors could be freed from or would give up their clinical practice, as Flexner called for. In 1902, for instance, the creation of full courses of pathology and bacteriology and their removal from the medical school into the pre-clinical stage in the Faculty of Arts and Science was greeted with relief by those teachers who had found "it increasingly difficult to teach [these new sciences] while pursuing a full career as practising clinicians." [35] A short ten years later

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[32] For examples of the efforts of individual Canadian schools, see Gidney and Millar, "The Reorientation of Medical Education," 52-78; A.A. Travill, especially 185-194; and to a small extent, Stanley Brice Frost, *McGill University: For the Advancement of Learning 1895-1971*, Vol. II (Montreal and Kingston: McGill-Queen's University Press, 1984)

[33] Travill, 185-194.

[34] Warner, 263

[35] Travill, 166

Dean Connell noted with "quiet confidence" the more than three-fold increase in the professoriate at all levels.[36]

J. Howard Walmsley, a general practitioner who worked in the Picton area for almost fifty years, received his degree from the school of medicine at Queen's in 1914, one year after the faculty of the medical school was fully reintegrated into the university.[37] Flexner was somewhat ambivalent about the facilities available there, with his greatest concern being that the Kingston General Hospital was not large enough to accommodate the needs of students for 'clinical material', but on the whole he believed it "represent[ed] a distinct effort toward higher ideals".[38]

Harold Geggie attended medical school at McGill University, from which he graduated in 1911. Established in 1824, this school was the largest medical school in Quebec,[39] and was certainly the oldest and perhaps most respected

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[36] Travill, 220. Dr. Walmsley, as will be explained later, was a general practitioner who started work in the Picton area about a decade after Dr. Geggie did in Wakefield. His records are not as clear as Dr. Geggie's but bear further research. I thank Stuart Renfrew, Queen's University Archives for pointing these records out to me, and Dr. Wamsley's daughter, Kathleen Girard, for allowing me access to the closed portions of the material.

[37] The Medical Department opened in 1854 as another faculty of the decade old Queen's University, but was forced to withdraw from the University in 1866. It stayed alive as The Royal College of Physicians and Surgeons, Kingston; it was more or less a proprietary school, but it maintained an affiliation with Queen's in order to be able to grant degrees. In 1880, Principal Grant was the prime impetus behind the Royal's "organic union" with Queen's, and the faculty reintegrated with the university. In 1913 the transfer was fully completed with the merging of the school's finances with those of the university. See A.A. Travill, *Medicine at Queen's 1854-1920* (Kingston: The Hannah Institute for the History of Medicine, 1988), 82-100, 157-177

[38] Flexner, 325

[39] Weisz, 98. Although there were three other medical schools in Quebec between 1900 and 1939, fifty-five percent of all Quebec medical graduates came from McGill.

in the country. It received an excellent rating from Flexner, who extolled its virtues from its "strictly enforced" entrance requirement of the University School Leaving Examination, through its "famous" anatomical and pathological museums, to its "excellent" library and clinical teaching facilities.[40] While Flexner was certainly presenting his own viewpoint on the state of McGill's educational merits, there is little doubt that Dr. Geggie attended one of the higher rated medical schools on the continent, and was therefore presumably exposed to one of the better physician education programmes available at that time.[41]

The medical school at McGill, which in 1904 had absorbed the faculty from Bishop's Medical School, in turn itself sought "full union" with the university in 1907.[42] This was also the same year in which the medical faculty there raised the curriculum from four to five years, which while adding a full year of clinical instruction at the senior end, allowed for expansion of the basic sciences in the junior years. The first of the Canadian medical schools to lengthen the course of study,[43] Queen's, University of Toronto and Dalhousie

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[40] Flexner, 324

[41] Gidney and Millar, "The Reorientation of Medical Education," 53, n.5. The medical schocl at the University of Toronto was equally as distinguished, but these authors note that "McGill University . . . though located in Montreal, was an important influence on Ontario's system of medical education."

[42] Frost, 44, 50

[43] T. Roddick, "Convocation in Medicine", *Montreal Medical Journal* 37 (July, 1908): 536. Dr. Roddick was expressing relief that the student numbers had not fallen off as greatly as had been expected, and hoped that "as the other universities in Canada fall into line with the adoption of a five-year course, we may again reasonably expect our full

followed suit the next year.[44] Flexner considered McGill somewhat "less fortunate" in its staff of full-time teachers, but its "genuine enthusiasm" went far to overcome these difficulties.[45] New facilities for the teaching of the new sciences had been built, and well-equipped laboratories were drawing students and researchers from other disciplines as well as medicine. Despite a fire in 1907 which destroyed the entire medical building at McGill, its larger and more modern replacement was opened in 1910 to Harold Geggie's optimistic prophesy that the medical faculty would "still continue to send forth into public life its Oslers, its Bells and its Shepherds."[46]

In the case of the development of the faculty of medicine at the University of Toronto, Gidney and Millar argue convincingly that the remaining proprietary schools were not so much "wrong as increasingly irrelevant" in the face of "the sheer potency of the reseach ideal in transforming people's notions of what a university should be."[47] As they sum up,

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share of students."

[44] Travill, 192-193; Editorial "New Auspices at McGill" *Montreal Medical Journal*, Vol. 37, No. 8 (August, 1908): 674; Campbell, 632. The medical schools at Halifax and London, on the other hand, which Flexner particularly villified in his report, did not fully integrate with their respective universities nor adopt the five year programme until the year after the report was released. See Editorial " Medical Teaching in Halifax," *CMAJ* 1 (1911): 984; Murray L. Barr, *A Century of Medicine at Western: A Centennial History of the Faculty of Medicine, University of Western Ontario* (London, Ontario: The University of Western Ontario, 1977): 165

[45] Flexner, 79

[46] H.J.G. Geggie, *Old McGill* (McGill University Archives, Yearbook, 1911): 21

[47] Gidney and Millar, "The Reorientation of Medical Education ," 75.

> [T]he creation of the faculty of medicine at the University of Toronto and the concomitant changes at Queen's in 1892 signalled some major shifts in the nature of the professional education which would begin to mark off the future from the past: the intrusion into medical education of those who were not practitioners; the new emphasis on the pre-clinical sciences as the essential foundations for the art of practice; the transition to a salaried professoriate; the idea that a medical school was not simply a teaching but a research institution; the notion that medical education was best served when lodged within the walls of a university.[48]

The history of obstetrical teaching parallels that of medical education more generally, in that it was believed by both doctors and by many women themselves that scientific medicine applied to birthing could provide a better outcome for both mother and child. It is probable that by the 1900s physicians attended the births of approximately half of the women in both the United States and Canada.[49] From the late nineteenth century on, most physicians were in agreement that a proper obstetrical training could not be obtained through an apprenticeship or a series of lectures alone, but there was less consensus over what constituted an appropriate education. The first major authors of obstetrical textbooks in the United States in the early 1800s had

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[48] Gidney and Millar, "The Reorientation of Medical Education," 68. Gidney and Millar contend that their "interpretation diverges" from those who believe that the demise of the proprietary schools occurred just because their "time had come". I would argue that they are, in effect, supporting this viewpoint, but that they are subjecting it to a much more intense and ulitmately more fruitful scrutiny. As medical students increasingly chose the university setting because they perceived it to provide a better professional education, for all the reasons Gidney and Millar elucidate, the proprietary schools died out.

[49] Judith Walzer Leavitt, "Science" Enters the Birthing Room: Obstetrics in America Since the Eighteenth Century," *The Journal of American History* 70 (1983): 295; Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in VictorianCanada* (Toronto: University of Toronto Press, 1991), 167

brought to print the foremost ideas on clinical observation and laboratory training from the European traditions,[50] and rapid changes were made in the practice of obstetrics by the end of the century with the more widespread use of forceps, the introduction of anaesthesia, and the gradual adoption of the principles of aseptic techniques.

Just as importantly for women in labour, James White in 1850 had revolutionized the teaching by allowing his senior class at the Boston University Medical College to view for the first time a normal labour and delivery. Even though the woman so used was from the 'lower' classes, the moral outrage from both his colleagues and the public provoked by this move no doubt was a primary reason why many other schools refrained from requiring regular student attendance at deliveries until many years later.[51] It was not until 1906, for example, that the medical students at the Burnside Lying-In Hospital in Toronto gained admittance to attend deliveries, although at the turn of the century most medical schools required attendance for at least six births.[52] McGill had allowed students to view deliveries before the 1870s,

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[50] Lawrence D. Longo, "Obstetrics and Gynecology", in *The Education of American Physicians: Historical Essays*, ed. Ronald L. Numbers (Berkeley: University of California Press, 1980), 210

[51] Longo, 211-214. White was attacked by his colleagues both in letters to the editor in the local paper, as well as by the Committee on Education in the American Medical Association. The AMA found that "while his practice was neither immoral or wrong, it was entirely unnecessary for purposes of instruction."

[52] Mitchinson, *The Nature of the Their Bodies*, 173; George M. White, "The History of Obstetrical and Gynaecologocial Teaching in Canada," *American Journal of Obstetrics and Gynecology* 77 (1959): 467; University of Toronto Archives B69-0003, Box 001/File. Certificate of William James Corrigan, proving that he attended six midwifery cases at St.

and required them to undertake six confinements up until 1910, when the numbers were rapidly increased to twelve in 1910, and to twenty in 1911.[53] This 'ocular' instruction, however, was a major shift in the education of students who until this time had been compelled to learn their obstetrics by circumspect feeling beneath sheets, a method designed to preserve the modesty of the patient but undoubtedly very unsatisfactory for the aspiring physician. However, this development signalled more than just better instruction in the physiology of labour and delivery. As both physicians and labouring women gradually accepted the results of White's controversial teaching methods, it foreshadowed the kind of cultural authority eventually claimed by 'scientific' medicine. The steady accumulation of specialized knowledge by physicians for pregnancy and parturition, whether or not it was effective therapeutically, became part of the package offered to women in the birthing chamber. The authority so gained by doctors by removing this knowledge from common understanding was at the same time ceded by women to physicians in the name of safer childbirth.

Flexner was nevertheless still complaining in 1910 that "the very worst showing is made in the matter of obstetrics," and much of his criticism was centered around the lack of practical clinical instruction. His contention was that too many medical students still never saw a live delivery; the manikin

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Michael's Hospital, signed by Dr. Kennedy G. McIlraith.

[53] McGill University Archives, Calendars 1910-1911, 303; 1911-1912, 59

was of "limited value" only, while didactic lectures were "utterly useless".[54] For Flexner, the optimum obstetrical experience consisted of scrupulous in-hospital training, under the watchful eyes of fully qualified practitioners, so that the practising doctor would be able to "secure the essentials even admidst the most unpromising environment".[55] A major study conducted the following year by J. Whitridge Williams revealed the inadequacies of both the professors and the products of this type of obstetrical education, and Williams admitted that "the average practitioner, through his lack of preparation for the practice of obstetrics, may do his patients as much harm as the much-maligned midwife." His summary and recommendations set out standards for obstetrical education and practice which he hoped would revolutionize physician midwifery to the extent that the demands of the "laity" would enforce their regulation.[56]

The high rating that McGill received from Flexner was partially based on its provision of ample in-hospital student training. As of 1880, the university faculty had taken over the University Lying-In Hospital (renamed the Montreal Maternity after 1887), and the patients appropriated for the

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[54] Flexner, 117

[55] Flexner, 96

[56] Williams, J. Whitridge, "Medical Education and the Midwife Problem in the United States", *Journal of the American Medical Association* 58 (1912): 7

growing needs of the medical school.[57] Finishing up his Arts pre-clinical years in 1909, Harold Geggie could then look forward to his third and fourth years, when students were to receive their obstetrical training along with their major instruction in surgery and medicine. At the Montreal Maternity, "bedside instruction in external palpation, pelvimetry and the management and after-treatment of cases" was promised, as well as "a course of individual clinical instruction". Students' obstetrical education was rounded out by lectures "on the principles and practice of the obstetric art", well-illustrated by "fresh and preserved specimens", by models and various forms of a mechanical pelvis.[58] The number of confinements required were perhaps more strictly enforced than in 1896, when James Cameron's obstetrical notebook revealed that he attended only three confinements during his studies at McGill.[59]

Two years later Howard Walmsley was preparing for his final two years at Queen's. As Flexner would have approved, the third and fourth year courses were separate,[60] with the third year being devoted mainly to learning

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[57] Hélène Laforce, "The Different Stages in the Elimination of Midwives in Quebec," in *Delivering Motherhood: Maternal* Ideologies and Practices in the 19th and 20th Centuries, Katherine Arnup, Andrée Lévesque and Ruth Roach. Pierson, eds. (London: Routledge, 1990), 44-45. According to Laforce, the teaching midwife resigned soon after this takeover, one of the factors leading to the demise of trained midwives in the province.

[58] McGill University Calendar (1908-09):297-98

[59] James C. Cameron, *McGill Obstetrical Notebook* (Montreal: E. Renouf, 1896) It is not known exactly how many confinements Dr. Geggie would have been required to attend, as the changes from six, through twleve to twenty may have applied to each class of first year students only. Whether or not there was enough time set aside in his own class's schedule to accommodate the extra deliveries is unclear.

[60] Flexner, 95-96. " . . . for the mingling of third and fourth year students in clinical work is severely reprehensible . . ."

the physiology and management of normal labour, while in the fourth year students investigated more thoroughly the diseases and problems of pathological problems in pregnancy. Flexner was less enamoured of the clinical facilities for obstetrics available at the Kingston General Hospital, a problem he attributed to its inconvenient location and the smallness of the community.[61] However, obstetrics and gynecology appear to have been more thoroughly mixed than at McGill, and there was extra emphasis given to both postpartum care and care of the newborn.[62]

A fundamental problem for all students heading into general practice was the ambivalent goal of the teaching in obstetrics. On the one hand it was beginning to be recognized that for a young doctor, obstetrics would most likely form the major portion of his practice at first, yet the provisions for surgical experience far outweighed opportunities for obstetrical training.[63] Many teachers, leaning towards specialization, were unprepared to accept that more than the basics of normal labour and delivery should be taught at the senior undergraduate level, seemingly oblivious to the fact that many of these doctors would not have easy access to either specialist or hospital facilities.[64] J. Whitridge Williams in his analysis of the results of his investigation into the

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[61] Flexner, 326

[62] Travill, 190

[63] Mitchinson, *Nature of the Their Bodies*, 173

[64] For a more detailed examination of the formation of the specialty of obstetrics, see William Ray Arney, *Power and the Profession of Obstetrics* (Chicago: University of Chicago Press, 1982); also Borst, 131-151

teaching of obstetrics recommended that the general practitioner should be educated "to realize that he is competent only to conduct [a] normal case of labor, and that major obstetrics is major surgery."[65] This was a debate that continued well into the middle of the twentieth century. As one commentator asserted two decades later, all undergraduates "must be taught the principles of obstetrics", but anything more "should be reserved for doctors who after graduation decide to "take up obstetrics".[66] A few years later still another author questions why recent graduates, having as much training in obstetrics as they do surgery, will "not even [attempt] a simple appendix, but will "attempt to build up a practice by doing obstetrics immediately."[67] But as H. R. Clouston, a classmate and lifelong friend of Harold Geggie remarked, while the obstetrical courses "generally merit approval", the questions that should be asked by instructors is "How far are these procedures applicable outside the hospital?"[68] How many other inexperienced physicians echoed the sentiments of the young Harold Geggie, one morning early in his own practice when he was faced with a forceps delivery for which he had been woefully unprepared?

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[65] Williams, 7

[66] Eardley Holland, "Maternal Mortality", *The Lancet* 228 (1935): 976

[67] Presley A McLeod, "Maternal Mortality from the Viewpoint of the Obstetrician", *CMAJ* 42 (1940): 56

[68] H.R.Clouston, "The Medical Curriculum as Viewed by a Country General Practitioner", *CMAJ* 28 (1933): 319

"How far from reality do the great ones of the earth live," he lamented. "How far from us, the ordinary workmen."[69]

Given that medical schools still continued to rely on the didactic lecture and the increased use of bedside clinical instruction during the time that Dr. Geggie was enrolled in medical school, it is somewhat difficult to ascertain the specifics of his obstetrical education. While there are several textbooks listed in the McGill's calendars, we have no sure knowledge which ones, if any, were used by either the professors or the students. Textbooks are useful in that they provide a kind of theoretical baseline from which we can evaluate later practice, but without lecture notes, we do not know how individual teachers may have modified the material in the texts. Nevertheless, that certain texts were listed in the calendar should imply at least that the basic information they contained was considered acceptable to the teaching and practice of obstetrics of the time, and for that reason alone, it is worthwhile to investigate their contents.

An examination of the obstetrical texts in this study will be confined to those current to the period when Dr. Geggie was attending medical school.[70]

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[69] H.J.G. Geggie, *The Extra Mile*, 41

[70] The texts used in the following discussion include Edward P. Davis, *A Manual of Practical Obstetrics* (Philadelphia: P. Blakiston, Son & Co., 1891); Thomas Watts Eden, *A Manual of Midwifery*, Third edition (Toronto: The MacMillan Co. of Canada, 1911); J. Clifton Edgar, *The Practice of Obstetrics: Designed for the Use of Students and Practitioners of Medicine*, Third edition (Philadelphia: P. Blakiston's Son & Co., 1907); David James Evans, *Obstetrics: A Manual for Students and Practitioners*, Second edition (Philadelphia and New York: Lea & Febiger, 1909); Barton Cooke Hirst, *A Textbook of Obstetrics* ?Second edition (Philadelphia: W.B. Saunders, 1898) and Fourth edition, (1903); Charles Jewett, ed., *The Practice of Obstetrics by American Authors*, Second edition (New York and Philadelphia:

Much more research is needed in both older and later texts to more fully comprehend the details of change in obstetrical practice that took place from the mid-nineteenth century until, for example, after the second World War. I do, however, accept the hypothesis that until the discovery of sulpha drugs in the 1930s, many of the principles of obstetrical practice, if not the details, remained relatively unchanged from the late nineteenth into the first few decades of the twentieth century.[71]

While it could be argued that all of the texts fit into the same category, several explicitly announced that they were for the use of both students and practitioners. Relecting the biases of the authors' urban private practices or their hospital-based obstetrics, these physicians understandably directed most of their teaching towards the future or present urban practitioner. Occasionally, however, they did acknowledge that not all doctors might have had all the necessary facilities at hand.

The basic underlying rationale upon which the writers both organized and justified the medical management of pregnancy and parturition rested on the almost universally held belief (by doctors) that the pregnant woman teetered precariously on the borderline between health and disease. These physician educators almost invariably began with the declaration that

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Lea Brothers, 1901); J. Whitridge Williams, *Obstetrics: A Text-book for the Use of Students and Practitioners* (New York and London: D. Appleton and Co., 1903), also Fifth edition (1925)

[71] Shortt, " 'Before the Age of Miracles', 124

pregnancy should be considered a normal and natural state, and that labour was, in the majority of cases, a "comparatively easy process". Just as invariably, in the next breath they asserted that the path to a safe and healthy parturition was fraught with particular dangers. One physician warned his readers that both patients and "their advisers are too prone to consider [pregnancy] a period of invalidism, and to forget that it is a [normal] physiological process," but he hastened to add that, "no one who has had an extensive obstetric experience can fail to observe that a large number of pregnancies are, when carefully studied, really pathological in nature."[72] "Nature alone, in the majority of cases, with very little artificial aid, is capable of terminating safely the birth of the child," intoned another," but at the same time it should not be forgotten that at any moment a dangerous complication may occur . . ."[73]

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[72] Edgar, 185

[73] Hirst, (1903), 296. Whether or not pregnancy should be considered a normal physiological event or pathological process seems to have been debated more in the journals than in these textbooks. Only a few examples are needed to provide an overiew of this argument that has lasted up until the present day. For instance, "We conclude from these results that labour is a physiological process, if the woman is but let alone . . .W.W. Chipman, "Conclusions after a Symposium in Obstetrics," *CMAJ* 14 (1924):704; "I am of the opinion that pregnancy and labour should be considered pathological, but should be treated along conservative lines maintaining an attitude of masterly inactivity rather than one of injudicious activity." Arthur Lennox, "A Few Remarks on Prophylaxis in Obstetrics," *CMAJ* 14 (1924): 698; "The practice of obstetrics would rapidly attain to a higher level if medical men would take to heart Mauriceau's dictum that "Pregnancy is a disease of nine months' duration." C.B. Oliver, "Obstetrical Practice Yesterday and To-Day," *CMAJ* 20 (1930): 469

It was therefore the duty of every physician, from the moment they were consulted, to keep their "pregnant patients under strict supervision."[74] The underlying message conveyed throughout was that women needed managing. Although the rhetoric on female physical frailty was softened in these texts in comparison with the late nineteenth century, doctors still perceived women to be emotionally and psychologically delicate, almost childlike.[75] Not only was the physician to "inspire her with hopefulness and courage" in a firm but sympathetic and gentle manner, he was also to be the one to "whom the woman in labor [was to look] for help and encouragment in her hour of trial."[76] To preserve her "self-control" for the hard work needed during labor, it was a wise physician who did not inform his patient of any abnormal findings, although it was suggested that he ought to "impart his knowledge to some responsible member of the family for his own protection, in case an emergency should arise."[77] Above all, it was the duty of every physician to gain the trust

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[74] Williams, 175

[75] See Wendy Mitchinson, "Causes of Disease in Women: The Case of Late 19th Century English Canada," *Health, Disease and Medicine: Essays in Canadian History*, Charles G. Roland, ed. (Toronto: The Hannah Institute for History of Medicine and Clarke Irwin, 1982): 381-395. Mitchinson describes the late-nineteenth century medical belief that excessive civilization was at the root of many of women's reproductive ailments. This perception seemed to be more muted in these obstetrical texts, although at least one author blamed early menstruation on the "higher nervous organization " of the children of the "superior classes." (Edgar, 22) Nevertheless I would agree with Mitchinson's analysis that doctors were able to extend their influence beyond medical boundaries under the guise of preventive medicine.

[76] Evans, 132

[77] Williams, 282

and confidence of his pregnant patients, so that they would seek advice from him rather than their "woman friends."[78]

Nevertheless, the authors of these texts were acutely aware that childbirth could also cause women real suffering, and within the limits of contemporary scientific therapeutics, supported certain measures which they believed would alleviate some of its distressing features.[79] These somewhat more practical aspects of medical obstetrical care also provide a context from which to assess the training that a young physician might have received during the first decade of the century. I do not intend here to discuss obstetrical education in its entirety, but to highlight areas in the medical management of labour that were perceived by women to offer them safer, easier and less painful deliveries. These have often been cited as important reasons why women began to choose the medical attendant over the midwife for their confinements.[80] While little is known about the decade of work immediately following Dr. Geggie's graduation, I contend nevertheless that an understanding of the conventional teaching in obstetrics to which he was likely

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[78] Williams, 175

[79] "Suffering" was a very popular word in these texts. As Wertz and Wertz point out, "the [late-nineteenth] culture expected women to suffer, and suffer they did, but the reasons were not simple." Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* (New York and London: Free Press, 1977), 110

[80] For example Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (New York and Oxford: Oxford University Press, 1986), especially 87-141; Edward Shorter, *A History of Women's Bodies* (New York: Basic Books,1982), 140-145; Borst, *Catching Babies*, especially 117-130. By investigating in detail one relatively small American midwest locale, Borst examines the role of gender, ethnicity and class to provide an unusually nuanced perspective about the changeover from midwife to physician.

exposed provides a starting point to a discussion of those issues relevant to his own practice.

Mortality and morbidity from puerperal infection continued to plague birthing women and their doctors, and the attempts at eliminating this problem shaped much of the way obstetrical care was addressed in these texts. Explicit instructions to physicians on the washing of hands and cleaning and sterilizing of instruments were a fundamental part of each discussion about proper techniques in everything from normal deliveries to emergency operative procedures. Failure to heed aseptic precautions might very well predispose a woman to gynaecological problems later in life, most authors believed, and they almost universally urged that vaginal examinations, if the labour were progressing normally, should be kept to the absolute minimum of no more than two per delivery.[81] No author mentioned replacing vaginal with rectal exams where possible, which would further reduce interference in the birth canal. As Dr. Geggie used this latter method very frequently, this may indicate that either rectal examinations were an example of a practice preferred by his own teachers, or that this was a procedure not yet universally adopted and one which he learned later on his own.[82]

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[81] Williams, 777; Evans, 140; Edgar, 477; Jewett, 236; Eden, 294

[82] There was little mention made of rectal examinations in any of the literature on obstetrical care, so where Dr. Geggie learned this procedure can only be a matter of speculation at this time. According to an obstetrician from McGill, it was adopted at the Montreal Maternity sometime in the first quarter of this century. As he noted though, rectal examinations were not entirely free from being implicated in puerperal infections, although any caused by rectal exams were considered "mild." See Herbert M. Little, "Obstetrics During the Past Twenty-Five Years," *CMAJ* 14 (1924): 905

All of the physician-authors were in favour of anaesthesia to relieve the woman's suffering, feeling it was justified on both "humanitarian and scientific grounds,"[83] and chloroform seemed to be the anaesthetic preferred by the majority. The physician was encouraged to persuade the woman to wait as long as possible before starting with the chloroform, preferably into the second stage of labour, because as one author explained, "it is only natural that as soon as the patient has experienced the soothing effects of the drug, the physician may find himself forced to continue its administration for a considerable length of time, unless he possesses more fortitude than is generally the case."[84] While all of the writers believed that only light analgesia was required throughout most of the second stage of labour, all were in agreement that chloroform should be taken to the "surgical degree" at the "acme of expulsion", not only to relieve the woman of the moment of the most severe pain but also to allow the doctor control over the head of the infant to protect the perinaeum from laceration.[85]

The methods used by doctors to terminate a labour before it had run its natural course were called operative obstetrics, which included among other things the use of forceps, podalic version (turning of the infant inside the womb to grab the feet), embryotomy (crushing of the infant's skull or eviscerating its

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[83] Jewett, 239

[84] Williams, 286

[85] Evans, 218; Williams, 291-293; Davis, 80; Eden, 294-296; Jewett, 239-240; Edgar, 865-866

body contents) , Caesarean section and medically induced abortion.[86] Even with careful techniques to prevent infection, these were often dangerous procedures, but they did probably constitute the skills in a physician's repertoire that were most valued by women who might otherwise have died or been severely injured without their use. Nevertheless, their employment brought charges of 'meddlesome midwifery' from other colleagues and patients alike, who accused doctors of putting a woman at risk in order to justify their fee or to simply attempt to save themselves time at what were often tedious affairs. Doctors so denounced often defended their actions with the contention that they were only trying to relieve women of unnecessary pain and suffering, and furthermore, women and their families themselves often demanded such measures even against the good judgment of the physician.[87]

The readers of these texts continued to be warned against the misuse of the operative procedures, although indications for their use were sometimes vague. "Failure of the pains is not of itself alone an indication for forceps," wrote Jewett, or, as Eden asserted, "forceps should not be applied merely to save the time of the medical attendant.[88] Generally forceps were called for when a delay in delivering the child would endanger the life of either the

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[86] Dr. Geggie used forceps, versions and embryotomies, but because he never attempted a Caesarean in homes, nor did he knowingly perform abortions, these will not be discussed here.

[87] Leavitt, *Brought to Bed,* 87-141

[88] Jewett, 680; Eden, 636

mother or the infant, leaving inexperienced physicians with few clear guidelines as to when that dangerous moment might occur. Williams, after offering perhaps the most useful criteria for regulating the use of forceps, nevertheless insisted that overall "definite objective symptoms should be present . . . but little weight should be attached to the statements of the patient."[89]

Podalic version was a method of retrieving an infant when forceps were contraindicated or had failed. This was an old operation which had fallen into "deserved disrepute" until physicians better understood sources of infection, as it necessitated the doctor inserting his hand into the uterine cavity, often up to the forearm, in order to grab the feet of the baby. While this "rehabilitated" procedure was not "devoid of risk", it was still considered a relatively safe strategy for both mother and child as long as the "strictest antiseptic precautions" were followed, the woman was not totally debilitated and her cervix was at least dilatable, if not already well open.[90]

The textbook discussion of embryotomy offers the clearest example that although physicians could offer their pregnant patients new technologies, women and their family and friends sometimes elected not to avail themselves

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[89] Williams, 356

[90] Williams, 347; Eden, 612-614; Edgar, 929. While none of the authors mentioned the use of anaesthesia for version, by this time it would likely have been taken for granted. Before anaesthesia was more generally accepted, however, some doctors preferred not to use it for these kinds of operations because they might unintentionally harm the woman more if they could not tell how much they were hurting her. (See, for example, Leavitt, *Brought to Bed,* 119; Wertz and Wertz, 118

of these opportunities. The authors relayed the growing feeling among medical practitioners that the increasing use of Caesarean section made the destruction of a living term foetus unjustifiable, although embryotomy was still preferred over this operation if the foetus were already dead. But as Edgar pointed out, there were still two circumstances surrounding embryotomy that "may greatly embarrass the physician in the performance of what is clearly his duty."[91] One of these conditions was the lack of available services, and it was acknowledged by other doctors also that country practices were often "without the necessary appliances for an aseptic abdominal operation."[92] But Edgar also indicated that even if Caesarean sections were available for women, they were not always willing to put themselves at risk and would rather sacrifice their infant instead. This was noted by Evans as well, who gave rather detailed instructions for the physician placed in this predicament.

> Embryotomy should never be performed on a *living child* when any other obstetric operation offers a reasonable chance of saving its life. The patient and her friends may decline any conservative operation and insist on embryotomy. In such a case, if the physician is of the opinion that a conservative operation would offer a reasonable chance of saving the child, he is at liberty to transfer the case to someone else should he so desire. When such a course is not open to him, the physician must under protest yield to the desire of the patient and her friends, as he has no legal right to compel them to follow his judgment.[93]

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[91] Edgar, 943

[92] Williams, 419

[93] Evans, 420

Despite the increasing influence of the medical attendant, the support of family and friends obviously still provided parturient women with some choice in the kinds of decisions that often had to be made at the births of their children. While it may have been desirable that young physicians maintained control over the confinements they attended, it nevertheless appeared that at times doctors were forced to compromise their authority and bow to the wishes of their patients.

While physicians were not without compassion for their patients, the interest in the management of childbearing was not solely for the benefit of pregnant women and their children. The professional influence gained by physicians in the name of scientific medicine helped to raise the profile of the practice of obstetrics, an aspect of medicine that one physician complained was seen by too many medical men as "sordid, drab, uninteresting and unremunerative."[94] As another argued, if women were convinced that physicians had their best interests at heart, not only would they be only too willing to cooperate, but that obstetrics also "[would] be elevated to the dignified plane which it so justifiably deserves."[95]

Dr. Geggie graduated from medical school at a pivotal moment in the education of doctors. The scientific approach to the teaching of medicine which had been gaining ground since the end of the nineteenth century had been

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[94] Oliver, 470

[95] Joseph N. Nathanson, "Prophylaxis in Obstetrics, with special reference to the value and importance of pre-natal care," *CMAJ* 14 (1924): 496

fully legitimized by the Flexner report in 1910. The university school model with its emphasis on laboratory science and research undertaken by full-time professors was taking hold, and the proprietary schools run by practitioners were quickly fading away. Although slower to be implemented, opportunities for student clinical practice gradually opened up as more schools recognized the necessity for adding more time to the medical curriculum.

The basic teaching in medical obstetrics also benefitted from the same changes that affected education in medicine more generally. Doctors expanded their understanding about the anatomy and physiology of pregnancy, and young physicians were entering practice armed with the ability, at least in theory, to deliver women more comfortably and more safely. Still, the infant and maternal death rates were not decreasing, and the public and government bodies were becoming increasingly concerned. Physician educators recognized by the time Dr. Geggie graduated that obstetrical cases were often not only the first endeavours of a young general practitioner, but that they would often form the basis of their practice. Thus, general practitioners, especially those working in the rural areas, received much of the blame for the poor obstetric results. The tension between those educators who believed anything beyond 'normal' obstetrics should become the domain of specialists and by those who believed that all doctors needed better preparation to handle the variety of cases with which they would be presented in their own communities, was reflected in the debates over the conflicting goals of medical obstetrical

education. These arguments about the depth of obstetrical training highlighted the dilemma of whether or not obstetrics as a medical specialty should exclude or incorporate the requirements of the general practitioner.

The education of a doctor and the training to which he or she was exposed presents only one side to the story of medical care. The difficulties in putting that education into practice outside the walls of the training institution, and the modifications and adaptations that had to be made once young doctors were on their own are obscured behind the veil of medical texts and lectures. So, too, are the patients who called them to their bedsides. Dr. Geggie was eager to leave medical school and get out of city. Despite winning the Wood gold medal at McGill for the best examination in all the Clinical branches, he was determined not to continue on with an internship, but to "be up against real medical problems on my own."[96] While only the barest outline of the first decade of his practice remains, the contours of the middle decades are more discernible, and will form the basis for the discussion in the following chapter.

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[96] H.J.G. Geggie, *The Extra Mile*, 25

Chapter Three

An Obstetrical Practice

Before examining in more detail Dr. Geggie's obstetrical records, it will be useful to situate the people among whom he worked within the social and economic context of Wakefield and the surrounding area. The lower Gatineau Valley was initially settled in the mid 1800s by Protestant families predominately from northern Ireland. French Canadians also filtered into the area from the overcrowded St. Lawrence lowlands, drawn by lumbering and mill work.[1] Internally migrating Irish Catholics and Protestants began to push northward from Carleton and Lanark counties in Eastern Ontario in search of more fertile soil, but as there was no Catholic church in Wakefield proper, the Irish Catholic settlers continued a few miles north to build a community around the mission at Farrellton.

The village of Wakefield itself appeared to be a relatively stable and prosperous community. By the time Dr. Geggie arrived, the woollen mill had ceased to operate after its last disastrous fire, but the grist mill still ground out oats for a few more years, and other commerical establishments developed and thrived. While the wood construction of most of the homes and businesses remained under constant threat from fire, much of what was lost after each fire was rebuilt. As the area gradually expanded and daily rail service began

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[1] Helen E. Parson, "An Investigation of the Changing Rural Economy of Gatineau County, Quebec," *The Canadian Geographer* 21 (1977): 24

at the turn of the century, it was feasible for people to work and shop out of the village in Ottawa and Hull, and for tourists and workingmen heading further north to find lodging in the boarding homes and hotels.[2]

The prospects were somewhat bleaker on the land. No matter why people were drawn to the area, most first had to establish their homesteads and small farms to sustain their families. There were few large farms in the area, as the rocky outcrops of the Gatineau Hills and the cool temperatures with short growing seasons left much of the land unsuitable for large acreages of profitable farming. Especially for the French and Irish Catholics, many of whom had already started out in poverty, the poor farms provided little more than a subsistence level of existence. Many French Canadian men, in particular, left their homes to work farther north in lumbering during the winter months to add to their meagre income. As was true for the whole area stretching from the Gatineau Valley over to Montebello, rural electrification came very late. Only five percent of farmhouses had acquired electricity by 1931, and only thirty-five percent as late as 1951.[3] It was to these homes that Dr. Geggie was often called, and where he found most of his work.

The lack of adequate communication and transportation were problems central to a rural practice. While the Wakefield countryside may not have had

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[2] Norma Geggie, *Wakefield and Its People:Tours of the Village* (Quyon, Quebec: Chesley House Publications, 1990): 31. See also Bruce Ballantyne, "Station Agent in the Gatineau", *Up the Gatineau!* 10, Arthur Davision, ed. (Old Chelsea, Quebec: Historical Society of the Gatineau, 1984), 2-3

[3] *Canada Census* 1931, Vol. VIII, Table 34; *Canada Census* 1951, Vol. II, Table 24

electricity, it did have a relatively modern telephone system that developed from lines first set up under Dr. Stevenson's organization as early as 1906. Dr. Geggie continued to support this venture, and before the lines were taken over by Bell, there were at one point four different exchanges which culminated in the hallway of his house.[4]

Dr. Geggie travelled in the earlier days by horse and buggy, often needing to change his team several times during the day. The first bridges were not built across the Gatineau River until 1914 and 1915; until then Dr. Geggie had to cross on cable scows. Even after he obtained motorized vehicles in the 1920s and 30s, both cars and a form of snowmobile, they could not be used regularly until the roads were in better condition.[5] On the unploughed roads of winter and the mired paths in spring he was forced to revert to his horses, which in any case he sometimes preferred for their ability to make it home on their own while he dozed. Reaching some of the more isolated farmhomes remained a problem well into the 1940s. At a labour one stormy December night, he commented somewhat anxiously in the middle of the delivery that it had been " long getting up, but snow stopping. 47 miles from home."[6] A year later it was hard to tell whether he was exasperated or

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[4] H.J.G. Geggie, *The Extra Mile: Medicine in Rural Quebec: 1885-1965*, Norma and Stuart Geggie, eds. (Self-published, 1987), 94-95

[5] Mrs. T. related that the snowmobile, "which had a windmill effect at the back . . . scared all the horses in the country." Interview 19 February 1997

[6] OBS note 117:40

relieved when he remarked, "Here after 4 hr. trip. Snowmobile, on foot and horse."[7]

Not enough is known yet about the effect the automobile had on rural medical practices. Michael Berger in his study of the automobile's influence on rural American health care, noted that physicians were one of the first groups to use cars. As people could be treated more quickly and doctors could fit in more patient visits during the day, he contended that the quality of medical care improved.[8] However, Charlotte Borst's research demonstrates that the automobile did not necessarily mean that doctors made more house calls, nor did she find that it enlarged the geographic area of obstetrical practice for her Wisconsin general practitioners.[9] I suspect that a closer scrutiny of Dr. Geggie's practice would produce similar findings. The geographic areas he covered by horse and buggy were still significant distances for the automobile; the trip to Poltimore alone (see map) still takes thirty minutes today, and the travelling that he did would have kept him out of the office for a good portion of every day. Although I have not studied this in his practice, the major difference the automobile may have created for Dr. Geggie was that it allowed him to reach women in labour more quickly, or conversely,

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[7] OBS note 4:41

[8] Michael L Berger, "The Influence of the Automobile on Rural Health Care, 1900-29," *Journal of the History of Medicine* 28 (1973): 320-322.

[9] Charlotte G. Borst, *Catching Babies: The Professionalization of Childbirth, 1870-1920*, (Cambridge: Harvard University Press, 1995), 124-125

he may have been able to wait longer before heading out for a delivery.

The obstetrical case notes from Dr. Geggie's practice provide an opportunity to study birthing just before it entered the insitutionalized atmosphere of the hospital. From the late 1700s, urban physicians had recognized that obstetrics was a fundamental part of building a general practice. "It was midwifery, concluded Dr. Walter Channing of Boston, that ensured doctors "the permanency and security of all their other business."[10] There is some evidence, however, that it was not until the early twentieth century that country general practices could count upon the same foundation. In Borst's study of the transition from midwives to physicians in rural Wisconsin, she discovered it was not until the early 1900s that younger doctors began taking maternity cases when they embarked on their careers, but by 1920 "obstetrics was to become an integral part of a general practice for both young and more established physicians."[11] A doctor who was found satisfactory for one confinement would more likely be asked back for the next, and might also be called for any emergencies that affected the family in the meantime. As Dr. Geggie's son commented, "delivering your first grandchild was

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[10] Quoted by Catherine Scholten in "On the Importance of the Obstetrick Art': Changing Customs of Childbirth in America, 1760 to 1825," *William and Mary Quarterly* 34 (1977): 438. See also the advice given to medical students in 1885 as quoted by J.M. Kerr in Anne Digby, *Making a medical living: Doctors and patients in the English market for medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994): 254

[11] Borst, 120. She contrasts her findings with that of Rosemary Stevens and possibly others who suggest that by the late 1920s, general practitioners were giving up obstetrics. (122) Certainly, it seems that Dr. Geggie's practice would fit in more with Borst's findings than that of Steven's.

considered a milestone," which referred not to his own grandchild, but to the progeny of women patients who had been with the same doctor for at least two generations.[12]

As was noted in the previous chapter, this tendency to build a practice on obstetrics was both acknowledged and sometimes decried by medical educators who were often uncertain as to exactly what kind of training should be provided for their graduates. The new graduates themselves were most likely just as unsure if they were indeed properly prepared for undertaking this responsiblity. Harold Geggie's wish to work with his 'Preceptor' for several more years undoubtedly had much to do with his initial inexperience with obstetrical cases. Having lost the very first patient he attended to diphtheria, he also found it necessary to call for help for his first haemorrhaging woman and for his first forceps delivery.[13] Knowing he was somewhat unprepared for the rural isolation in which he would have to practice, he knew he needed to depend on Hans Stevenson's advice, if not his presence, and the six months he had with him must have seemed all too brief.

It is clear that Dr. Geggie's reputation and his practice did eventually become well-established, and many women trusted him to deliver many, if not all, of their babies. One woman recounted how she chose Dr. Geggie over a

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[12] From telephone conversation with Dr. Stuart Geggie, February 1995.

[13] H.J.G. Geggie, *The Extra Mile*, 34

another local doctor, and had him there for six out of her seven children.[14] Another came back to him for her second child, even though living twenty miles away. One that the doctor himself wished that "her purse were as wide and deep as is the smile she gives me . . . " had nineteen pregnancies delivered by him, eight of which were accompanied by "much haemorrhage".[15] Another "indestructible" multipara he attended fourteen times in twenty-one years, and many of her pregnancies presented with complications.[16] Although there are as many instances throughout the records where he saw a woman only once, it is impossible to tell if dissatisfaction were the primary cause for a single visit. Some of these single calls may have been similar to the one where a woman invited him to attend her for her ninth delivery, her first physician-attended birth following the births of eight living children.[17]

In an age when payment for medical care had to be squeezed out of already inadequate budgets, family economics and pride may have decreed that many normal pregnancies were to be coped with 'naturally'. Before the days of medical insurance, finances and the economics of medicine were of particular concern to both Dr. Geggie and his patients. Very little work has been published on the earnings from medical practice during the early twentieth

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[14] Interview 20 April 1997, Mrs. J.

[15] H.J.G. Geggie, "An Address to the McGill Undergraduates Society", (given February, 1950): 10, 12

[16] H.J.G. Geggie, *The Extra Mile*, 78-79

[17] OBS note 94:36

century, although Anne Digby's monograph on English physicians has made a notable contribution to the work on nineteenth century physicians.[18] Physicians may have enjoyed an enhanced prestige since many of the issues surrounding professionalization were settled in the later years of the nineteenth century, but while general practitioners may have earned a comfortable living, a high or even stable income was not more assured until closer to the mid-twentieth century. The Depression was particularly hard on both doctors and their patients. Charles McKenzie was forced to leave the prairie town of Ituna when he could not collect even "the smallest fee", and even his salary from the town "was on loan from a bank that was closing."[19] When the stock market crashed in 1929, Samuel Peikoff lost everything, including the hospital he had started in Rossburn, Manitoba, and he was forced to begin a new practice in Winnipeg.[20] Although no records of accounts are available, Dr. Geggie, too, undoubtedly had greater trouble collecting his payments during the worst years of the Depression. As other doctors working

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[18] Anne Digby, *Making a medical living.* For briefer treatments of this issue, see Jan Coombs, "Rural Medical Practice in the 1880s: A View From Central Wisconsin," *Bulletin of the History of Medicine* 64 (1990): 35-62; Charles G. Roland and Bohodar Rubashewsky, "The Economic Status of the Practice of Dr. Harmaunus Smith in Wentworth County, Ontario 1826-67," *Canadian Bulletin of Medical History / Bulletin canadien d'histoire de la médecine* 5 (1988): 29-49. For the twentieth century, see J.M. Crummey, "The daybooks of Robert MacLellan: a comparative study of a Nova Scotia family practice during World War l," *CMAJ* 120 (1979): 492-497; Shortt, "Before the Age of Miracles," 135-137. Physician account books, which may be the most abundant archival source on medical practice at least in Ontario, invite further research in this area.

[19] Diane McKenzie, ed., "Reminiscences of Dr. Charles McKenzie," *Saskatchewan History* (1985): 64

[20] Samuel S. Peikoff, *Yesterday's Doctor: An Autobiography* (Winnipeg: The Prairie Publishing Company, 1980), 82-83

during this era also noted, patients would often pay their accounts with goods. Turkeys, a load of straw, potatoes, lumber, or chunks of beef or mutton were some of the items Dr. Geggie received as barter for services. One family paid all their accounts in citron jam, 'forty dollar' jam, as Dr. Stevenson had described it. Dr. Geggie once took three lakeside cottage lots on account, and sold the cottages he built on two of them "just in time to send my first two sons to school in Ottawa."[21]

Although these calculations cannot be considered entirely accurate, for each of Dr. Geggie's obstetrical cases that I could trace through the daybooks, an attempt was made to determine both the amount owing and the amount paid up. While most patients paid on instalment, few appeared to settle the full amount of their bill; some seemed never to have paid at all. The fee for an uncomplicated delivery rose from fifteen dollars in the 1920s to twenty-five dollars in the 1940s, while prenatal visits rose from one dollar to two, although there was never any charge for postpartum visits within the week or two following the delivery. However, the extra charges could add up. Patients were assessed a mileage fee for long distances or false alarms, and extra costs were incurred for visits in which tests were taken or drugs dispensed, for complications or use of forceps during delivery, although this was not necessarily the case, and for any operations, such as the opening of breast abscesses, with follow-up visits for dressing changes. In 1921, for example, one

[21] H.J.G. Geggie, *The Extra Mile*, 63-65

woman's pre-eclamptic condition necessitated eleven prenatal visits between August and October (thirty-three dollars), an induced labour, which turned out to be difficult (thirty dollars), and six postpartum checkups (five dollars), although the charges did not start until three weeks after her delivery. There may have been other amounts to pay, for the following February the family paid Dr. Geggie fifty dollars by cheque, and received a credit for five tons of hay, worth seventy-five dollars.[22] Two decades later, Dr. Geggie arrived at another bedside too late to deliver the baby, but he did suture a small perineal tear for the mother (twenty dollars). He was called back to see this same woman three weeks later because of threatened breast abscesses, which, despite treatment with sulfonamide, became so severe that eventually two operations were required to drain them. The total cost for her rocky postpartum course of twenty-one visits came to one hundred and ten dollars. In this case it could not be determined if Dr. Geggie was ever paid.[23] There is no indication that Dr. Geggie ever refused to see a patient even if he knew they would be unable to pay; indeed, he believed that "one of the best advertisements open to us is to answer every call that comes to us, keeping an eye on the patient's predicament, not on his purse."[24] Nevertheless, he did render an account to each patient, and some of them must have seemed

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[22] Daybook, 16 August 1921 to 17 February 1922

[23] OBS note 32:43; Daybook, 1 May 1943 to 15 October 1943

[24] H.J.G. Geggie, "An Address to the McGill Undergraduate Society," (given February, 1950): 17

insurmountably high to families who were struggling to make ends meet.

Even though no information is available on the first decade of his practice, it is still possible to trace how Dr. Geggie's practice in obstetrics grew from 1920 until his eldest son took over more of the obstetrical work after 1945. Total obstetrical visits averaged about fifteen percent of his practice when compared with other reasons for which he was called.[25] For the six years in the 1920s for which records exist, Dr. Geggie averaged about 6.5 births per month, which jumped during the 1930s to an average of 10 per month and then dipped slightly during the first five years of the 1940s to 8.6 per month.[26] If delivering at least ten babies per month defines a "specialty practice in obstetrics" even in the present day,[27] then Dr. Geggie very nearly qualified for at least fifteen years during the middle of his career. As he noted later on, if one's obstetrical cases go well, "if he has any luck he is mentioned as a 'specialist'."[28]

These calls for birthing help were not usually, of course, spread out evenly over the month, and were very often clustered so close together that he

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[25] The total number of obstetrical visits he made, which included prenatal and postpartum care, was compared to the total number of visits he made for the two sets of years, 1921-23 and 1941-3, and the percentage was calculated from this.

[26] See Graph 1, Appendix 2. Miscarriages (arbitrarily designated as such from 0-5 months gestation) and premature births (6-8 months gestation) accounted for about one-sixth of the obstetrical practice, and the figures of those women who sought out medical treatment for these conditions have been included here.

[27] Borst, *Catching Babies*,137

[28] *The Extra Mile*, 79

was sent scurrying from one to the other. Occasionally a scrawled note at the end of one case note indicated that he was "off to the next". Some women were left in the middle of their slowly advancing labours as he rushed off to attend to someone else, hoping that his return would be in time to preside at their births. Nevertheless, some days were more memorable than others. One November day with nothing but travelling time between cases, Dr. Geggie worked from midnight to noon to deliver three babies.[29] Even though he once arrived along with the baby, all of these cases were relatively uncomplicated, but they may have triggered memories of almost exactly one year earlier. For this other trio of deliveries spread out over sixteen hours, the results were not quite so successful. In the middle case, the results of a fall sustained by its mother three days earlier caused the death of the infant, and his attempts to save the mother herself from uncontrolled haemorrhaging were also ultimately futile.[30] Some deliveries themselves were busier than others. Over the course of the surviving records, Dr. Geggie attended thirty-five twin births (1.7 percent of his total confinements), and once a set of triplets occurred. All three babies were well when he left, but he noted later that the first and second born had died on the twelfth day.[31]

Dr. Geggie estimated that he "lost an average of one mother every

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[29] OBS notes 98:33, 99:33, 100:33.

[30] OBS notes 96:32, 97:32, 98:32.

[31] OBS note 87:34

second year" and the numbers bear him out.[32] For the twenty-two years between 1920 and 1949 for which total obstetrical cases can be determined, he appears to have had thirteen women die from maternity related causes. While his worst year was in 1936, with three women out of 122 dying (a rate of 24 per 1000 live births), his overall average was closer to 6/1000, although his rate did drop from 7/1000 in the 1920s and 30s, to 4/1000 in the 1940s.[33] In his practice, he rated haemorrhage as the primary factor in maternal deaths, followed by toxaemia and then puerperal sepsis.[34] Four out of the thirteen women who died essentially exsanguinated; of these, two bled from internal haemorrhages concealed until birth, while two had a placenta praevia, in which the placenta, placed low down in the uterus, detaches before the completed birth of the infant.[35] In a rural setting without easy access to transfusion, excessive bleeding following a delivery or from a miscarriage was a constant worry and a major complication. Any bleeding of significance he carefully recorded on the bedside notes, and this problem was notable enough

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[32] H.J.G. Geggie, *The Extra Mile*, 79 Another estimate he gave was the loss of twenty mothers over a fifty year period. (79)

[33] This rate was calculated on the entire obstetrical practice, including miscarriages and premature births, as these women were also susceptible to the potentially life-threatening conditions of haemorrhage or infection.

[34] Dr. Helen MacMurchy from the Federal Department of Health published the results of a survey she conducted in 1926. She believed that puerperal sepsis was the chief cause of maternal death, followed by toxemia, haemorrhage, prolonged labour and shock. This will be discussed more fully in the following chapter. See Helen MacMurchy, *Maternal Mortality in Canada* (Ottawa: Department of Health, 1928): 19-22

[35] OBS notes 97:32, 71:38; 1:36, 7:40

to be mentioned just over ten percent of the time. Toxaemia, or eclampsia, was another difficulty that was considered potentially dangerous for the mother. Treatment initiated antenatally often helped to avoid the symptoms of widespread oedema, elevated blood pressure, and protein in the urine which could lead to convulsions. Because many women never saw the doctor beforehand, however, Dr. Geggie was at times presented with a convulsing mother who may or may not have been in labour. While he encountered the disease many times throughout his practice, only one or possibly two deaths resulted from toxaemia, one being a young woman who never really regained consciousness even after the removal of her dead foetus.[36]

While obstetrical records alone do not reveal whether or not the women developed fevers in the days following their deliveries, Dr. Geggie himself believed that puerperal sepsis was the most uncommon factor in the maternal deaths. He was well aware of the importance of cleanliness, boiling water, and proper examining technique, and always maintained that one vaginal examination during labour, to which he fairly rigorously adhered, was enough. Despite the precautions he attempted, it was no doubt inevitable that there would be some women who developed infections, and from the years in which the cases could be traced through the daybooks, there were three maternal deaths blamed on infection. Even then a postpartum haemorrhage, a possible retained placenta and thirteen pregnancies were most likely vital contributing

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[36] OBS note 42:35

factors in one case.[37]

The most common contributing factor to women dying in childbirth, Dr. Geggie believed, was "an exhausted woman, exhausted from farmwork, homework, [and] too many pregnancies too close together."[38] Six out of the thirteen women who died had eight or more pregnancies, the highest at sixteen. In his own survey of his 1927 obstetrical cases, he listed almost fifteen percent of the women as being "anaemic and exhausted", some undoubtedly from untreated toxic goitre which was prevalent in the region, but most from overwork. Women came to him for tonics containing stimulants and iron in the hope of combatting their discomfort and fatigue. Daily routines often included farm work, resulting not only in weary women but in miscarriages and stillbirth from falls or heavy lifting. One mother admitted, after losing her baby near term, that she had been butted in the abdomen by a calf.[39] Even if a woman were relieved of outside chores, housework itself was arduous enough. In an area where electrification had come so late, household

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[37] Daybook 17 September 1920, OBS note 21:39. The remaining cases of maternal death occurred from a strangulated bowel, "acute yellow atrophy", a weakened heart, tuberculosis and two from pulmonary emboli.

[38] H.J.G. Geggie, *The Extra Mile*, 79. This was also noted by many of the physicians who responded to MacMurchy's questionnaire, who cited overwork and exhaustion as almost ten percent of the reasons why women died from childbirth. MacMurchy, *Maternal Mortality*, 27

[39] Daybook, 21 June 1922

tasks often burdened rural women more than their urban counterparts.[40]

Infant mortality in Dr. Geggie's practice remained high over the years relative to the national average.[41] Over the years there was only a slight general downward trend discernable, from 10.5 percent to 9.3 percent, although it is only through the daybooks during the years 1921-23 and 1941-43 that the fate of children can be most accurately traced. It is also very possible that there were more infant deaths for which no mention was made. Many women he never saw again after their delivery, and he may not have made note of the child's condition even if he knew about it.

Even though many women in this district were poor, the birth weights of infants remained relatively high. The birth weights were calculated at regular intervals for the years studied, and while the lowest weights were recorded during the years of the Depression, they nevertheless fluctuated only between seven and a half and eight pounds for all the years studied. If, as is claimed, the nutritional status of the mother is reflected in the birth weight of her infant, then most women here appeared to have been at least adequately nourished.[42] While these results can only be considered as suggestive, and

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[40] Electricity was needed before running water could be brought into homes, as electric pumps were necessary to fill the tanks in the home. One woman remembers that as each house along her road came on line, the first thing that families did was to install an indoor washroom. (Interview 15 April 1997, Mrs. S.)

[41] See Table 2, Appendix 2

[42] For a study of birth weights conducted on infants in Montreal during its industrializing period, see W. Peter Ward and Patricia C. Ward, "Infant Birth Weight and Nutrition in Industrializing Montreal," *American History Review* 89 (1984): 324-345.

likely hide pockets of adverse trends within this population, it would appear that as long as families were able to feed themselves, even subsistence farms may have provided a level of nutrition that for the most part allowed women to give their infants a sufficient start to life.

The time before, during, and after births, however, remained perilous times for infants, and each contributed its share to perinatal mortality. Premature births were not uncommon: for those born dead Dr. Geggie often remarked on the age of the foetus and its condition; those who were born still breathing usually did not survive beyond a week. Pregnant for the ninth time, a woman in labour in her sixth month was delivered of a "macerated foetus dead a month in membranes." Another mother, confined to bed for four months because of a threatened miscarriage, could not make it to term and a spontaneous delivery at six months produced a baby who lived only two days. He may have been a little more sceptical of the prematurity of an apparently "healthy and vigorous" baby boy when he remarked " '6 mos' [father] says . . . couple not married long".[43] One mother, however, was more fortunate than most. Following a walk outside on chilly February day ("my mistake") eighteen year old Mrs. B., six and a half months pregnant, returned home chilled and went to bed early. Later that night Dr. Geggie was called to help deliver her very premature infant girl. The infant survived by being cared for within the confines of a basket next to the stove, and being fed applesauce until it was

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[43] OBS notes 56:41, 101:43, 41:38

strong enough to nurse. In a house with no electricity, no water and only the woodstove for heat, it was a constant struggle for the young couple to provide the extra care she required.[44]

Problems causing death or injury to the foetus could also occur at the moment of the birth itself. Jacalyn Duffin notes in her study of Langstaff that "in the eyes of the attendants" the ability to resuscitate an infant, was "perhaps the most impressive of [his] abilities".[45] Likewise, Dr. Geggie's reputation benefitted from his competence in reviving an infant girl early in his career, and he continued to vigorously try to resuscitate any infant who did not breathe spontaneously at birth. A "lively" or "howling" baby was cause for satisfaction; one abnormally still was a source of concern. With experience, he accumulated a number of procedures that were usually effective in restoring the child, including alternating hot and cold water baths, mouth-to mouth-respiration or insufflation, or in the later years and for an extreme problems, adrenaline or coramine.[46] Most took only about ten minutes to revive, although some were considerably longer. Failure to breathe at birth appeared to be due most commonly to compression of the cord, because it had become either tightly wrapped around the newborn's neck or otherwise crushed during

[44] Interview 23 April 1997, Mrs. B.

[45] Jacalyn Duffin, *Langstaff: A Nineteenth-Century Medical Life*, (Toronto: University of Toronto Press, 1993), 189

[46] As he observed in his memoirs, "It was an event of great note when coramine appeared. A man had done his duty when he prescribed coramine ten minims after meals and at bedtime; he had gone one better, and nothing else could be expected, when he gave coramine hypodermically". *The Extra Mile*, 55

the birth. After one particularly critical case he wrote,

> Prolapse anteriorly cord! Almost Pulseless. Great Pressure on uterus brought very big boy. Soft, white and flaccid. Slight pulsation of cord. Coramine 1c.c. Adrenaline .5 c.c.. In 10 min. a few breaths in hot bath. Mother's blood in buttocks about 8 c.c. Good color. Insufflated.[47]

The baby seizured over the next two days, and although he appeared to improve with medication, and was still alive ten days later, the final outcome is unknown. Present day obstetricians, who now better understand the diffusion of certain drugs across the placental barrier, would perhaps question whether or not some of the medications in use for deliveries might also have had some bearing on breathing difficulties at birth. To some extent Dr. Geggie was also aware of this problem, as several times he queried whether or not the drugs he had given the mother were having an adverse effect on the newborn. Records like these give an indication of not only the different techniques the doctor attempted in a struggle to revive a dying baby but also the anxiety a sick baby could cause him. The birth of a baby boy who was "completely apnoeic and somewhat tense and rigid" caused him to wonder if his condition could possibly be due to the morphine he had given the mother, although it had been "6 hrs. 45 min. ago". The baby had "only three small series of respirations" and his "heart was almost gone", but fortunately three minutes later was crying well after hot baths and insufflation.[48]

The most common congenital defects causing death he noted were

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[47] OBS note 5:41

[48] OBS note 10:38

hydrocephalus and spina bifida. These normally occurred together and although most of the babies died at birth or shortly thereafter, occasionally, despite making "no effort to make live . . . living all [the] same."[49] Other major abnormalities included anencephaly (without a brain) and hydatidaform monsters (a multiple, cystic growth), which, while not common, seemed to occur in women who already had previously abnormal pregnancies. A suddden breech birth brought a hydrocephalic child with a "big patch of bifid spine in [the] mid region"; the mother's only other pregnancy had been fifteen years earlier and that child had been anencephalic. In a particularly tragic instance, one mother's third attempt at a living child following two previously "monstrous" pregnancies, produced a premature dead child, and she herself died several weeks later of a pulmonary embolus.[50]

The case notes reveal that Dr. Geggie was very attentive to the state of the newborn infant. He routinely noted its condition at the moment of birth, and invariably wrote down the sex and weight when the baby's condition stabilized. "There is something uplifting about washing and dressing a newborn baby," he wrote once, "relief and thankfulness that all's well."[51] While he must have delivered hundreds of babies under very basic conditions, there were some circumstances so unsatisfactory to his mind that he was compelled

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[49] OBS note 18:39

[50] OBS notes 54:42, 1:49

[51] H.J.G. Geggie, *The Extra Mile*, 103

to comment. He may well have felt a keen sadness at the unexplained deaths of two presumably previously healthy young babies for which he was forced to call the coroner. One at four months had died in "conditions bad and filthy".[52]

In the earlier years Dr. Geggie would rehearse to himself on the long drive to a labouring woman the procedures relating to different difficult birthing positions with which he might be presented, as he often did not know in advance when he would be called, or what he would find when he arrived.[53] Many women did not obtain prenatal care but the percentage of women seen at least once before their delivery did rise from approximately 30 percent in the 1920s to 55 percent in the 1940s.[54] Most of the recorded prenatal visits were specifically related to the woman's pregnancy, although occasionally a wife's pregnancy would be noted when he was called to treat another member of the family. Dr. Geggie would normally return to check up on his patients after their delivery, and he therefore made many more postpartum visits than prenatal. Again, the percentage of women seen following their confinements increased from 64 percent in the 1920s to 77 percent in the 1940s, although in

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[52] OBS note 56:43

[53] H.J.G. Geggie, *The Extra Mile*, 80

[54] In 1927, the year in which he himself tracked his deliveries, he saw 44 percent of the women ahead of time. Four of the five women interviewed, who were having their babies in the 1940s, all saw the doctor on a fairly regular basis prior to their births. All of these women were anglophone, and I suspect were not desperately poor. How prenatal care shakes out ethnically and economically is unknown, although Dr. Geggie certainly apppeared to be called to homes where he undoubtedly had no hope of getting paid. Interestingly enough, the one woman who said she never saw the doctor except in the last month "to make arrangements" had the most children (seven); her first four were each born a year apart.

1927, he noted that he visited almost 89 percent.

The majority of women were seen only once or twice for prenatal and postpartum care. While more visits usually meant there had been some trouble with the pregnancy, this did not usually indicate a fatal outcome.[55] For those women who were seen five or more times before their pregnancy, recognized pre-eclampsia or threatened spontaneous abortions caused the most concern, although several women seemed to have gone to Dr. Geggie up to fifteen times for regular check ups and/or minor complaints. Potential or actual puerperal infections explained the highest number of postpartum visits during the 1920s, but the threat of these was somewhat diminished during the 1940s after sulfonamide came into use. Mastitis leading to breast abscesses, however, was always an occasion for concentrated postpartum care, and as already noted, accounted for the twenty visits made to one poor woman in 1943 who required two operations and numerous dressings before she recovered. Health and feeding concerns about the infants explained the ten to thirteen visits each that he made to at least five families throughout the years under study.

By Dr. Geggie's arrival in 1911, it would appear that many women expected the physician to attend their confinements. Although it is very likely that in the 1830s and 1840s women in the growing community at Wakefield

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[55] In Langstaff's nineteenth-century practice, frequent postpartum visits were a "poor prognostic sign" in that almost half of mothers who were seen more than five times died. Duffin, 188

had to look after each other when they had their children, the first doctor had arrived in the 1850s, and almost uninterrupted medical care had been available since that time.[56] Given the wide area over which he travelled, and the isolated homes to which he was called, it is no doubt plausible that for some deliveries Dr. Geggie found himself alone with the mother, with perhaps only the father or an older child close by. As he liked to say, a good obstetrician is one who has "the good qualities of a midwife - one not too surgically minded - one able to row a river, climb a mountain and do his stuff solo, with a fainting husband, a coal oil lantern, and a mattress on the floor".[57]

Nevertheless, women were present at many births. Although Quebec has a long history of institutionalized education for midwives in comparison to other provinces, there is no indication that these trained women were ever a factor in a rural area such as Wakefield township. It is possible that most women with an education in midwifery worked closer to the larger cities in Quebec. According to Quebec scholar Hélène Laforce, the once "legalized, structured and competent" profession was subjected to increasingly stringent control as the Quebec Corporation of Doctors solidified its position in 1870. Laforce documents how the diploma midwives were continually faced with new

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[56] During this earliest period, there was a nurse in the area who travelled "on foot or on horseback to alleviate the distress of her scattered neighbours". The mother of Dr. Stevenson, Ann Pritchard, also worked as a midwife when needed. See Norma Geggie, *Wakefield and Its People*, 19-20.

[57] Harold Geggie, "Address of the McGill Undergraduate Society", 5 This was a real but perhaps unusual case to which he was referring.

restrictions right up until the 1980s because they were seen as the most threatening to the livelihood of the physicians, but doctors hoped that even the "self-educated" country midwives would gradually die out on their own once all pregnant women were convinced of the need for medical care and hospitalization for their births.[58] Dr. Geggie himself regarded midwife training as inadequate to prepare them to be able to judge when and how to intervene in labour and no doubt his beliefs that "obstetrics should be in the hands of wholly qualified and experienced doctors" were echoed by many other physicians.[59]

While there appeared to be no diploma midwives to either share or compete with Dr. Geggie's obstetrical load, there were women known as midwives or sage femmes working in women's homes. While the sage femme was most likely a relative or close friend of the parturient, she was neverthless different from other neighbour women who perhaps had less expertise or interest in the actual birthing but who would often be available for more domestic duties. Some of these women may have been midwives in the more traditional sense, who with skills, customs and practices learned from the 'old country' that were passed from mother to daughter, undertook the birth themselves. As it was put to me by a daughter of one of these women, their

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[58] Hélène Laforce, "The Different Stages of the Elimination of Midwives in Quebec", *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries*, Katherine Arnup, Andreé Lévesque, and Ruth Roach Pierson, eds. (London: Routledge, 1990), 41-42

[59] Harold Geggie, "Anaesthetics and Analgesics in Childbirth", 9

practice was usually confined to close relations within one branch of a family, and they were employed mainly because the women they served thought medical care was too expensive. However, the fact that many of the people among whom these midwives worked considered themselves "self-made people", who did everything for themselves, indicates perhaps it was more than a matter of money that kept them from calling the doctor.[60]

Many of the sages femmes or midwives were 'untrained' older women who were mainly qualified by the number of children they had born themselves.[61] Although throughout his records, Dr. Geggie has noted the names of about sixteen different women at deliveries, most remain somewhat shadowy figures. Some of these women he liked and appreciated; others he was desperate to get out of the room. Some of Dr. Geggie's somewhat low regard for midwives may have come out of his own experience. From his own

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[60] As noted, this information was related to me by a woman whose mother and grandmother had delivered children in their family. The mother did not want to be interviewed, stating to the effect that this was the old way whose time had now passed. There was some indication as well that some of these women were considered 'healers', whose skills extended beyond midwifery, and the friction between themselves and the doctors this might have caused may explain some of the reluctance to talk to an outsider. See Venetia Crawford and Gunda Lambton's new book, *The Wildest Rivers–the Oldest Hills: Tales of the Gatineau and Pontiac* (Maitland, Ontario and Ogdensburg, New York: Voyageur North America, 1996), especially 124-128 for more suggestive work on folk medicine and healers in the area.

[61] One woman who had asked Dr. Geggie to deliver her eleventh to her eighteenth pregnancies eventually became a sage femme herself. It appears as if she, anyway, thought well of her doctor; "Tu m'as toujours fait du bien." Geggie, *The Extra Mile*, 100. For more information on the life of an earlier country midwife, see Laurel Thatcher Ulrich, *A Midwife's Tale:The Life of Martha Ballard, Based on Her Diary 1785-1812* (New York: Vintage Books, 1991. Somewhat later treatments can be found in Roger Paradis, "Henriette, *la capuche:* The Portrait of a Frontier Midwife," *Quebec Studies* 1, no. 1 (Spring, 1983): 130-150; Joan E. Kennedy, "Jane Soley Hamilton, Midwife," *The Nova Scotia Historical Review* 2, no. 1 (1982): 6-29

compilation of birthing statistics that he put together from 1927, under the category of "nursing" he noted "none" for three quarters of the confinements,[62] and in mid-career he estimated that he had averaged about "ten cases with experienced help every year."[63] Some help was not always what either he or the mother would have hoped for. After one particularly long labour, ending with a difficult forceps delivery and a partially prolapsed uterus, even the mother commented "rotten anaesthetic--deliver me from grandmothers".[64] Dr. Geggie's first postpartum infection he attributed to one "grandmother-midwife" who, sensing she had been 'tricked' into leaving the room, returned in time to lacerate the mother's perineum by "dragging the baby into the world" with hands that had come directly from the hen house.[65] Another time he arrived too late to find the baby already born, but her "perineum [was] all picked away by Mrs. — when coming breech".[66] Even when a midwife may have been the first choice, a doctor was often called if anything did happen to go wrong. He was sometimes called in a hurry to find himself confronted with the disastrous results of a situation that had proven more than the midwife herself could handle. His 1927 records reflect the horror of one such delivery

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[62] It is not known if by "none" he meant none at all, or none that was any help. Whatever the case, the result was the same to him.

[63] Harold Geggie, "Anaesthetics and Analgesics in Childbirth, 9

[64] OBS note 22:38

[65] H.J.G. Geggie, *The Extra Mile*, 41-42

[66] Daybook, 14 Feb 1922.

for which he was called in consultation. Despite the presence of two other doctors, his diagnosis was "neglected transverse lie" (the baby lying crosswise), the delivery he tersely described as "dreadful", and the condition of the baby he marked as "dead. Arm torn off [by] midwives."[67]

On the other side of the coin, his memoirs reveal it was "the friendly neighbourhood midwife" who made his first long vigil in Wakefield more bearable by the endless cups of tea she supplied him with during the night.[68] A woman from town who had sometimes accompanied Dr. Stevenson "on occasion having to tuck her newly kneaded bread under the buffalo robes as it rose",[69] turned up in Dr. Geggie's records the day she fainted helping him."[70] Beyond their company, however, some women also seemed to be valued for their expertise, and although most appeared to be women who had gained experience in this kind of 'practical' nursing from their own lives, a few may have been licensed nurses. On several occasions when the infant arrived before he did, perhaps due to "lack of supervision by friends",[71] he noted the name of the women who had presumably delivered the child. For example, one December day "on [his] arrival [Miss —] had delivered a very large female

[67] OBS note 25:27. It appeared that he may have been called (too late) in consultation on this case. It is impossible to know if the other doctors had also arrived late, or if they themselves should take some of the blame for this botched birth.

[68] H.J.G. Geggie, *The Extra Mile*, 32

[69] Norma Geggie, *Wakefield and Its People,* 16

[70] OBS note 28:29

[71] From a letter written by Harold Geggie to Stuart Geggie, 7 February 1949.

child dead. Breech. Spina Bifida."; another time for a baby girl who had arrived twenty minutes before his arrival, "cord [was] cut and tied by Mrs. —;" several years later Mrs. — was "in attendance" at a breech birth.[72] After one apparently very satisfying delivery, Dr. Geggie praised his helper for the "slow expulsion [of average boy] under complete control and deep [chloroform] ably given by Mrs. — while assistant."[73]

No matter how much women depended on each other for help before and after each birth, however, it does appear that many eagerly embraced the physician for the actual event. That Dr. Geggie firmly believed in a managed labour and delivery as being far superior to the 'wait and see' method is evident. In a paper written around 1930, he described in fair detail the measures he employed for normal deliveries at that time. Effective pain relief was of prime importance in allowing patients to rest and relax during the first stages of labour when the pains may be distressing but useless. He routinely balanced a uterine stimulant, which would increase and strengthen contractions, with what he felt was a judicious use of anaesthetic to relax the uterus and guard against potentially dangerous overstimulation. This balancing of one drug against the other, he claimed, allowed for a more rapid and safer birth, with minimal discomfort and trauma for both mother and child. As a wider variety of painkillers and sedatives became available, he

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[72] OBS notes 111:33, 27:36, 9:44

[73] OBS note 65:43

added them to his regimen of obstetrical management. While he obviously approved of what he considered was the appropriate use of drugs, he also made it quite clear that there were other measures that could and should be instituted initially, such as " proper enemas; proper voiding or catheterization, [which] often mean shorter and easier labour, and are often neglected." Unruptured membranes when the foetal head was low in the pelvis and the cervix was fully dilated he also considered an impediment to a shorter labour.[74] Perhaps more controversial was his contention that just as it was necessary to manually dilate a cervix where a "rapid delivery is indicated", so too could "much time . . . be saved by manually dilating a cervix in the normal case."[75]

Dr. Geggie shows himself in step with the ever-increasing belief that childbirth as a natural process could be improved upon. "We interfere with nature again and again in surgery and improve on nature's work. If so in surgery, why not in obstetrics," he once wrote.[76] While physicians writing in the journals in the first two to three decades of the twentieth century may

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[74] These last measures are universal, time tested remedies that were also used by midwives. See Paradis, 139

[75] H.J.G. Geggie, "Anaesthetics and Analgesics", 4, 5. Manually dilating the cervix predisposed a woman both to infection and tears, and was therefore not usually recommended unless the baby had to be removed quickly. However, it definitely did speed up the birthing process when the dilatation period was long, painful and tiring the woman out. This method was mentioned in the textbooks, and was used by at least one other doctor, who advised that manual dilatation would accomplish "by the fingers, without suffering, in three to five minutes, which would have taken by nature's patient and long-suffering method hours to accomplish." N.Preston Robinson, "Normal Labour," *Montreal Medical Journal* 13 (1902): 772

[76] H.J.G. Geggie, "Anaesthetics and Analgesics in Childbirth", 2. His son was unclear whether his father meant to publish this essay.

have disagreed whether pregnancy was a physiological or a pathological condition, they all seemed to concur on two things. First, most agreed that pregnancy as a "natural process still remain[ed] a hazardous occupation."[77] Second, many strongly believed that parturient women, already compromised by the "tremendous strain" of the previous nine months, were often pushed by a long labour into exhaustion or depletion, which in turn predisposed them to postpartum infections and subsequent and debilitating gynaecological problems. All denounced the fact that the future health of women should have to depend on the expertise of the gynaecologist. Not interfering in labour then was seen as harmful as too much 'meddlesome midwifery'. "Watchful waiting", one professor cautioned, "[was] a good watchword for the lying-in room, but its too general adoption [was] attended with disastrous consequences."[78] An Ottawa physician reiterated that "[p]atience in obstetrics is next to aespesis, but it must be the active patience of close observation . . . [the mother must not be allowed] to become totally exhausted, or the baby in imminent peril of death before determining on a line of action."[79] So, too, did Dr. Geggie believe that the "time factor [was] a very great element in childbirth", and all

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[77] W.W. Chipman, "Problems of Obstetrical Practice," *CMAJ* 13 (1923): 379. See also Robinson, 770-775; H.M. Little, "On Obstetric Nursing," *Montreal Medical Journal* 38 (1909): 485-494; also "Obstetrics during the Past Twenty-Five Years," *CMAJ* 14 (1924): 903-908; Robert Ferguson, "A Plea for Better Obstetrics," *CMAJ* 10 (1920): 901-904; Lennox Arthur, "A Few Remarks on Prophylaxis in Obstetrics," *CMAJ* 14 (1924): 697-700; W. Pelton Tew, "Recent Advances in Obstetrics and Gynaecology," *CMAJ* 31 (1934): 521-527

[78] Ferguson, 902-903

[79] Joseph N. Nathanson, "Prophylaxis in Obstetrics, With Special Reference to The Value and Importance of Pre-Natal Care," *CMAJ* 14 (1924): 495

measures employed "to hasten the process" were "to gain time and preserve the strength of the patient, and so make for a more normal puerperium."[80] While much of what these physicians wrote was no doubt in response to the call to improve the maternal mortality rate, women subjected to multiple and closely spaced childbearing often did develop serious problems with prolapsed pelvic organs, fistulas that communicated with the urinary tract or bowel, or severe haemorrhoids or varicose veins. These may not have been life-threatening conditions but remained lifelong contributors to the poor health of many women.[81] The misuse of interventions in labour, such as drugs and forceps, could, of course, cause the very symptoms which by their use, physicians were hoping to avoid, and these methods could also be used by an impatient and "busy practitioner" to save time.[82] Nevertheless, the focus on shorter, less painful deliveries must have been compelling for both doctors and their patients who genuinely desired to lessen suffering in childbirth. Physicians themselves described how women and their relatives "pleaded" with them to 'do something.'[83]

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[80] Geggie, "Anaesthetics and Analgesics in Childbirth", 4

[81] See Margaret Llewelyn Davies ed., *Maternity: Letters from Working Women* (1915) Reprint ed. (New York: Norton, 1978) for examples of what a group of working-class Englishwomen bore as an aftermath of pregnancy.

[82] Ferguson, 902

[83] Veronica Strong-Boag and Kathryn McPherson, " The Confinement of Women: Childbirth and Hospitalization in Vancouver, 1919-1939," *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries*, Katherine Arnup, Andrée Lévesque and Ruth Roach Pierson, eds. (London: Routledge, 1990), 75-107. Women's role in shaping childbirth is the main theme in Judith Walzer Leavitt, *Brought to Bed: Childbearing in*

By the time of Dr. Geggie's practice, anaesthetics were in common use for childbirth, and chloroform remained the anaesthetic of choice for him throughout the twenty-two years under study.[84] Anaesthetics for childbirth had been employed, to some extent and not without controversy, in North America and Britain since the mid-1800s, following the first application in obstetrics of ether in Georgia 1845 and chlorform by James Young Simpson of Edinburgh in 1848.[85] Chloroform had been made particularly famous by Queen Victoria's use of it for her eighth child in 1853.[86] Dr. E. D. Worthington and Dr. A. E. Holmes have been credited with chloroform's first obstetric use in Canada in January 1848, but despite indications that at least some women

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America 1750-1950 (New York, Oxford University Press, 1986)

[84] For discussions of anaesthesia in childbirth, see Leavitt, especially 116-141; Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* (New York: The Free Press, 1977), 109-131; Edward Shorter, *A History of Women's Bodies* (New York: Basic Books, 1982), 145-149; J.T. H. Connor, "'To Be Rendered Unconscious of Torture': Anaesthesia in Canada, 1847-1920," (M. Phil. thesis, University of Waterloo, 1989) For an excellent and innovative discussion of the adoption of anaesthesia, see Martin Pernick, *A Calculus of Suffering: Pain, Professionalism and Anesthesia in Nineteenth-Century America* (New York: Columbia University Press, 1985)

[85] W.T.G. Morton of Boston is credited with launching the history of anaesthesia with the first public demonstration of ether anaesthetic for surgery in 1846, but Dr. Crawford W. Long, who had used ether as a recreational drug during his medical training in 1840, tried it with success on his wife for their second child in 1845. He did not publish his results until 1849, several years after Morton's demonstration. Frederick J. Speilman, "The Art of Anesthesiology: Dr. Crawford W. Long, *Newsletter of the American Soceity of Anesthesiologists* 59, no. 9 (September, 1995): 8-10

[86] Stanley Sykes, *Essays on the First Hundred Years of Anaesthesia*, Vol. 1 (London, Churchill Livingstone, 1960), 78-80. The *Lancet's* editor, Wakely, insisting that no one would have the temerity to give such a dangerous drug to Her Royal Highness, published that he had been told she had not been "rendered insensible". Sykes reviewed the records, and taking into account Victoria's strong mindedness, concludes that John Snow, the anaesthetist who administered the chloroform, had not lied to Wakely, but had probably told a half-truth. The Queen had analgesia (pain relief), not anaesthesia.

ardently desired it to relieve their pain in labour, its use did not become immediately widespread.[87] In at least two documented rural Canadian practices of the late 1800s, chloroform had been used very infrequently.[88] While general anaesthesia for surgery was rapidly adopted, its use in midwifery continued to be debated. Not only did the use of anaesthetic agents seem to split along national lines (ether was preferred in the United States, chloroform in Canada), some physicians believed that forceps were a contraindication for anaesthesia, while others decreed their use was precisely the correct time to employ it.[89]

Ether and chloroform not only made the patient "insensible to pain", when skilfully used they also relaxed the uterus to slow down and regulate contractions.[90] Neither anaesthetic was considered wholly safe, but the edge

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[87] Connor, 27; Akitomo Matsuki, "A Chronology of the Very Early History of Inhalation Anaesthesia in Canada," *Canadian Anaesthetists Society Journal* 21 (1974): 92-95; Akitomo Matsuki and Elemér K. Zsigmond, "A Bibliography of the History of Surgical Anaesthesia in Canada: Supplement to Dr. Roland's Checklist, *Canadian Anaesthetists Society Journal* 21 (1974): 427-430; David A.E. Shephard, *Watching Closely Those Who Sleep: A History of the Canadian Anaesthetists' Society, 1943-1993*, supplement to *Canadian Journal of Anaesthesia* 40 (1993): 3

[88] Melville Watson, "An Account of an Obstetrical Practice in Upper Canada", *CMAJ* 40 (1939):186; Duffin, 199-201

[89] Connor, 145-6

[90] One enthusiastic supporter of chloroform described the benefits of light chloroform anaesthesia, which included everything from regulating the pains, moving the labour along faster, allowing more control over the actual delivery, and relieving "to a great extent the anxiety of the patient's relatives". See A. Louise McIlroy, "Analgesia and Anaesthesia in Childbirth", *CMAJ* 24 (1931): 24

seemed to have been given to ether for patient safety.[91] The hazards of chloroform had been well reported in the literature, but explanations of the underlying causes of the deaths reported were confusing and not definitive. In the early 1900s it was thought that most deaths were related to overdosage, but David Brown, one historian of anaesthesia, argues that "the increased scrutiny of chlorform anaesthesia through the years undoubtedly made anaesthetists more cautious of the drug's dosage, which in turn probably increased the number of deaths resulting from . . . dysrhythmias during light-chloroform anaesthesia."[92] The risk of death from chloroform anaesthesia seems to have varied anywhere from one in 1000 to one in almost 3000 cases[93], although Brown reports that, even in the earlier days, many anaesthetists only rarely saw any deaths from chloroform.[94] Certainly, Dr. Geggie never reported even one death from chloroform anaesthesia.[95]

Although Dr. Geggie could not help but be aware of the dangers of

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[91] David Brown, *Risk and Outcome in Anaesthesia*, 2nd ed. (Philadelphia: J.B. Lippincott Co, 1992), 6-9

[92] Brown, 6-9. In 1911, A.G. Levy 'demonstrated the occurrence of ventricular fibrillation associated with *light* chloroform anaesthesia." Shephard, 4

[93] William Victor Johnston, *Before the Age of Miracles: Memoirs of a Country Doctor* (Toronto: Fitzhenry and Whiteside, 1972), 43 (1:1000); Shephard, 4 (1:2873)

[94] Brown, 8

[95] One older anaesthetist in Ottawa told me that chloroform was used at the Ottawa General as late as 1952, for deliveries only, and was usually given by the nurse unless forceps were being used. He stated that the main complication was liver toxicity. Although he had used chloroform in India before coming to Canada, throughout its use, he, too, never remembered any deaths from it. As he commented, there must have been "angels sitting on our shoulders." 16 June 1997, Telephone conversation, Dr. Kim Chatterjee.

chloroform, it was a moot point for him; as he asserted, "ether may be good enough in hospitals", but because of its high volatility, it was quite unsafe for use in homes, where "lamps and open stoves are in use." He also recognized that chloroform was the cheapest anaesthetic available, and maintained that it was "quite safe even in the hands of inexperienced persons."[96] While it was used mainly for its analgesic effect once labour had become well established, Dr. Geggie advocated, as had some authors of medical texts, that it be taken to "an almost surgical degree" at the moment of delivery to avoid perineal lacerations. He often wrote that the baby was born "between pains [while the mother was] under deep anaesthesia."[97]

Although in a small minority of cases Dr. Geggie noted that a woman, was, for example, "afraid of chloroform", or "wife very crazy over chloroform"[98] he used this anaesthetic without incident to mother or child on average in well

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[96] Geggie, "Anaesthetics and Analgesics in Childbirth," 2, 3. Chloroform was given by placing a few drops of liquid on a gauze, which was then held in an open mask over the patient's nose. This would sometimes have to be done by Dr. Geggie himself at the same time as he was managing the delivery. He much preferred to have help with the chloroform, either from an experienced woman helper, or from his sons, whom he trained during their teens to accompany him on some deliveries just for that purpose. Dr. Stuart Geggie told me that a finger always had to be kept between the mask and the patient's face to allow for some room air to be mixed with the vapourized gas.

[97] Geggie, "Anaesthetics and Analgesics in Childbirth," 8. Although most physicians seemed to support just "whiffs' of chloroform, there was also some precedent for a deeper anaesthesia in the literature. For example, C.B. Oliver, "Obstetrical Practice Yesterday and Today, *CMAJ* 22 (1930): 474. As was typical of many country doctors in a town without dentists, Dr. Geggie was sometimes asked to remove a woman's troublesome teeth before she wakened after her delivery. "C'est les dents qui some le prie!", he once wrote. Another time he remarked, "Three teeth removed - about 20 left to remove." OBS notes 38:33, 82:42.

[98] Daybook 25 June 1922

over eighty percent of his obstetrical cases. The percentage of use dropped approximately ten percent by 1949, attributable perhaps to the addition of the sedative Nembutal being given intravenously that year.[99] Nembutal usually made the women quite drowsy, which meant that chloroform was more often reserved for the final hard bearing down pains that signalled the imminent birth of the baby.

Although chloroform was clearly the anaesthetic of choice in most of Dr. Geggie's deliveries, there are good indications that he was open to experimenting with other methods. Perhaps one of the reasons he was attracted to trying nitrous oxide was because one of its major proponents, Dr. Wesley Bourne, was a classmate of his. Physicians had realized the analgesic and anaesthetic properties of nitrous, or laughing gas, since the late 1800s, but it was not until 1910 that newer technologies had made it a much more satisfactory medium for regular use. Bourne outlined from his own study the properties of this gas which made it less harmful than either chloroform or ether, and also pointed out that the woman remained pain free but conscious and able to help with her delivery.[100] Its use is mentioned only three times in Dr. Geggie's records, although since it stretched over a period of a year from May 1921 until March 1922, he perhaps employed it more often than he noted. It is also unknown why he stopped using "gas oxygen", as at least one delivery

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[99] See Graph 2, Appendix 2

[100] Wesley Bourne and James W. Duncan, "Nitrous Oxide-Oxygen Analgesia and Anaesthesia in Obstetrics", *CMAJ* 11 (1921): 818-822

was considered "very successful",[101] but he did feel that "economics" made "gas-oxygen impossible for any but the few."[102] As a *Canadian Medical Association Journal* editorial later suggested too, although it agreed nitrous oxide was superior to the other anaesthetics, it was feared that the "necessary apparatus" would make it difficult to be used in "domiciliary practice".[103] The gas stored in tanks had to be delivered under pressure, and as Dr. Geggie remarked after the last known use, "gas 0_2 2 1/2 hrs went dry and took over chloroform." However, the woman "knew all about affair but no pains."[104]

Dr. Geggie experimented more consciously with a different form of obstetrical anaesthetic on a series of eleven patients in 1926. In 1924, the well-known American anaesthetist James T. Gwathmey had perfected the method of a sequential method of anaesthesia suitable for obstetrics that was considered easy and inexpensive to administer.[105] When the patient was in active labour and the cervix was beginning to dilate, she was to be given three hypodermic injections of magnesium sulphate, the first containing morphine,

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[101] Daybook, 09 June 1921

[102] H.J.G. Geggie, Anaesthetics and Analgesics in Childbirth", 3. I suspect here that he was referring to the "economics" of the doctor's practice, and not whether or not the patient could afford it.

[103] Editorial, "Anaesthesia During Childbirth", *CMAJ* 23 (1930): 565

[104] Daybook, 20 March 1922

[105] James T. Gwathmey, "Obstetrical Anaesthesia", *Surgery, Gynecology and Obstetrics* 51 (1930): 195. As the author put it, "In not a single instance has an anaesthetist been used with the method, even in its initial development. The ingredients are cheap, and the mixture can be prepared easily by any phamacist, or by physicians who are accustomed to prepare their own medicines."

followed by a rectal installation of a mixture of ether and oil. While the first reference to this technique in the *Canadian Medical Association Journal* was found in September 1925,[106] Dr. Geggie's first recorded use occurred only a few months later in April 1926, suggesting perhaps that he was eager to try out a new technique which seemed to hold good possiblities for use in rural practice when he was often on his own. As other articles praising this method from studies based at the Montreal Maternity and the Ottawa Civic Hospitals were presented in the *CMAJ* in June and July of 1926,[107] he also may very well have learned more about this procedure from colleagues there.

Dr. Geggie tried out this new method over a period of two months, and recorded his results and impressions on the back of each beside obstetrical record. Only seven of the eleven patients in this series received this new technique, but as he used his usual chloroform and uterine stimulant on the four who were not included, he was then able to compare the two methods. Overall there was some question in his mind that with the ether in oil, labour was unduly prolonged, and he was also worried about infection from the multiple injection sites.[108] Generally the results were "good for mother", in

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[106] John Graham, "Rectal Anaesthesia in Obstetrics", *CMAJ* 15 (1925): 935-939

[107] R.N. Ritchie, "Rectal Anaesthesia in Obstetrics", *CMAJ* 16 (1926: 679-680; William J. Stevens, "Synergistic Analgesia in Labour", *CMAJ* 16 (1926): 804-806

[108] OBS note 15 April 1926, 20 April 1926, 22 April 1926, 23 April 1926, 25 April 1926. These are not numbered in the usual way, and are the only extant bedside notes from April. Therefore, dates have been used to identify these records.

that most could not remember much and found it "like a dream",[109] although one "[didn't] like that as well as chloroform".[110] However, he found that the difficulty he had in resuscitating the "etherized" infant made the procedure "somewhat alarming",[111] and his experimenting abruptly stopped after a "long hard labor and ether inhalation" led to the death of an infant girl.[112] As far as the records show, he never tried this method again.

This overwhelming use of chloroform is strong evidence that the majority of women found its employment unproblematic, giving weight to the theory that the development of obstetrical anaesthesia and relief of pain were one of the most welcomed new medical techniques, and a major reason why women about to give birth preferred physicians who had access to these procedures rather than midwives who did not. Probably the most well-documented example of women's quest for pain relief in obstetrics concerns the campaign for 'twilight sleep', a mixture of drugs that rendered the woman quite amnesic to the events of her delivery.[113] Although it has been pointed out that in Canada demands for twilight sleep were not as vigorous as in the

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[109] OBS note 17 April 1926

[110] OBS note 28 April 1926

[111] OBS notes 15 April 1926, 17 April 1926, 20 April 1926,

[112] OBS note 8 May 1926

[113] See Judith Walzer Leavitt, "Birthing and Anaesthesia: The Debate Over Twilight Sleep," *Signs: Journal of Women in Culture and Society* 6 (1980): 147- 64; also Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* (New York: The Free Press,1977), 150-54.

United States, doctors were nevertheless aware of women's interest, and debated the benefits and disadvantages of this technique in the literature.[114] They were certainly aware that women now "refused to submit to the sufferings borne by their mothers and grandmothers."[115] For the women in Wakefield, Dr. Geggie's use of chloroform makes it appear that they were given little choice about pain relief, but on the other hand, it is more likely that not only was it desired, it was expected. In fact, Dr. Geggie's youngest son distinctly remembers the frequent and demanding plea, the "endormez-moi!" of labouring French Canadian women. As one women interviewed put it, "I never asked for anything, that was just the thing".[116]

Chloroform was just one part of the "balancing act" with which Dr. Geggie managed the majority of confinements he attended. Comprising the other half was the uterine stimulant Pituitrin, and its use roughly paralleled, though at a lower rate, that of chloroform throughout all the years studied. Pituitrin, brought onto the market only in 1909, had rapidly gained wide acceptance for use in obstetrics throughout the Western world.[117] It is therefore possible that Dr. Geggie at least heard about this medication during

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[114] Strong-Boag and McPherson, 169, n.84

[115] McIlroy, 21

[116] Interview 19 February 1997, Mrs. T. She nevertheless believes "it's the way to go yet. I can't believe in all this suffering today, because you never suffered with the Dr. Geggies [sic]".

[117] For a literature review of the first four years of its use, see B.P. Watson, "Pituitary Extract in Obstetrical Practice," *CMAJ* 3 (1913): 739-757

his medical training, and it may also be likely that he read about this recognized way of managing labour that became possible with the advent of the new pharmaceuticals.[118] The use of Pituitrin was heavily debated as well in the literature, and there were as many differing opinions on how or even if it should be utilized at all before the uterus was emptied as there were authors.[119] Dr. Geggie, however, held it "as not a debatable point in the least," and as he wrote,

> Pituitrin, I consider, to be the best friend of the labour patient and the obstetrician, but a better friend still, when controlled by chloroform. By accurately diagnosing the position of the fetus and the condition of the cervix and membranes . . . Pituitrin may be given to almost every patient with a normal presentation in increasing doses . . . By so doing chloroform can be given safely when pains become too stiff to bear, and the patient can be carried along hour after hour with proper doses of these two drugs, with satisfaction all around. The cooperation and the confidence of the patient is obtained and kept, and the obstetrician soon gains the reputation in the neighbourhood as a humane operator.[120]

Dr. Geggie was well aware that the use of Pituitrin had the potential to cause spasm of the uterus, or that it could increase the strength of contraction

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[118] W.B. Howell, "Review of *De l'Anesthesia Obstétrical et en particulier de l'Action du Chlorform Associée a celle de l'Hypophyse*", *CMAJ* 16 (1926): 1273; McIlroy, 24-25. She noted that the "committtee of the British Medical Association recommends the use of pituitrin to counteract the paralysing effect of chloroform upon the uterine contractions."; Oliver, 474. "The judicious use of pituitrin has been a great boon to women in confinement . . . Immediately after its administration chloroform anaesthesia should be started. The mother in nearly every case sleeps peacefully through the delivery and is saved hours of suffering."

[119] For some examples in the *CMAJ* alone, see Editorial "Pituitrin," 10 (1920): 678-680; Adam H. Wright, "Ergot, Quinine and Pituitrin," 12 (1922): 383-386; Ross Mitchell, "The Use of Pituitary Extract and Scopolamine-Morphine in Obstetrics," 11 (1921): 351-355; H.M.L. Editorial, "Pituitrin," 13 (1923): 678-679; C.B. Oliver, "Obstetrical Practice Yesterday and Today," 22 (1930): 469-475; McIlroy, 21-26

[120] H.J.G. Geggie, "Anaesthetics and Analgesics", 2

to the point of rupture of the uterus, but he still thought its use in normal labour was advantageous in procuring for women less exhausting deliveries. He advised minute doses to be increased slowly to "test out a patient's tolerance", and to do no more than to "simulate normal pains". There were also times when he realized the drug would be ineffective, and there was nothing to do but wait.[121] From the records there was never any indication that he encountered any serious adverse effects from this drug, and his experience with its use was very considerable.[122]

One of the greatest debates in medical literature and physician education was over the use of forceps, and whether their utilization could be perceived as beneficial or detrimental to the practice of obstetric. As Wendy Mitchinson contends, "[a]s with most medical technology, the use of forceps had its own ebb and flow."[123] It has already been noted that Dr. Geggie may not have been as well educated as he would have liked in their use during his medical training, (apart from the mechanical pelvis) which may have been in keeping with the conservative approach of teaching institutions who decried the indiscriminate use of instrumentation. While he may have been inexperienced in their use, he was nevertheless quite disgusted by an older colleague to whose aid he had been called when the older man prepared to use

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[121] H.J.G.Geggie, "Anaesthetics and Analgesics", 3

[122] See Graph 3, Appendix 2

[123] Wendy Mitchinson, *The Nature of the Their Bodies: Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto Press, 1991), 211

"unwashed forceps from his last case, loosely wrapped in newspaper."[124] By the time we catch up with the more seasoned physician, warnings against the routine use of forceps had not disappeared, but physicians most concerned with obstetrical care seemed to be more anxious about the increasing employment of the Caesarean section operation. [125]

In Dr. Geggie's practice, the use of forceps had an 'ebb and flow' all of its own and the fluctuation simply reflected the number of cases where Dr. Geggie thought their use appropriate.[126] If any decline can be found, it could perhaps be attributed to improved transportation links with Ottawa as he may have suggested to his patients with known or newly recognized problems that they might deliver more safely at one of the hospitals there. Anaesthesia was always given if forceps were to be used, but conversely, the use of chloroform did not indicate routine forceps extractions.

What is more evident, however, is that Dr. Geggie did not use forceps lightly, and that he was usually prepared to be patient in cases that he thought were becoming too drawn out. Several times he noted that the forceps had been boiled but they had remained unused. At other times he mentally checked off possible courses of action, for example, "Wait? Version? Forceps?", while at other labours we can see the forumulated plan in "Version with

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[124] H.J.G. Geggie, *The Extra Mile*, 50

[125] See for example Holland, 974; Little, 907

[126] See Graph 4, Appendix 2

prepared forceps in case of need."[127] Each use of forceps he justified in either the obstetrical notes or the daybook record; protracted labours in which Pituitrin seemed to be of no help, or posterior presentations in which unassisted delivery was sometimes difficult were two reasons for resorting to the instruments.[128] Sometimes he was unable to apply the forceps as he wished, and because of slippage was forced into turning the baby and extracting it feet first (podalic version). On one woman who had been in labour over twenty-four hours before he was called, and whose membranes had ruptured hours earlier, he questioned whether high forceps might not have been a better choice over the version that he did perform which resulted in a stillbirth.[129] Perhaps, though, forceps just brought a quick end to the confinement of a violent and uncooperative young women whose pains died out each time he tried to use chloroform.[130]

In a country practice without a hospital nearby, the options for extracting an infant under difficult birthing situations were usually limited. Shortt maintains that "Caesarian [sic] sections and other obstetrical manipulations were a not uncommon aspect of rural confinements", and in the often isolated rural environments in which Dr. Geggie worked, "obstetrical

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[127] OBS note 15:41; OBS note, 46:41

[128] Examples found in Daybook 16 March 1920, 11 June 1920; 9 November 1920

[129] OBS note 46:32

[130] OBS note 97:43

manipulations" were indeed necessary skills acquired during his many years of practice.[131] When faced with any situation in which it was necessary to deliver the child rapidly, he performed a podalic version, dilating the cervix with his fingers if it were not already wide enough so he could turn the foetus and grab a foot. He always used an anaesthetic for this obviously painful procedure, not just because of the internal manipulation but also because it was sometimes necessary for a helper to push hard on the abdomen from the outside. Versions were attempted anywhere from two to ten percent of the time per year, with essentially no noticeable increase or decrease over the years under study. The mother usually survived, although things were a little tougher on the baby. One had its right arm inadvertently broken which needed to be set; another suffered a temporary paralysis of its arm that was treated by being "hitched up to head".[132] The situation was somewhat more desperate for a woman confined for her fourteenth time, when Dr. Geggie simply could not deliver the head of the baby. At 1:30 in the morning, they "started for [the] Grace Hospital", where four hours later he left the woman "fit" after he "with difficulty, my whole weight on abdomen and [other doctor] by rotation and traction" finally extracted a 15 pound, 5 ounce dead boy.

Until the advent of improved surgical techniques and antibiotics, many women and their infants died from Caesarean sections. Dr. Geggie never

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[131] Shortt, "Before the Age of Miracles," 132

[132] OBS note 46:29, 65:42

attempted this operation, but when faced with no other option, he did destroy the infant to save the life of the mother. Most times the foetus was already dead, but because of severe haemorrhaging and the potential of deadly infection, it was sometimes necessary to remove the lifeless body manually, usually by piercing the head to evacuate the brains. Only four out of the fifteen times these embryotomies were performed did he have to destroy a live foetus, and these were usually on large babies whose mothers' internal passages were too small or too deformed to allow the heads to pass. In one particularly difficult and horrifying early morning, "the neck parted" from the head of an infant, which "remained impacted", necessitating an ambulance ride to an Ottawa hospital. Apart from the mother admitting that this child, her eighth, was not her husband's, there is no mention of how she fared; Dr. Geggie, however, both mentally and physically exhausted "returned at noon, dead". A few years later, he attempted a version "with forceps hook and cranioclast ready" on a woman who had been in hard labour for twelve hours without the head moving into position for delivery. Forceps were attempted "but given up and head got usual treatment."[133]

Official teaching in Roman Catholicism stressed the importance of infant baptism, and therefore the preservation of the mother's life at the expense of the infant's was a practice not condoned by the clergy. Throughout the course of Dr. Geggie's work within a large Roman Catholic population, however, the

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[133] OBS notes 99:35, 137:38

mother's life remained of primary importance; there was never any indication that she should be sacrificed for the sake of the unborn foetus. Nowhere in the records or in Dr. Geggie's memoirs does this question ever arise, and his son cannot remember this issue ever being discussed. While not a Catholic himself, in footling deliveries he very often baptized the foot or leg before the head was born in acknowldgement that the infant might potentially die before the head was born. That he was sensitive to the religious beliefs of the majority of his patients seems certain, as he held to the belief that a good general practitioner should be part "one good priest of any convenient sect, of liberal theology and wide sympathy".[134]

In his study on the history of anaesthesia in Canada, James Connor discovered that a rural general practitioner from Sherbrooke, Quebec, may have been the first Canadian doctor to use ether for major surgery.[135] What is perhaps more important to medical historians than the actual event is the reminder that rural physicians might have been up on current practice as much as those living in more urban areas. Jacalyn Duffin, too, in her investigation into the nineteenth-century country medical practice of James Langstaff, illustrated how he implemented at least some new procedures relatively quickly after their appearance in the medical journals that he had

[134] H.J.G. Geggie, "An Address to the McGill Undergraduate Society", 6

[135] Connor, "To Be Rendered Unconscious of Torture," 22-24

read.[136] The few innovations in Dr. Geggie's practice that can be traced in the medical literature, whether they were tentative or permanent, also suggest that given the conditions under which he had to work, he was also interested in keeping as up-to-date as possible. Indeed, he encouraged medical students to apprentice with him during the summer, not only because he believed this was one way to expose young doctors to the field of general practice but also because it was a way that he himself could stay abreast of the latest techniques in medicine. "Each would correct and help the other - each would learn," he wrote.[137]

While the number of obstetrical visits comprised barely one-sixth of all other reasons for which Dr. Geggie's patients saw him, it is apparent that overall, obstetrics took up much more of both his time and his interest than other areas of his practice. Throughout his records there are occasional fragments of surveys and tables that he began but rarely completely finished, and all of them are concerned with the care and treatment of pregnant women and their infants. Nowhere to be found, for example, are compilations of patients with fractured limbs, or numbers of patients with appendicitis. This seemingly abiding interest was possibly one good reason why he kept his obstetrical bedside notes, which have provided such a rich resource from which historians can subsequently chronicle his practice.

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[136] Duffin, 252

[137] H.J.G. Geggie, "An Address to the McGill Undergraduate Society," 16-17

In this chapter I have attempted to explore many of the dimensions of obstetrical care that can be gleaned from a reading of this one specific practice. While the basic principles of obstetrical care that Dr. Geggie learned from medical school remained intact, such as the measures necessary to prevent infection, he adapted his birthing routine to the needs of the people and the rural nature of the area in which he worked. While he did experiment with some different drugs over the years, he followed a method of conducting labour that balanced chloroform with a uterine stimulant, a routine that he kept virtually unchanged throughout the years under study. While the percentage of women in the Wakefield area who chose him as their birth attendant is unknown, Dr. Geggie very likely was present at almost as many births as he could physically handle, and he eagerly welcomed each of his three sons as they one-by-one joined him “in harness” and helped relieve his load.

Figure 1. Harold Geggie, 1918.

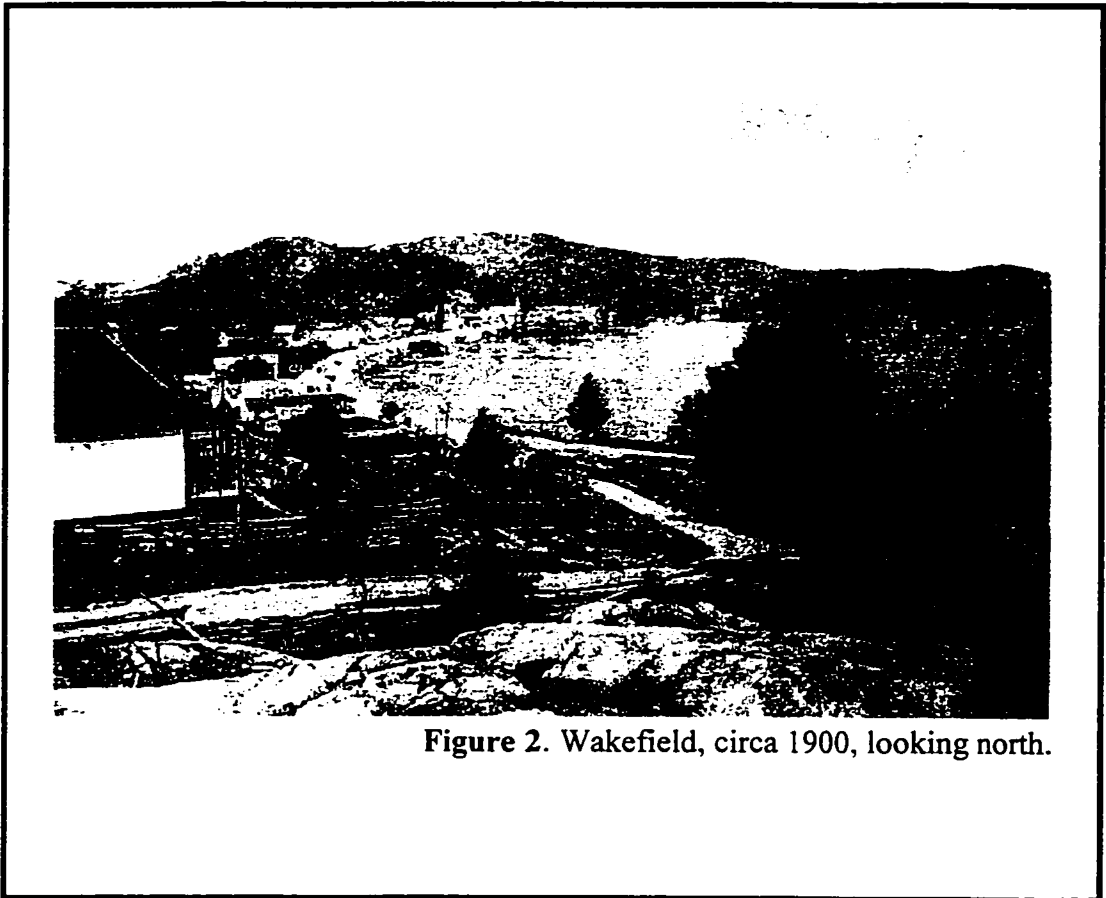

Figure 2. Wakefield, circa 1900, looking north.

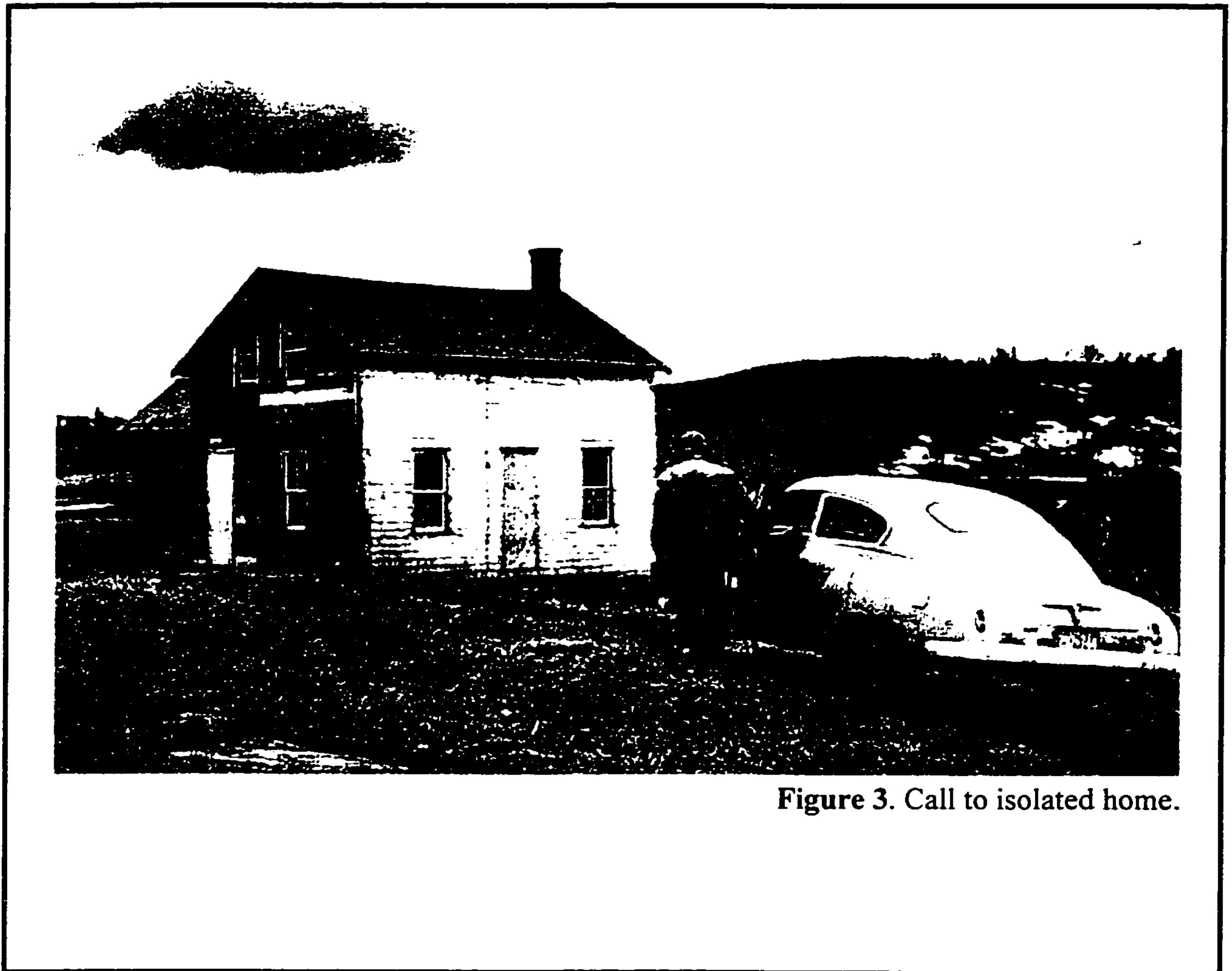

Figure 3. Call to isolated home.

Figure 4. Family care.

Figure 5. Doctor visits the whole family. Note drug case.

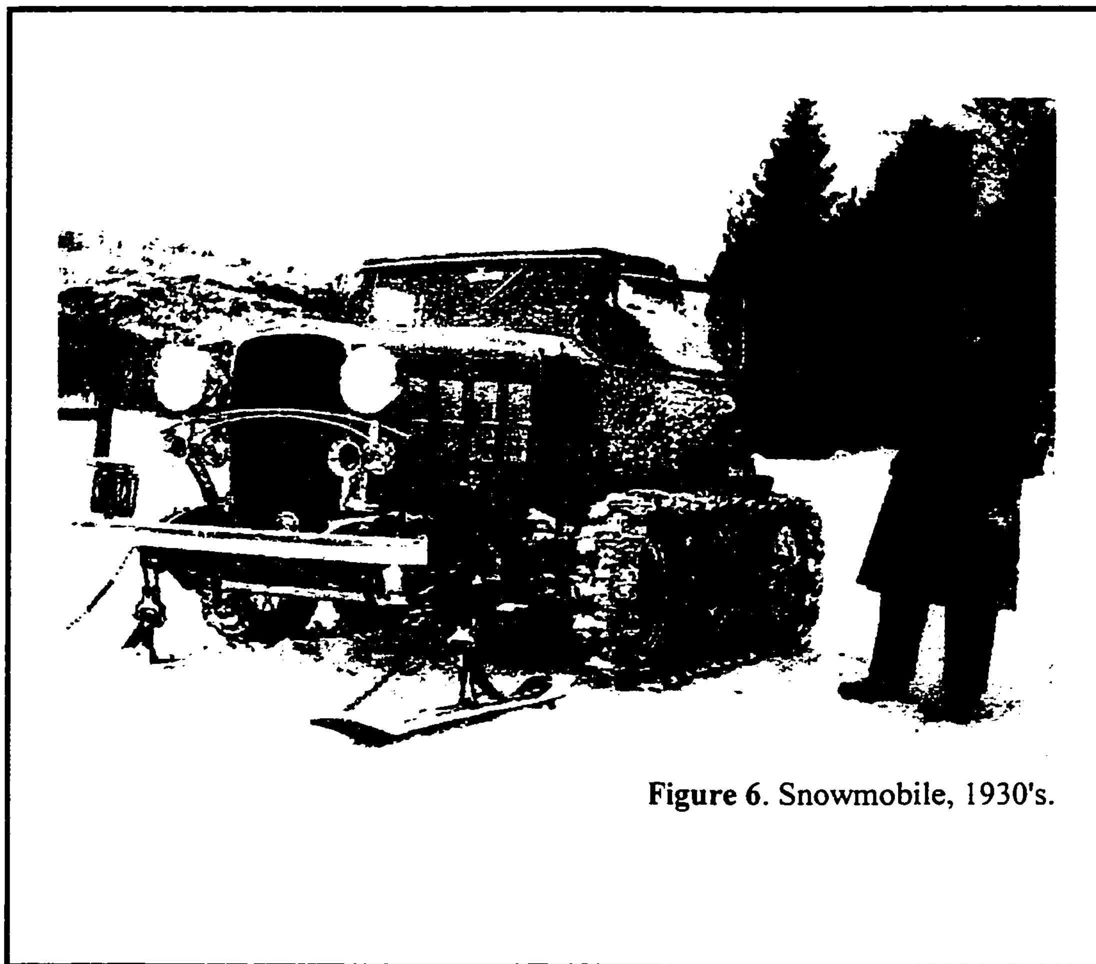

Figure 6. Snowmobile, 1930's.

Figure 7. Women's presence at delivery.

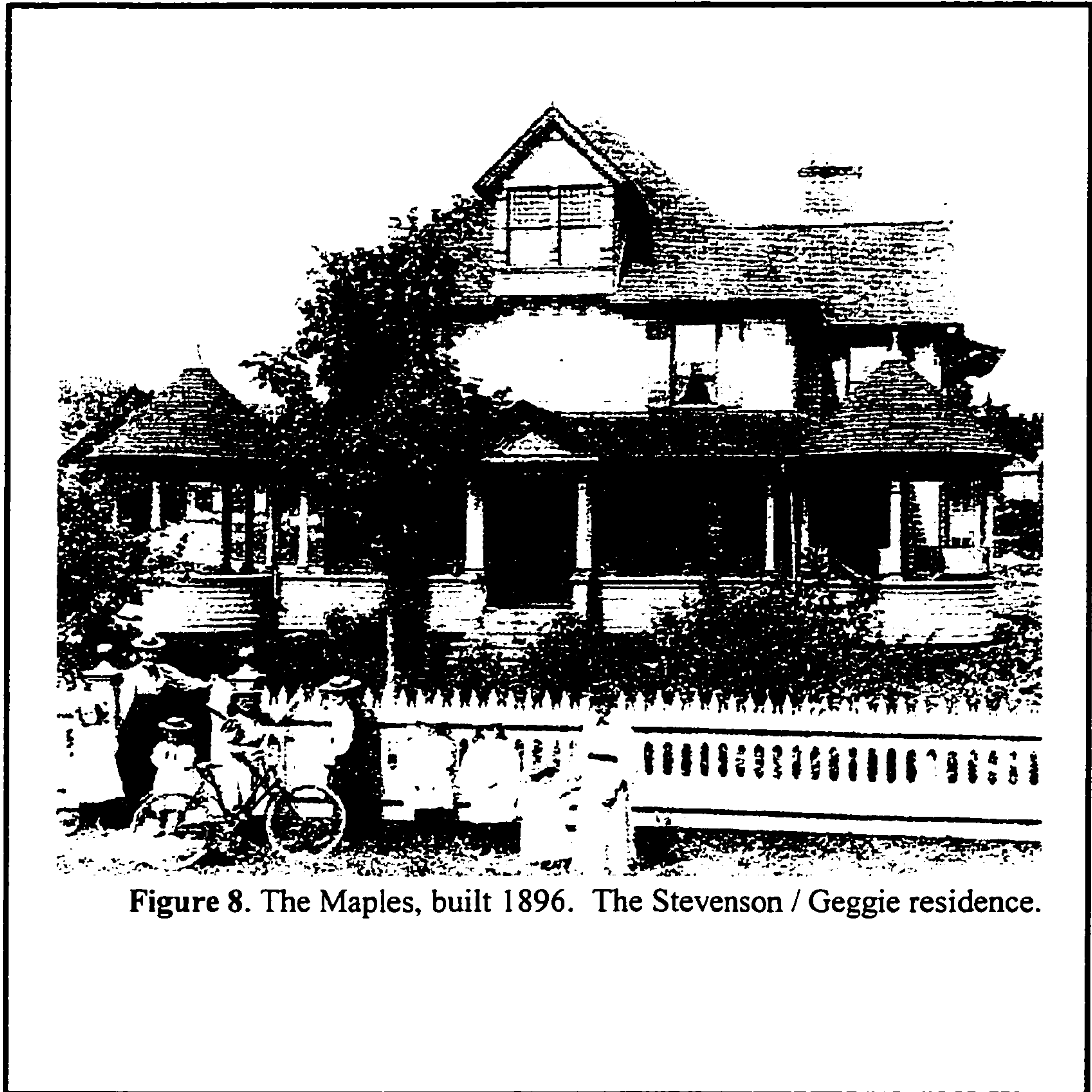

Figure 8. The Maples, built 1896. The Stevenson / Geggie residence.

Figure 9. Drs. Harold, Stuart, David and Hans Geggie with nurses on steps of old Wakefield hospital.

Chapter Four

Obstetrical Care in Early Twentieth-Century Rural Canada

The preceding two chapters have explored the medical training of general practitioners in the early part of this century and how one physician put that training into practice. The focus of this chapter will shift from a close examination of Dr. Geggie's specific obstetrical practice to the wider context of other known obstetrical practices of both his predecessors and his contemporaries. The emphasis will continue to be on the country rank and file practitioners; those who spent most of their working lives in the small towns and villages that housed, until mid-century, the majority of the population.[1] This broader perspective will perhaps illuminate more clearly the kind of obstetrical care offered by country doctors in the early twentieth century, helping to further refine our understanding of the transformation in birthing over the last two centuries.

The characterisitics of a medical practice are dictated to a large extent by factors that are unique to the particular locale in which the practice is situated. As various historians have pointed out, caution must therefore be exercised when scholars attempt to set one individual medical practice within the wider context of the practice of medicine more generally. One of the major strengths of John Harley Warner's monograph on therapeutics was his

[1] The practices of Canadian physicians will be highlighted, but for the sake of comparison the work of some American doctors will also be included.

discussion of the meaning of specificity to an early nineteenth-century American physician, which he described as "an individual match between medical therapy and the specific characteristics of a particular patient and of the social and physical environments."[2] As he noted, physician justification for differing therapeutic regimens rested particularly on an intimate knowledge of both patient characteristics and geographic space, a concept which he expanded to include distinctions between patients themselves, between rural and urban environments and between American and European nationalities.[3] The roles played by specificity and regionalism did not end with the nineteenth century, and continue to be important into the present day. As stated in an earlier chapter, the development of Canadian medical education from the nineteenth into the twentieth century was not just that of the United States "writ small". How variations in instruction among medical schools might have translated into differences in individual medical practices is one area that remains fruitful territory for examination. More attention needs to be paid to the differences inherent in rural and urban medical practices, and the historical role that geographic locale has had in delineating specifics of medical service. While the concept of gender in medicine has garnered significant

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[2] John Harley Warner, *The Therapeutic Perspective: Medical Practice, Knowledge and Identity in America, 1820-1885* (Cambridge, Massachusetts and London, England: Harvard University Press, 1986): 58

[3] Warner, 186-206. For example, while American physicians studying in Paris or Vienna eagerly incorporated European ideas on the scientific rationale behind therapeutics, they considered European knowledge and ideas about treatment as immaterial or even harmful to the American populace.

attention, the roles of race and class, etc. have not been as well scrutinized.

Historians must therefore be prudent when they attempt to either compare medical practices or to place them within some sort of context. Duffin contends that it is not yet possible to understand whether James Langstaff's practice was typical of other physicians in his cohort.[4] This caveat must also apply to the practice of Harold Geggie in the early twentieth century. Until we have more well-documented local examples, our perception of rural general practice, including rural medical obstetrical care, will remain somewhat fragmented. Much more research needs to be undertaken to determine the importance of patterns and motifs in medical practice, which may then offer more hope for a synthetic reappraisal.

Historians have thoroughly documented the transition from the midwife to the (mainly) male medical attendant in the birthing room that took place over the late nineteenth into the first half of the twentieth century.[5] There is

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[4] Jacalyn Duffin, *Langstaff: A Nineteenth-Century Medical Life* (University of Toronto Press: Toronto, 1993), 7

[5] Charlotte Borst has added the important dimension of the differences among midwives themselves in her regional study of midwives. See her "The Training and Practice of Midwives: A Wisconsin Study", *Bulletin of the History of Medicine* 62 (1988): 606-627; as well as her *Catching Babies: The Professionalization of Childbirth, 1870-1920, (*Cambridge: Harvard University Press, 1995) See also Jean Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth* (London: Historical Publications, 1988); Jane B. Donegan, *Women and Men Midwives: Medicine, Morality, and Misogyny in Early America* (Westport, CN: Greenwood Press, 1978); Judy Barrett Litoff, *American Midwives, 1860 to the Present* (Westport,CN: Greenwood Press, 1978) Examples pertinent to Canadian midwifery include Mitchinson, Wendy, *The Nature of the Their Bodies: Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto Press, 1991), especially 162-175; Lesley C. Biggs, "'The Case of the Missing Midwives': A History of Midwifery in Ontario from 1795-1900": 20-35 and Hélène Laforce, "The Different Stages of the Elimination of Midwives in Quebec," both in *Delivering Motherhood:Maternal Ideologies and Practices in the 19th and 20th Centuries,* Katherine Arnup, Andrée Lévesque, and Ruth

some recent evidence that suggests that physician-attended births may have become more usual even earlier than once was thought. In her examination of James Langstaff's practice, Duffin found that by the 1870s and 1880s Langstaff was attending close to seventy percent of the deliveries in his area, in comparison to Judith Walzer Leavitt's findings which showed that fifty percent of American births were not attended by physicians until the 1900s.[6] Wakefield had acquired its first doctor as early as 1865, and had received almost uninterrupted medical care from physicians since that time. Because of census restrictions, it is impossible to determine what percentage of deliveries were attended by doctors in this area, but on Dr. Geggie's arrival in 1911, it would appear that many women, if not most, were prepared to accept a physician at their confinements. Thus, we do not see here the more overt struggle or transition between physicians and midwives that occurred in other areas.

At the same time, as more rural women expected to have a 'medical man' to their homes, governments and medical associations were becoming alarmed at the lack of physicians who were finding their way into the outlying

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Roach Pierson, eds. (London: Routledge, 1990),20-35, 36-50; J.T.H. Connor, "'Larger Fish to Catch Here than Midwives': Midwifery and the Medical Profession in Nineteenth-Century Ontario," *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, Dianne Dodd and Deborah Gorham, eds. (Ottawa: University of Ottawa Press, 1994),103-134.

[6] Duffin, 180

areas.[7] As medical knowledge expanded and became more complicated, opportunities to specialize became increasingly available, and doctors who selected this option usually remained in the cities and larger towns where they could be more assured of an adequate living from prosperous clients. These problems of distance and economics in attracting physicians into the countryside were not new. Gidney and Millar record the complaints of both early nineteenth century physicians and patients who were confronting the realities of rural existence. As one pioneer protested: "Nobody above the rank of a common cowleech would travel around a circle of forty or fifty miles, in the wilderness, for the pittance which could be collected." Women such as Susanna Moodie and Anne Langton both agreed that it was impossible to attract medical help even when badly needed.[8]

Distance and the difficulty of reaching potential patients were indeed impediments to local medical care, but physicians' inability to receive "sufficient remuneration" was also the result of unlicensed practitioners, of varying degrees of competence, cutting into their business.[9] By the early 1900s, the 'unorthodox' physicians had either faded away or, in the case of the

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[7] In an interesting turnabout from the present day, the Canadian Medical Association in the 1930s actually pleaded in vain with the provincial governments to place recent graduates in sparsely populated areas. See Cynthia C. Abeele, "'The Mothers of the Land Must Suffer': Child and Maternal Welfare in Rural and Outpost Ontario, 1910-1940," *Ontario History*, 80 (1988): 185

[8] Robert Gourlay, quoted by R.D. Gidney and W.P.J. Millar, in *Professional Gentlemen: The Professions in Nineteenth-Century* Ontario (Toronto: University of Toronto Press, 1994), 38, 39

[9] Gidney and Millar, *Professional Gentlemen,* 39

more organized homeopaths and eclectics, had to conform or compete within the licensing requirements of the regular doctors.[10] Even James Langstaff, who began his medical career in the mid 1800s in a village outside Toronto, apparently had no major relationship with any 'unorthodox' physicians.[11] There were occasional references throughout Dr. Geggie's accounts to other doctors with whom he came in contact, but even if he did not sometimes approve of their work, there is no indication that they were anything but men who had taken the orthodox route to medicine.

By the early 1900s there were still, however, many young doctors who were embracing not only the "unstructured and ill-defined life of a general practitioner" but were also choosing to undertake this career in the relative isolation of the countryside.[12] Their reasons for doing so fell somewhere

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[10] In Quebec in 1847, and in Ontario, in 1869, the homeopathics and eclectics were absorbed into le Collége des médecins et chirugiens de la province de Québec and the College of Physicians and Surgeons of Ontario respectively. As one physician is reported to have said "the Ontario Act was serving a good purpose in hugging Homeopathy and Eclecticism to death". For Ontario, see R.D. Gidney and W.P.J. Millar, "The Origins of Organized Medicine in Ontario 1850-1869," *Health, Disease and Medicine: Essays* in Canadian *History,* Charles G. Roland, ed. (Toronto: The Hannah Institute for the History of Medicine and Clarke Irwin, 1982): especially 77-80, 87; and for Quebec, Jacques Bernier, *La médecine au Québec: Naissance et Evolution d'une Profession,* Québec: Les Presses de l'Université Laval, 1989): 6, 79-83

[11] Jacalyn Duffin, *Langstaff: A Nineteenth-Century Medical Life* (Toronto: University of Toronto Press, 1993), 30. One reviewer of Duffin's book does note, however, that Langstaff used some alternative treatments that suggest he may have had some contact with the more unorthodox practitioners. See Andrew Holman, "Review of *Langstaff: A Nineteenth-Century Medical Life* in *The Canadian Historical Review*, Vol. 75 (1994): 638

[12] S.E.D. Shortt, "'Before the Age of Miracles': The Rise, Fall and Rebirth of General Practice in Canada 1890-1940", *Health, Disease and Medicine: Essays in Canadian History,* Charles G. Roland, ed. (Toronto: Hannah Institute for the History of Medicine and Clarke Irwin, 1984), 128

between a high-minded altruism and their wish to be a "useful citizen or benefactor,"[13] to an intense clinical interest in the variety of both scientific cases and anomalies presented in general practice. As one of Harold Geggie's classmates put it, [a]s for "human interest only the parish priest can begin to compete with him."[14] Dr. Geggie himself was looking to escape the confining atmosphere of big city life, and was anticipating the challenge of being on his own in country practice.[15]

While doctors came to medicine via many different routes, what many seemed to share as they left medical school was a belief that their training had somehow fallen short in preparing them for the practicalities of a country practice.[16] Certainly Dr. Geggie voiced these fears as he struggled with his first forceps case alone. These feelings of inadequacy seem to have been articulated more by these early twentieth century physicians than those who graduated several decades earlier, partly reflecting perhaps the move in the medical schools away from apprenticeship in favour of more laboratory and in-hospital training. In combination with didactic lecturing, apprenticeship had a long history in the preparation of new physicians. It is not known how

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[13] James Sprague, as quoted by Shortt, in "Before the Age of Miracles," 128

[14] H.R. Clouston, "The Medical Curriculum as Viewed by a Country General Practitioner," *CMAJ* 28 (1933): 318

[15] H.J.G. Geggie, *The Extra Mile*, 25

[16] Shortt, "Before the Age of Miracles," 126-127

extensive this practice was;[17] although it seems to have been fairly widespread, it may have been confined to the more rural areas and was not so much a part of the medical training of those educated in the larger urban schools or of those who could afford to augment their experience with studies abroad. Four out of the six rural physicians in Paul Berman's study of early nineteenth century doctors in New England apprenticed with an older practitioner,[18] and Charlotte Borst found almost six hundred registered Wisconsin physicians who had been educated in this "older American educational paradigm" before 1905.[19] Even well into the twentieth century, a critic of the current medical curriculum was still supporting the idea of apprenticeship but realized that it would likely be impossible to find both the numbers and the quality of "willing veterans" who could supervise their younger counterparts.[20] Neverthless, the tradition was still alive, and helps explain why Dr. Geggie sought to fill in the gaps in his experience with a 'preceptor', as did some of his contemporaries, before striking out on his own.

Even in an area such as Wakefield that expected medical attendance, young physicians were not necessarily assured of being welcomed to the hearths and homes of the area residents. This was especially true for those

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[17] Duffin, 29

[18] Paul Berman, "The Practice of Rural Obstetrics in Rural America, 1800-1860," *The Journal of the History of Medicine and Allied Sciences* 50 (1995): 177-178

[19] Borst, *Catching Babies*, 94

[20] H.R. Clouston, 317

physicians from outside the community. As Charlotte Borst notes in her comprehensive study of the obstetrical practices of Wisconsin general practitioners over the turn of the century, "[d]espite the fact that by the end of the nineteenth century educational qualifications were increasingly important for professional services, ties to the community remained an important determinant of successful medical practice . . . Physicians acted as emissaries of science, but the reception of these emissaries was conditioned by the social and political positions these doctors already occupied within the community."[21] Borst uses the relationships between ethnicity, social position and scientific education to help explain how physicians in Wisconsin were able to gradually displace midwives. As she understands it, while scientific medicine was making physician-attended births generally more attractive to women, immigrant women who were not served by a physician from their own language and culture hung onto midwife-assisted births longer. Conversely, those immigrant doctors who were working in their own communities where they were known and accepted, were very busy.

Extending her analysis helps to understand why Dr. Geggie found it difficult at first to be accepted into Wakefield and surrounding communities. He was not a 'native son' of Wakefield, and and while he felt comfortable with "French-speaking inhabitants", he obviously felt unfamiliar with the ways of

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[21] Borst, *Catching Babies,*126-130

the poor Irish in the district.[22] Thus, the younger man not only desired a chance to gain experience with his older 'Preceptor', but he also needed Dr. Stevenson's help to introduce him into the community. Although we cannot see what the difference may have been for the older doctor, it might be assumed, as the youngest son of one of the original families settling in Wakefield and as one who grew up amongst the other villagers, Hans Stevenson gained the confidence of his patients much more quickly. How much easier it must have been, too, for a physician like W.B. Parsons, who joined his father and elder brother in their thirty year old practice in Red Deer, Alberta, as opposed to A.B. Walter, whose high hopes of bringing the most modern aspects of medical care came up against his "inexperienc[e] in the ways and life of the New Brunswick farmer." As Walter quickly realized, " . . . what was required of me was merely the art of general practice and the furnishing of a village sensation–the modern methodical, unadorned, surer ways and means of medicine were not impressive enough."[23]

The community sanctioning of a particular physician to attend maternity cases also depended very much on word of mouth, a form of women's control of which male physicians were very much aware.[24] Charles McKenzie arrived

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[22] H.J.G. Geggie, *The Extra Mile*, 30, 33

[23] W.B. Parsons, "Medicine in the Thirties," *Canadian Doctor* 46 (1980): 70; A.B. Walter, "Problems of Country Practice in New Brunswick," *CMAJ* 13 (1923): 227

[24] M. Jeanne Peterson points this out in her discussion on general practice in England a half century earlier. Medical students were told "Woe to the unhappy practitioner who has failed in his treatment of [women's] trouble; his condemnation will be widely heard. On the other hand he who has been successful will have the trumpet of fame

just in time to 'catch the baby' at his first delivery, and was relieved that his first case on his first day of his new posting had turned out so well. Hugh MacLean was afraid his first patient would die, but she not only lived, she had him back to attend her first confinement.[25] Langstaff's first 'slow summer' may have been related to him initially setting up his practice in a village five miles away, but even after relocating to his home of Richmond Hill, he was "observed 'in action' for other reasons" before being invited to attend one woman's labours.[26]

A display of uncertainty brought problems for a young physician hoping to build up a reputation in a new community. In Dr. Geggie's case, "rumour took a hand" after his initial lack of success, and he had to face the knowledge that potential patients were questioning his work. His calls for help from Dr. Stevenson came back to haunt him as he had to endure the whispering that "[t]he young doctor did not know his work " and that "[h]e'll never fill the old man's shoes."[27] After Dr. Stevenson's death, the bottom dropped out of his practice, as patients seemed reluctant to commit themselves to one with so little experience. As he wryly noted, "[i]n three weeks my patients were all

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sounded with extravagant force". *The Medical Profession in Mid-Victorian England* (Berkely: University of California Press, 1978), 129

[25] Charles McKenzie, ed. by Diane McKenzie, "Doctor in the Coal Branch," *Alberta History* 33 1985): 2-3; Hugh MacLean, " A Pioneer Prairie Doctor," *Saskatchewan History* 15 (1962): 60-61

[26] Duffin, 27 and 182

[27] H.J.G. Geggie, *The Extra Mile*, 34

better, afraid of me, or dead."[28] His "reputation, if not his future", was finally made when a desperate summons from a neighbour woman to the beside of her friend, already attended by another doctor, turned out successfully. Dr. Geggie performed a version (turned the baby inside the womb) which allowed the other doctor to finally extract a lifeless baby on which he himself apparently was not going to attempt any resuscitation. Dr. Geggie worked hard on the little girl for twenty minutes, using mouth-to-mouth breathing and hot and cold water baths to stimulate her breathing. At the time his memoirs were written, that child "anything but a lifeless morsel of humanity", was running a hotel. The neighbour woman repeated the story of his success to all who would listen, thereby ensuring a clientele more willing to invite him into their homes.[29]

The topic of high maternal and infant mortality began to receive increasing attention throughout the early years of this century, and by the 1920s, these seemingly intransigent problems were finally stimulating more organized medical and government action.[30] Social reformers, working since

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[28] H.J.G. Geggie, *The Extra Mile*, 47

[29] H.J.G. Geggie, *The Extra Mile*, 51

[30] For examples, see Alan Brown, "Infant Mortality," *CMAJ* 4 (1914): 690-708; Helen MacMurchy, "On Maternal Mortality in Canada," *CMAJ* 15 (1925): 293-297; Joyce Antler and Daniel M. Fox, "The Movement Toward a Safe Maternity: Physician Accountability in New York City, 1915-1940," *Sickness and Health in America: Readings in the History of Medicine and Public Health*, J.W. Leavitt and R. L Numbers, eds. (Madison: University of Wisconsin Press, 1978): 375-392; Suzanne Buckley, "Efforts to Reduce Infant Maternity Mortality in Canada Between the Two World Wars", *Atlantis* 2 (Spring 1977): 76-84; Cynthia Comacchio Abeele, "'The Mothers of the Land Must Suffer': Child and Maternal Welfare in Rural and Outpost Ontario, 1918-1940," *Ontario History* 80 1988): 183-

the late nineteenth century to improve conditions for women and children, had helped to focus attention following the first World War on the numbers of children dying during or after birth. From there it was a short step to investigating the health of the mothers who bore them. Dr. Helen MacMurchy, a physician turned civil servant, who by 1920 headed the Dominion Government's newly-created Child Welfare Division, was commissioned by the Canadian Medical Association to investigate maternal mortality in Canada. Her report, based on information obtained from physicians and published in 1926, uncovered what she believed showed a maternal mortality rate of 6.4 per thousand births for that year, and she put the blame on the largely preventable problems of puerperal infection (sepsis), haemorrhage, toxaemia, dystocia or prolonged labour and shock."[31] However, many women reformers and even several physicians who responded to her study also cited "poverty, and the attendant variables of overwork, malnutrition and fatigue . . . as factors in a significant number of deaths."[32] Initiatives to improve the general

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205 and Abeele, "'The Infant Soldier': The Great War and the Medical Campaign for Child Welfare," *Canadian Bulletin of Medical History / Bulletin canadien d'historie de la médecine* 5 (1988): 99-119; Katherine Arnup, *Education for Motherhood: Advice for Mothers in Twentieth-Century Canada* (Toronto: University of Toronto Press, 1994); Dianne Dodd, "Helen MacMurchy: Popular Midwifery and Maternity Services for Canadian Pioneer Women" in *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, Dianne Dodd and Deborah Gorham, eds. (Ottawa: University of Ottawa Press, 1994): 135-161

[31] Helen MacMurchy, *Maternal Mortality in Canada* (Ottawa, Department of Health, 1928), 19-22

[32] Katherine Arnup, *Education for Motherhood: Advice for Mothers in Twentieth-Century Canada* (Toronto: University of Toronto Press, 1994), 60

health of women were quickly derailed by an increased emphasis on medical intervention in the management of pregnancy and labour, and the debate then shifted away from easier access to better public health care being provided to discussions within the medical profession itself as to what among more closely-supervised prenatal care, more intense obstetrical training or increased use of hospitalization would be most efficacious in lowering the rate of maternal death.[33]

There are some indications that there were fewer maternal deaths in rural areas than in urban centres, at least in the first half of the twentieth century. American statistics for that time period show that until 1940, urban maternal mortality remained higher than rural.[34] In MacMurchy's report, the

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[33] Jo Oppenheimer, "Childbirth in Ontario: The Transformation from Home to Hospital in the Early Twentieth Century," *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries,* Katherine Arnup, Andrée Lévesque, and Ruth Roach Pierson, eds. (London: Routledge, 1990), 64-65; Buckley, "The Search for the Decline of Maternal Mortality: The Place of Hospital Records", *Essays in the History of Canadian Medicine*, Wendy Mitchinson and Janice Dickin McGinnis, eds. (Toronto: McClelland and Stewart, 1988),153-154; Irvine Loudon, "Puerperal fever, the streptococcus, and the sulphonamides, 1911-1945, *British Medical Journal* 294 (1987): 485-490; and Loudon, "Obstetric care, social class and maternal mortality, *British Medical Journal* 293 (1986): 606-608; Dodd, 151. Dodd's work is the most nuanced and perhaps the most sympathetic to MacMurchy's situation. To be fair, MacMurchy, as a physician herself and as a member of the federal civil service from which she was required to present an 'official' position, had to walk a fine line. Dianne Dodd praises her report as "innovative in revealing the role played by secondary causes in maternal death, such as exhaustion, poor nutrition, and other health complications". (Dodd, 152) That attention to increased medical supervision over childbirth won out over other less technological measures to improve women's chances in maternity should perhaps be viewed as a testament more to the power of the medical profession than to MacMurchy's expressed unwillingness to continue to address those issues.

[34] Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (New York and Oxford: Oxford University Press, 1986), 184. Anecdotal evidence also suggests a lower rural rate, although it is difficult to compare one with another. Langstaff's overall rate was not recorded, but a contemporary of his apparently lost 1.6 women per thousand, a remarkable result for the mid-nineteenth century. Victor Johnston began his practice in Lucknow, Ontario about a decade after Dr. Geggie, and although he admits his

provincial rural maternal deaths are consistently below those in the cities in the early 1920s.[35] However, as noted in the last chapter, Dr. Geggie's overall maternal mortality rate for the years between 1920 and 1949 was six per thousand deliveries, and for each year for which the rate could be determined in his practice, his rate was consistently above the national average. Both government and medical officials laid much of the blame for maternal deaths on poor aseptic technique on the part of attending physicians and nursing personnel, which resulted in often fatal puerperal infections for mothers. Most doctors seemed to be aware of the emphasis placed on infection, but general practitioners in the rural areas often denied that sepsis was the leading cause of death in their patients. Dr. Geggie believed that haemorrhage was a far greater threat, and although many of his colleagues admitted that women in their practice occasionally contracted a postpartum infection, most could not remember any women dying from it.[36] Even in 1902, J.R. Clouston believed

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obstetrical practice was not large, he had only one maternal death in 1100 confinements (0.9 per 1000). See Melville Watson, "An Account of an Obstetrical Practice in Upper Canada", *CMAJ* 40 (1939): 182; William Victor Johntson, *Before the Age of Miracles: Memoirs of a Country Doctor* (Toronto: Fitzhenry and Whiteside, 1972): 113

[35] MacMurchy, *Maternal Mortality*, 58. As she notes, however, the rural maternal mortality rate was higher in England and Wales. What remains quite unclear is why the maternal mortality rate in Quebec was among the lowest of all the provinces. In 1925, it was significantly lower than the others, while in 1926, only PEI was lower. On the other hand, infant mortality was considerably higher than the rest of the provincial rates. (See MacMurchy,*Maternal Mortality*, 38, 44) Quebec collected its own statistics, and it is unknown if there were any differences between methods there and the rest of the Canadian registration area.

[36] See S.P. Ford, "An Analysis of Three Thousand Cases of Obstetrics," *CMAJ* 7 (1917): 415. Ford called placenta praevia, a condition commonly predisposing to severe haemorrhage, "the dread of all rural practitioners" and never mentioned sepsis in his summation of his 3,000 obstetrical cases. One doctor could not recall a "single *puerperal*

that puerperal sepsis "happened only in rare instances, and there are men who have been in active practice for five, ten, and even fourteen years who have never had the misfortune to lose a case as the result of confinement or miscarriage . . ."[37]

It has long been apparent that improvements in either maternal or infant mortality rates involved complex issues.[38] What has been less addressed perhaps are some of the difficulties in discussing and comparing maternal mortality rates, but many writers have recognized that under representation of these rates was a real possibility.[39] This was noted even by many of those

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sepsis" developing from home births; another stated he never had a "fatal case of sepsis." See Hugh MacLean, "A Pioneer Prairie Doctor, *Saskatchewan History* 15 (1962): 63; Johnston, 40. In Laurel Halladay's study on maternity homes in Saskatchewan, she points out that in this rural province the maternal death rate in 1932 was only 4.4 per 1000, and that only very rarely was the death of a mother remembered. Laurel Halladay, " 'We'll See You Next Year': Maternity Homes in Southern Saskatchewan in the First Half of the Twentieth Century" (M.A. Thesis, School of Canadian Studies, Carleton University, 1996), 86.

[37] J.R.Clouston, "The Country Practitioner of To-Day," *Montreal Medical Journal* 31 (1902): 776

[38] Both Loudon and Oppenheimer suggest that the urban maternal mortality rate, which was always higher than the rural, did not drop until the introduction of sulfonamides and antibiotics after WWII. (Loudon, "Puerperal fever, the streptococcus, and the sulphonamides," 489; Oppenheimer, 67) Buckley discusses the role that the use of sulfonamides played in reducing maternal mortality, but insists that other factors were more important, such as changes in obstetrical practice, changes in nutrition, more control over other infectious diseases, and the role contraception played in decreasing fertility. (Buckley, "The Search for the Decline of Maternal Mortality", 163). Anne Digby points out how more recent historical work has discovered that general improvements in living standards did not automatically lead to better health and resistance to disease but that improvement was more relative to local sanitary measures and to more stringent occupational health standards. See her *Making a medical living: Doctors and patients in the English market for medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994): 70-71

[39] For instance, Judith Walzer Leavitt discusses the problems in nineteenth century calculations in *Brought to Bed*, 23-25

most involved in the reform movement.[40] Canadian historian George Emery, in his more recent work comparing the regional variance in women's risk of mortality in the mid-twentieth century with respect to marital status, age and number of pregnancies (parity), also feels that rates were under reported. He reminds us that the published national figures on maternal mortality included deaths that occurred both directly and indirectly ("pregnancy as a contributing cause") from maternity, but excluded those considered "non-obstetric", (where "pregnancy was present but incidental"). Thus, figures from fatalities from such diseases as typhoid, tuberculosis, or influenza, those that were quite common during most of the time period of Dr. Geggie's practice, often disregarded the connection with childbearing, and "[t]he effect of the 1925-1949 period rules was the assignment of 15 percent of Canada's **reported** maternal deaths (largely the **indirect** maternal deaths) to non-obstetric categories".[41]

Even an examination of the raw data from an individual obstetrical practice can produce similar problems of underreporting. As Jacalyn Duffin

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[40] Dr. W. J. Bell, the pediatrician for the Board of Health in Ontario, stated in his 1921 report on maternal mortality to the Annual Meeting of the American Child Hygiene Association that even when the mortality statistics were showing a rise, they were under represented "owing to the fact that some physicians prefer to report death as due to almost any other cause rather than puerperal sepsis or one of the other causes of maternal mortality". As quoted by Oppenheimer, 62. Another physician, writing for *The Lancet*, suggested that "the more careful scrutiny of death certificates is bringing into the category of maternal mortality deaths which in former years would have gone elsewhere". Holland Eardley, "Maternal Mortality", *The Lancet* 228 (1935): 974. Yet another author comments that stillbirths and miscarriages "are as much losses as are the losses from infant mortality". H.W. Hill, "Prenatal Negligence and Loss of Population", *CMAJ* 11 (1921): 615

[41] George Emery, "Age-Parity and Marital Status Compositional Influences on the Maternal Mortality Rate in Canada, 1930-1969: A Regional Comparison", *Histoire Sociale / Social History* 25 (1992): 231 (bold in original)

has pointed out, deriving the maternal mortality rates from sources based largely on obstetrical case notes is problematic. Being unable to see beyond the actual birth prevents us from determining whether or not complications arising from childbirth continued into the weeks following, and whether or not these led to the death of the mother. Statistics based on these figures alone may be too low.[42] The use of daybooks, however, may provide more of an opportunity to follow a postpartum course, and as in Duffin's study of her nineteenth-century physician, daybooks were used in this study where possible to reconstruct the prenatal and postpartum visits made to each obstetrical patient. In this way the deaths of some women that occurred beyond the day of childbirth could be ascertained, and arguably the mortality rates might not only be more accurate, but potentially higher. One wonders if results quoted from other practices would be altered upwards if daybooks were available to track fevers and other complications.

By the early twentieth century, no matter where their stated preferences lay in the reform of obstetrical care, few doctors would disagree with the potential role supervised prenatal care could play in maximizing maternal and child health. In a glowing tribute to the British professor J.W. Ballantyne, considered by some to be the 'founder' of modern scientific prenatal care, an admirer attested to the now "universal" acceptance of an idea "but one generation" old, and avowed that "the English speaking world owes a debt [to

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[42] Duffin, 204

Ballantyne] that can only be repaid by the homage of children yet unborn."[43] Ballantyne had given form and shape to a growing movement that was shifting the focus away from "lifestyle advice" for pregnant women to scientific medical supervision.[44] One Ottawa physician Joseph Nathanson obviously supported this viewpoint when he suggested in 1924 that newly pregnant women should be instructed as to "personal hygiene, the type of housework which she may carry on, her mode of living, [and] the recreations in which she may indulge" which would be the very beginnings of a "sustained and active watchfulness . . . uppermost . . . in the mind of the medical attendant."[45]

Nathanson preceded this statement by insisting that with sympathy and tact a woman's confidence could easily be won, and once she is convinced of the importance of prenatal care, she would "invariably show a desire for cooperation beyond our most sanguine expectations."[46] His paternalistic sentiments echoed very much what had been written on prenatal care in the obstetrical textbooks since the turn of the century, and reflected the general perspective of the medical profession at that time on women and their health

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[43] H.M.L., "Ballantyne and the New Midwifery", *CMAJ* Editorial 13 (1923): 441

[44] Ann Oakley, *The Captured Womb: A History of the medical care of pregnant women* (Oxford: Basil Blackwell, 1984), 25, 46-54. See also Joyce E. Thompson, Linda V. Walsh, and Irwin R. Merkatz, "The History of Prenatal Care: Cultural, Social, and Medical Contexts," *New Perspectives on Prenatal Care*, Irwin R. Merkatz and Joyce E. Thompson, eds. (New York: Elsevier Science Publishing Co., 1990): 14

[45] Joseph Nathanson, "Prophylaxis in Obstetrics, With Special References to the Value and Importance of Pre-Natal Care", *CMAJ* 14 (1924): 496.

[46] Nathanson, 495

concerns.[47] Physician interest in monitoring the entire period of pregnancy was also tied into the idea of preventive medicine, the catchword phrase that became pertinent to all medical fields.[48] While the benefits of prenatal care were to some extent supported by research into diseases of pregnancy such as toxaemia, other writing suggests even more was at stake. H.W. Hill, in his article "Prenatal Negligence and Loss of Population" neatly sums up what many other physicians also believed. As he asserted, not only the medical profession but "all interested citizens, and the public generally" should monitor potential childbearers "particularly with regard to disease, nutrition and heredity in the broadest senses of those terms."[49] Much in evidence here was the strongly eugenic component to the concern over women's maternal health that surfaced following the first World War. Hill was also rather blatantly suggesting that women who did not seek medical advice for their pregnancies could be considered negligent toward their unborn children, a precursor to present-day doctors who target pregnant women over the issues of smoking and drinking. Undoubtedly, these attitudes were not incidentally related to aspirations of prestige among the elite members of the obstetric profession, but they point as well to evidence that doctors experienced increasing confidence

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[47] Wendy Mitchinson, *The Nature of Their Bodies*, especially 48-76

[48] Arthur Lennox, "A Few Remarks on Prophylaxis in Obstetrics," *CMAJ*14 (1924): 697. Lennox noted that "the whole trend of modern medicine, in all its branches, is towards prevention of disease, and in this praiseworthy movement obstetricians, the world over, are keeping up with their professional brethren in the other branches of this medicine."

[49] Hill, 618.

in women choosing them as medical attendants for their confinements.

The rhetoric concerning antenatal care, however, exposed a considerable separation between prescriptive literature and descriptive reality.[50] As one historian points out, most of the writing was directed towards middle-class women and even the assurance that normal pregnancies should not stop women from continuing with their "regular work" could be detrimental for the health of pregnant farm women who laboured long hours on their farms and in their homes for large families.[51] Comments about modes of living and "indulged" recreations would have little meaning to these women, nor would they to their doctor. Protests poured into MacMurchy's office over the conditions in which expectant mothers found themselves, "performing tasks fit for men's strength" with often no one to help them "through the ordeal."[52]

Neither did all doctors believe that prenatal care was the answer to all the problems of pregnancy. Herbert Little, at the time assistant professor of obstetrics at McGill, rather suspected that the zeal for increased surveillance had actually frightened some patients away, or at least had "taught them to look for trouble, rather than to recognize and avoid it."[53] Dr. Geggie himself

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[50] Post-partum care was not given as much attention in the medical textbooks and in the journals as was prenatal care, although such "obstetric follow-up" was not "unknown in Canada", as was claimed by one professor of obstetrics in the *Canadian Medical Association Journal.* Herbert M. Little, "Obstetrics during the Past Twenty-five Years," *CMAJ* 14 (1924): 908

[51] Abeele, "The Mothers of the Land Must Suffer," 193-4

[52] MacMurchy, *Maternal Mortality*, 56

[53] Little, 908

wondered how much medical prenatal care could be expected to accomplish without attention to other social and economic factors in the lives of women. Following the death of one mother and the fifth miscarriage of another, both of whom he considered "intelligent" women who had been "anxious to cooperate" but who had been without household help, he wrote that "the most extensive and complete [prepartum] program would still be incomplete unless social service and domiciliary assistance is provided at the same time." On the other hand, he postulated that social services could do nothing for those in whom "there's no intelligence to work with."[54]

It is fairly certain that the degree of prenatal attention prescribed by the urban medical clinicians was not attained by country doctors or their pregnant patients. However, some practices, including Dr. Geggie's, averaged at least a rate of fifty percent of patients who were receiving some prenatal care by the 1930s and 1940s.[55] This number may have been even higher. While it is probable that on unknown obstetrics calls Dr. Geggie might not know the conditions of either the woman or the home, as long as physicians continued to make housecalls, it is likely that they had more intimate knowledge of family situations than anyone else outside the immediate family. They therefore may have been in a better position than present-day historians

[54] H.J.G. Geggie, "Letter," 6, 7

[55] A.F. McKenzie, writing in the 1930s, thought that he saw about 60 percent of his cases prior to delivery, or was at least "notified that my services would be required about such a time." "Notes on One Hundred Obstetrical Cases in Rural Practice," *CMAJ* 30 (1934): 175

realize to assess potential complications that might arise.[56]

But Dr. Geggie also felt that "there was more fatalism long ago," a perspective borne out by the experiences of other general practitioners of the time. An attitude of resignation often permeated the lives of both women and men, a combination perhaps of religious faith and an understanding of the harsh conditions under which many of them struggled to survive. Women and their doctor realized that giving birth was not without pain and often sorrow, and deaths that resulted were a not uncommon phenomenon that likely in some way touched the lives of most people. Husbands and wives undoubtedly grieved over their lost children, but appeared resigned to their fate. "God gave me sixteen children," one woman commented. "He knew I couldn't look after them; He took eight . . . "[57] Another father, too far from the city and unable to afford the operation necessary for his child's survival, stated matter-of-factly that if the baby died, he could "have another next year for nothing."[58] Men were more likely to mourn the passing of their wives who died in childbirth. Women, vital partners in securing the viability of pioneering homesteads, were valued as much for their economic contributions as for their companionship.

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[56] For a particularly illuminating discussion of doctors and, in this case, middle-class homes, see Annmarie Adams, *Architecture in the Family Way: Doctors, Houses and Women, 1870-1900* (Monreal and Kingston: McGill-Queen's University Press, 1996), 36-72. In her study, she points out how professional medical concern over matter of health made the home a very 'public' place.

[57] H.G.J. Geggie, *The Extra Mile*, 51

[58] Diane McKenzie, ed. "Reminiscences of Dr. Charles McKenzie," *Saskatchewan History* (1985): 56

A mixture of love and need was evident in this man's words as he pleaded with the doctor to "[d]on't worry about the keed . . . You save the missus. She got cows to milk and bread to bake [and needs] to look after the keeds. I need her. She's a good woman."[59]

Twentieth-century physicians built on the trend of labour management begun in nineteenth-century practice, and they continued to intervene in labour. Both contemporary physicians and present day historians alike have claimed that the routine use of anaesthesia and forceps especially, made physicians increasingly interventionist and 'meddlesome'. However, for those doctors who reported that it was neighbour-women midwives who attended most deliveries in the earlier years, it was precisely for these measures that they were called if the difficulties of the case warranted medical help.[60] For those like Dr. Geggie who most of the time appeared to be the primary attendant called for deliveries, it was likely that measures employed did sometimes shorten a tedious wait on the part of the doctor. Physicians themselves recognized that childbirth could be dangerous, and many were

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[59] Samuel S. Peikoff, *Yesterday's Doctor: An Autobiography* (Winnipeg: The Prairie Publishing Company, 1980), 33

[60] Dr. Peikoff was told that the "middle wife" would try for two days before the doctor was called. While the doctor thought this was "bizarre", he also realized that he had "no right to make the call unless [the father] requested it." Peikoff, 27. See also S.H. Smylie, Archives of Ontario, Smylie Memoirs, MU 2853, Book 9, 420; Diane McKenzie, "Reminiscences of Dr. Charles McKenzie", 55

genuinely sympathetic to a woman's plight.[61] Women who were exhausted from family duties to begin with may very well have welcomed a quick end to what was for many an unfortunate yearly ritual. As Dr. Geggie wrote, "how often does the patient "who stands pains well" prove to be exhausted by standing it so well."[62]

Without more detailed records such as those from Dr. Geggie's practice, it is difficult to evaluate where his labour management techniques fit in with other practices. However, some bedside case notes do survive from the practice of J. Howard Walmsley, a graduate of Queen's University medical school in 1914. Following a stint as a surgeon in the Canadian Army Medical Corps during the first World War, he set up general practice in Prince Edward County in 1920 where he worked for almost fifty years. Although from the beginning of Dr. Walmsley's practice there was a hospital in Picton, he noted that "[p]eople hadn't gotten accustomed to going to the hospital . . . and maternity cases were treated in their homes with a few exceptions."[63] While pre- and postpartum visits could not be closely calculated during the years 1921 to 1926, when the most detailed records are available, and while at sixty-

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[61] A closer examination of physician's records has convinced several authors of this. For example, Anne Digby, *Making a medical living: Doctors and patients in the English market for medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994): 278; Wendy Mitchinson, *Nature of Their Bodies*, 361; Amalie Kass, " 'Called to Her at Three O'Clock AM': Obstetrical Practice in Physician CaseNotes," *Journal of the History of Medicine and Allied Sciences* 50 (1995): 207

[62] H.J.G. Geggie, "Anaesthetics and Analgesics in Childbirth, 1

[63] David Taylor, ed., *Prince Edward County Yarns as told by Dr. J. Howard Walmsley*, Bloomfield: Prince Edward County Historical Society, 1985), 12

six the number of confinements was very small, total obstetrical visits did comprise about fourteen percent (a number similar to that of Dr. Geggie) of his overall general practice at that time.[64] Prenatal visits during the years 1941-1943 for Dr. Walmsley ranged from fifty-six to ninety-three percent (as opposed to the approximately fifty-five percent for Dr. Geggie during those years). From the small number of records available, Dr. Walmsley appeared to have passed the fifty percent mark of patients seen prenatally about a decade earlier. That most of those he attended remained at home during this period is suggested by his use of chloroform, as the sole known exception was the only obvious hospital visit when ether was then the anaesthetic of choice.[65]

Dr. Walmsley's student lecture notes from Queen's clearly indicate that, when necessary, chloroform was an accepted part of obstetrical practice, and based on his available patient records from the 1920s, chlorforom was used

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[64] Queen's Archives, J.H. Walmsley Fonds, A.Arch 3621.14; Patient records 1921-1926, Series 4; Daybooks #12, 1940-1942; Daybook #13, 1943-1945. The small number may reflect a new doctor starting out in practice, who needed time to build up his patient load, but the records themselves are confusing. While only a total of 66 deliveries were counted from his daybook records during the years 1921-1926, there were 66 confinements alone counted from his 1924 account book (and 53 from the 1925 account book) Why there is such a large discrepancy is unknown, unless his daybooks included only those he had delivered at home, and his account books took in hospital deliveries as well. If that is the case, many more women were choosing to have their babies in the hospital than was first thought. This might be traced more accurately with access to the Picton hospital records. In 1933 and 1934, and again in 1941-43, what appear to be more accurate tallies of confinement cases were kept in the front of the account books, but these count births only, and not miscarriages or other obstetrical visits.

[65] Home deliveries continued in the area until at least the early fifties, according to a recently retired physician who had begun work there in 1941. He recounted that some women either did not want to go to the hospital or could not afford it. The town was supposed to have paid him $10.00 per delivery, but he often would not get paid. Telephone conversation with Dr. S.H., 6 February 1997.

approximately twenty percent of the time, a much lower percentage than Dr. Geggie's use. On the other hand, from what can be calculated from Dr. Walmsley's practice, he found it necessary to apply forceps in about thirteen percent of his cases, a little higher than Dr. Geggie's nine percent during the 1920s, or another Ontario physician's seven percent slightly earlier.[66] Much more research needs to be undertaken to determine the relationship between forceps use and the employment of uterine stimulants.

It is interesting that Dr. Walmsley was also taught in medical school about the use of Pituitrin, as there is no mention of it in the obstetrical textbooks in use at the time. However, even though Dr. Walmsley's lecture notes demonstrate that "Ergot" and "Pituitary Gland [extract]" were part of a physician's obstetrical kit, he wrote that these were "good in severe haemorrhage," and therefore he was likely taught to use them mainly after the foetus was delivered, and not for strengthening contractions before delivery.[67] The drug may thus have come into more common use after 1914. While Dr. Walmsley recorded the use of these two drugs in some deliveries, it is unclear whether or not he used them more often than was noted.

Dr. Geggie may have been more 'interventionist' than other of his contemporaries with his use of Pituitrin, although its use in other practices varied considerably. Dr. Walmsley employed Pituitrin to aid labour in only

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[66] Ford, 418

[67] Queen's University Archives, J.H. Walmsley, Obstetrical lecture notes, AArch. 3621.14, Box 2/3

thirteen percent of his confinements, considerably lower usages than in Dr. Geggie's perhaps more managed labours. However, one older physician, obviously an early advocate, had overcome his initial scepticism about its use and stated he "now never [goes] to a case without it," attributing its properties to his decreasing use of forceps over the previous eighteen months.[68] Still another doctor recollected that though Pituitrin might be sometimes used "to hasten labor", more often he "left things up to nature and spent the time playing cribbage with the husband, or looking over the farm, or even target shooting."[69]

As noted by Shortt in his article on general practioners, many of those who have left a written record as a retrospective look at their careers expressed satisfaction with the choice they had made. Although he may have been writing for an audience, few became as carried away about obstetrics as one doctor who waxed eloquently about "the greatest miracle of all the ages", and who never entered a lying-in room without feeling such "a profound sense of responsiblity resting upon [him], as well as the great honour conferred."[70] Some physicians cited the lack of mental stimulation a problem of country practice, and wondered if their city colleagues would think they were of

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[68] Ford, 418

[69] Parsons, 73

[70] Ford, 413

"another species" if they could just see what they had to cope with.[71] Most, however, seemed to have found fulfilment in their role as healers in their communities. Dr. Geggie himself believed that rural general practice was "the best medical life there is", not necessarily because of the financial return but "in the kind of coin that matters most—the satisfaction of having done a big job fairly well, where there was no one else to do the job at all."[72] After one delivery, (and perhaps because it was Easter morning) he wrote: "Home again and so to bed well content."[73]

From the late nineteenth century on, many women had available to them an increasingly wide array of measures for parturition which included the use of forceps, pain relief and anaesthesia. Evidence from Dr. Geggie's practice demonstrates that they obviously continued to desire these measures to relieve the travail of childbirth. Physicians during the earliest years of Dr. Geggie's career could offer only limited advantages to women and their infants as a whole as long as safety from infection, haemorrhage and diseases of pregnancy eluded them. By the later years, in the 1940s and 50s, as doctors learned more about both the physiology of pregnancy and the science of bacteriology, concrete gains were beginning to be made in the struggle against

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[71] J.R. Clouston, "The Country Practitioner of Today," *Montreal Medical Journal* 31 (1902):781-782; Hugh Smylie also appreciated most the "fraternizing with other doctors, and being able to discuss cases" after his move to Toronto. See Smylie Memoirs, 450.

[72] H.J.G. Geggie, "An Address to the McGill Undergraduate Society", 2

[73] OBS note 29:37

both maternal and infant morbidity and mortality. While childbirth could still be a frightening experience, fewer women and children were dying from it. The following chapter will explore some of the ways in which women in the Wakefield area managed childbirth, and how it fit into the daily rhythm of their lives.

Chapter Five

Women and Childbirth

My primary focus throughout most of this study has centred mainly on the medical aspects of obstetrical practice provided by one rural general physician in the early twentieth century, and the positioning of that practice within the broader context of rural medical obstetrics within Canada during this period. Drawing on information from the obstetrical notes, Dr. Geggie's memoirs and especially the oral interviews, in this section I will attempt to provide a sense of the experience of birthing in Wakefield in these years.

To apply the term 'birthing experience' to those women who were exhausted and worn-out women and who had to endure the almost yearly ritual of adding another child to a family where resources were already strained seems somewhat pretentious. Nevertheless, from the evidence left to us, it is possible to piece together some of the strategies employed by women in Wakefield to arrange their childbirth in ways most suitable to their own situations, and this deserves further consideration. While the actual experience of labour and delivery may have remained similar for most women in this area, there was a remarkable variation in how they organized their lives around the births of the children.

Many historians who have written on the social aspects of childbirth

have analysed the role of women in the transformation in birthing.[1] On the one hand, it has been argued that the sphere of midwifery and childbirth, in which women were knowledgeable, skilled and comfortable, was wrested from their control by struggling male doctors whose professional status and economic remuneration depended upon a hegemonic access to the birthing chamber.[2] On the other hand, historians have rightly pointed out how women did suffer from dreadful births and deadly infections at the hands of both their midwives and medical attendants, although some have attempted to show that advancing medical technologies were linearly progressive and of undisguised benefit to the pregnant woman and her infant.[3] Other more balanced studies have only indicated just how complex this issue really is.[4] While the new

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[1] For comprehensive histories of childbirth, see in particular Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* (New York: The Free Press, 1977); Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (New York and Oxford: Oxford University Press, 1986)

[2] For example, Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 Years of Experts' Advice to Women* (New York, Anchor Press, 1978); Ann Oakley, *The Captured Womb: A History of the Medical Care of Pregnant Women* (Oxford: Basil Blackwell Publisher: 1984); Lois James-Chatèlat, "Reclaiming the Birthing Experience: An Analysis of Midwifery from 1788 to 1987 (Ph.D. Thesis, Department of Sociology, Carleton University, 1989

[3] Edward Shorter, *A History of Woman's Bodies* (New York: Basic Books, 1982)

[4] One feminist historian has pointed out that some (especially early) feminist writing on the history of birthing and medicine has also been somewhat unbalanced, as it has tended to see "technology itself as both masculine and destructive." Instead, she argues that keeping an acute historical perpsective on both past and modern medical concerns will allow scholars to explore how both men and women may or may not have benefitted from new medical technologies. Deborah Gorham, "Birth and History," *Histoire Sociale / Social History* 17 (1984): 383-394. For other insightful articles on this perspective, see Regina Markell Morantz and Sue Zschoche, "Professionalism, Feminism, and Gender Roles: A Comparative Study of Nineteenth-Century Medical Therapeutics," *The Journal of American History* 67 (1980): 568-88; Roger Jeffery and Patricia M. Jeffery, "Traditional Birth Attendants in Rural North India," *Knowledge, Power and Practice: The Anthropology of*

techniques of forceps, anaesthesia and antisepsis often did offer real relief to many women from the feared dangers of childbirth, at the same time they also provided the means by which physicans could interfere much more easily in childbirth.[5] As long as birth remained in the home, it has been argued, educated upper and middle-class women were not just passive recipients of an increasingly intrusive medical care, but eagerly chose to invite male accoucheurs to their confinements along with their traditional birth attendants. American historian Judith Walzer Leavitt, in particular, has quite convincingly demonstrated how some women were able to shape the circumstances surrounding their own birthing experiences by actively seeking out doctors who would provide relief from the perils of their confinements.[6] As Catherine Scholten concluded, "[t]hough women might socially be the most acceptable assistants at a delivery, men were potentially more useful."[7]

Medicine and Everyday Life, Shirley Lindenbaum and Margaret Lock, eds. (Berkeley: University of California Press, 1993), 7-31

[5] Wendy Mitchinson, "Historical Attitudes Toward Women and Childbirth", *Atlantis* 4 (1979): 31. See also Mitchinson, *Nature of Their Bodies:Women and Their Doctors in Victorian Canada*, (Toronto: University of Toronto Press, 1991)

[6] Leavitt, *Brought to Bed*, especially the chapter "'The Greatest Blessing of This Age': Pain Relief in Obstetrics, 116-141. Other authors who share this same notion that women were at times able to choose what they needed from available options include Nancy Schrom Dye, "History of Childbirth in America," *Signs: Journal of Women and Culture* 6 (1980): 102; Denyse Baillargeon, "Care of Mothers and Infants in Montreal Between the Wars: The Visiting Nurses of Metropolitan Life, Les Gouttes de Lait, and Assistance maternelle," *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, Dianne Dodd and Deborah Gorham, eds. (Ottawa: University of Ottawa Press, 1994), 163-181

[7] Catherine M. Scholten, "'On the Importance of the Obstetrick Art': Changing Customs of Childbirth in America 1760 to 1825," *William and Mary Quarterly* 34 (1977): 444

During the time that physicians attended pregnant woman in their own homes, women and their families were subjected to a closer medical scrutiny than occurs today. Doctors acquired a much more intimate knowledge of their patients and their living conditions during their long waits at obstetrical cases.[8] One writer estimated that "by reason of his obstetrical practice alone" a nineteenth century physician likely spent "two to three months out of each year in the homes of others."[9] The obstetrical case notes only outline some of these more social aspects of Dr. Geggie's medical practice. His memoirs, often composed if not actually written down during the lulls in a busy day or night, help round out the contours suggested by the case records and provide us with a keen sense of rural "social doctoring" in the area during the early decades of this century. Not only are we shown into patients' homes and lives, but by reflection, we can also gain some understanding of what is important to the physician.

For normal confinements at homes in the village or for those easy to reach when the weather was good, Dr. Geggie could easily keep himself apprised of a woman's condition through quick visits or the telephone until her labour had progressed to the point where he was needed. For families more isolated or where complications might be expected, however, it was necessary

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[8] See Steven M. Stowe, "Obstetrics and the Work of Doctoring in the Mid-Nineteenth Century American South," *Bulletin of the History of Medicine* 64 (1990): 540-566

[9] Melville C. Watson, "An Account of an Obstetrical Practice in Upper Canada," *CMAJ* 40 (1939): 181

that he remain in the home throughout the labour and delivery and until he was satisfied that all was well. Families often had to provide Dr. Geggie with meals and a bed where he could catch a few hours sleep. One woman interviewed remembered that, thanks to the baking she had "prepared ahead of time," her husband and the doctor had some breakfast together downstairs following the birth of her daughter.' Sometimes the accommodations offered by Dr. Geggie's hosts provoked a few comments from him. "Red letter days" of fine tables groaning under the best farm fare only came at intervals; in other homes, his survey "with mingled hopes and dismay the contents of the pot", usually left him inventing excuses about fasting and feast days.[10] Only desperation helped him accept the bed that was "tolerably inviting, but [then] lack of sleep made any bed welcome."[11] One passage from his memoirs is particularly useful to quote in full, as it sheds light on the living conditions in one home and at the same time, on several dimensions of a country obstetrical practice. Following the birth of a baby, when it was too inconvenient for him to leave that night:

> . . . the problem of putting in the time was to be faced. I hadn't my buffalo robes from the sleigh, which had often made me a bed beside the stove in a log hut. In this home, bedding was very short, barely enough for the mother's bed. Besides, the "sage femme" in the district had brought her three-month-old infant with her the afternoon before. It was rolled up in numerous wrappings, and laid crossways at the end of

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[10] H.J.G. Geggie, *The Extra Mile*, 119

[11] H.J.G. Geggie, *The Extra Mile*, 89-90. This particularly humourous incident, related to bed bugs, described the "blessings" of bilingualism in a unilingual home; one could sometimes complain without risking real offence.

> the bench. There was only the choice between the drafty floor and this same bench. A coon coat helped a bit, but hardly reached from shoulder to ankle. The ankles stuck out, and happened to be just across the finger-wide jamb of the outside door. The bench was hard, but not half so hard as the frosty breezes across my ankles. It was not so bad till after one a.m., when one begins to wake up again. At times the new baby wailed and sneezed promisingly; there was no difficulty breathing. By times, the three-month old howled industriously, got the nipple, and slept again.[12]

Despite a belief in modern medicine, many women in Wakefield still clung to the traditions of their past. Dr. Geggie described some of the ancient remedies that had been handed down from the 'old women':

> In almost every parturient's home was an eggcup or glass of hand-picked grains of whole, unground wheat. Each day in the latter months, the patients would carefully count out and swallow nine grains. "J'ai pris mes neuf grains," giving surety of an easy delivery . . . Cold water must not be given to a woman in labour. "Il faut casser l'eau" with gin or make it lukewarm. The parturient must turn off her back or put her arms above her head, or comb her hair . . . time after time I've seen [the cord] tied to the thigh, or held by an old lady for hours, when all that was needed was to express the detached placenta . . . The breasts must be kept warm; no water on them, and the best preventative of abscess is a weasel skin to cover them.[13]

In one home, Dr. Geggie recounted how the water was on to boil, and all the supplies that he might need were neatly lined up beside the "well-made clean bed." The requisite glass of wheat grains were also present, as was the "St. Joseph's belt" of red bias tape of wool . . . sent from St. Joseph de Montreal" around the patient's waist. In fact, he noted, "[e]very precaution

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[12] H.J.G. Geggie, *The Extra Mile*, 99

[13] H.J.G. Geggie, *The Extra Mile*, 98. The 'weasel skin' remedy for breast abscesses was also found in the mid 1800s in Langstaff's practice, Richmond Hill, Ontario. Duffin, 205.

had been taken; it remained only for me to act".[14] One woman interviewed briefly discussed following the "old, old saying" that women should remain in bed for nine days postpartum "till everything [went] back into place," nine being the crucial number.[15] The comfort and moral support that abiding by these customs provided, or conversely, the fear of the unknown if they were not followed, may have helped to perpetuate this mixing of the so-called traditional and more modern practices.

No matter what kind of delivery women chose, however, they continued to form networks of support for each other at their confinements and throughout the lying-in period, although both familial and financial resources affected the degree of support each woman could summon. Most women who delivered their babies in their own homes arranged for some female help to be with them through childbirth. In what appear to be fortunate circumstances, Mrs. J, for the last month before each of the six births that she had at home, had " a girl to help me . . . [and] to be there to look after the children when I was in bed." She also asked "a couple of other friends" to come over during the actual birth, and had pre-arranged with her sister-in-law, who "who had done

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[14] H.J.G. Geggie, *The Extra Mile*, 102-103

[15] Interview 20 April 1997, Mrs. J. This was a common belief, mentioned in frustration by one New Brunswick doctor, who related that "the postpartum patient should get up on the ninth day irrespective of the size and condition of the involuting uterus, that being the day on which, as everybody ought to know, it goes back into place.". A.B. Walter, "Problems of Country Practice in New Brunswick," *CMAJ* 13 (1923): 228. See also the same practice remembered in Newfoundland in John K. Crellin, *Home Medicine: The Newfoundland Experience* (Montreal and Kingston: McGill-Queen's University Press, 1994), 183

for . . . a few others" to be there as well to help the doctor.[16] Mrs. J. and Dr. Geggie were therefore well supplied with both experienced help and several pairs of willing hands devoted to looking after the mother and her infant. Those women who continued to choose the sage femme to help in childbirth, reserving the physician only for emergencies, also relied heavily on neighbourhood support. One infant girl, the result of one such "natural childbirth" was "passed around among the neighbours, and well looked after" while her mother recovered from a severe post partum infection.[17] Another woman, determined to have the help she wanted for her fifth child, travelled to her cousin's house for her confinement when her cousin's own familial responsibilities prevented her from leaving.[18]

Some women, either lacking a neighbourhood support network or choosing not to use it, were able to pay for extra help. Mrs. T. and Mrs. M. scheduled no other outside help, but relied on the fact that the doctor "always" brought a "lady who helped with births" with him when he came, who would return over the next few days to bath the newborn child.[19] Still others made arrangements to enter maternity homes in the villages whose owners took in pregnant women. Run by women able to help Dr. Geggie with birthing as a

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[16] Interview 20 April 1997, Mrs. J.

[17] H.J.G. Geggie, *The Extra Mile*, 80-81

[18] H.J.G. Geggie, *The Extra Mile*, 101-103

[19] Interviews 19 February 1997, Mrs. T; 17 April 1997, Mrs. M.

way to supplement their income especially during the hard times of the Depression, these homes were a useful option for those who lived far out of town, for those who had encountered problems with previous deliveries, or for those who simply might have felt more comfortable in a maternity home.[20] In Wakefield village itself there were at least three homes available at different times. One of the busiest belonged to Mrs. Nesbitt, a woman who, as the eldest girl of her eleven siblings, likely learned about delivering babies at her own mother's bedside, and was often called upon by Dr. Geggie to accompany him to other women's homes for their births. As her own daughter remembers, although they had no running water, her mother always seemed to be prepared for the women who would appear at their home two or three days ahead of time. Their babies would be born "very quietly" and both mother and child would remain for about ten days following their deliveries. One woman returned three or four times for the births of her children.[21] Although it is unknown how often they were used, maternity homes did provide an alternative service for both women and their doctor.

Two of the five women interviewed elected to have at least one of their

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[20] For a comprehensive examination of a much more organized system of maternity homes, see Laurel Halladay, "We'll See You Next Year: Maternity Homes in Southern Saskatchewan in the First Half of the Twentieth Century" (M.A. Thesis, Carleton University, 1996)

[21] Telephone conversation, Miss Vera Nesbitt, 02 July 1997. Miss Nesbitt remembers her mother being away sometimes for up to two days, during which time her father would have to look after the family. Mrs. Nesbitt's primary role was to help the doctor, however, and she did not attend births to look after domestic chores. She was paid by the family who employed her, although as her daughter stated, sometimes payment was "in chickens."

children in this kind of facility. Mrs. M., living in a small three room rented house, decided it might be easier to have her first child at a maternity home in the village of Wakefield. Because she was not from the area, and had neither mother nor mother-in-law to be with her, she may have felt somewhat nervous about being alone. Her timing was impeccable; she made arrangements with Mrs. Nelson one day, and went into labour the next.[22] The next time, with a four year old son whom she could not leave, this now more experienced mother had her second child at home. Mrs. S., on the other hand, had been sent by Dr. Geggie into Ottawa for her first delivery when complications had been discovered. By the time her second child was on the way, she had both a younger child and elderly in-laws to look after in her own home, and told Dr. Geggie that she "didn't like to go away, to be that far away where my husband couldn't bring her [daughter] in to see [her] very much." She was then able to negotiate with her doctor to book into a maternity home in Low, a village about twenty kilometres north of Wakefield, where both of them would be more assured of having experienced help should she again have problems.[23]

Some women did travel out of the community to the hospitals in Hull

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[22] Mrs. Nelson was a sister of Mrs. Nesbitt, whose home was used as a maternity home after Mrs. Nesbitt's. Her niece believes she may have learned about delivering babies from helping her older sister.

[23] Her first pregnancy had threatened to end early with profuse bleeding from a placenta praevia. She remembers being strapped on an old ironing board, and sent, via the baggage department in the train, to the Grace Hospital. With improved transportation, the hospital in Ottawa was also an option for the doctor as well.

and Ottawa. Even though she had had six children at home, Dr. Geggie suggested that she prepare to go to the Grace for her seventh, as it was due in the middle of winter and he by this time had retired his 'snowmobile'. This she seemed quite willing to do; one of the benefits she later admitted to was not having to make her own pads, which protected the bed at all home births and which she had had to make for her six other confinements.[24]

Although the postpartum procedure followed was likely less stringent than what had been advocated in the earlier textbooks, remaining in bed for ten to fourteen days following deliveries was still considered the norm during the years of Dr. Geggie's practice. The fear that excess movement might bring on postpartum haemorrhage or improper replacement of the internal organs was still strong. While it would appear that there were many women who could arrange extra household help and who no doubt needed and enjoyed the extra rest this time out from regular domestic duties could offer, for some women with young children at home and little help, this rule must have been difficult to follow. We can catch occasional glimpses of independence in women who arranged their lying-in period somewhat differently, although much of this evidence is indirect. One woman remembered rumours that women in one of the smaller rural villages had their baby "and went into the field to work right after."[25] Suggesting an understated censure, on one occasion Dr. Geggie wrote

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[24] Interview 20 April 1997, Mrs. J.

[25] Interview 20 April 1997, Mrs. J.

in his notes that the woman was "out of bed" three days following delivery, and six days after was "now keeping house."[26] Immediately following another delivery, in which one woman gave birth to her third child just before Christmas, Dr. Geggie commented rather laconically that the mother "was taking coffee and toast up on one elbow–counts on making Xmas cake this week and wash tomorrow."[27] However, one woman interviewed stated that, following the birth of her second child, " I just made up my mind I [was] going to get up. And so I got up."[28] Just as pre-birth preparations had to be adapted to suit the needs of women and their families, it is also very likely that many other women needed to arrange their postpartum course to fit into the practical realities of their own lives.

Thus, many women in Wakefield were still able to adhere to certain traditional cultural practices at the same time that they selected the benefits of pain relief and safety that modern medicine seemed to offer. But there are also some indications that even as birthing was still considered home based, women were beginning to relinquish more control over the process. It is likely that physician-delivered obstetrics administered in this area for such a long time was gradually subsuming or taking precedence over many of the more traditional practices that may have been more the custom for mothers and

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[26] Daybook 20 January 1923

[27] OBS note 96:43

[28] Interview 17 April 1997, Mrs. M.

grandmothers of the parturient woman. The solidification of 'scientific medicine' also narrowed the boundaries within which women could negotiate; while delivering babies remained to some extent an art, the strengthening foundation of science upon which it increasingly rested fortified physician confidence in labour management techniques. This is not to say that doctors were secure in their knowledge of the medical aspects of pregnancy and parturition; indeed, historians have been surprised by the degree of uncertainty to which they admitted. Dr. Geggie, like other rural physicians, was constrained by the conditions of the rural enviroment within which he had to operate. However, while he undertook some experimentation, he used relatively similar techniques in the management of labour for practically all the women he attended throughout the years under study, and once labour was underway, women had little choice over the procedure. There is little evidence, though, that women who wanted the doctor at the bedside wished for any kind of a choice; on the contrary, they seemed to strongly desire what he had to offer.

Chapter Six

Conclusions

Birthing changed greatly for North American women over a century and a half; what had been a women-centred event based in the home was by the latter half of the twentieth century confined to a medical institution supervised by university-trained physicians. It is clear that developments in medical obstetrics are strongly implicated in this transformation in childbirth, and while women gradually gained safer births for themselves and their infants, several historians have demonstrated that the changes were not necessarily always beneficial.

However, recent literature often overlooks the fact that, at least until the 1950s, changes in obstetrical practice were far from strictly linear, but remained contingent on the local resources available for women and their attendants. Rural medical obstetrical care remained and still does remain a different entity from urban practice. While in the cities most births were taking place in hospitals, women in Wakefield, until the middle of this century, had no access to a local hospital. Some were delivering their infants in homes that, without running water, electricity or much heat, were likely considered decidedly antiquated by the early 1950s. At the same time, Dr. Geggie was evidently a skilled obstetrician, employing drugs and obstetrical techniques familiar in urban practices, and in spite of the remote nature of the area these women did have access to skilled medical obstetrical care. However, there

were limits to his practice, and he himself was constrained by some of the conditions in which he had to work as, for example, he could not add safer anaesthetics or Caesarean sections to his repertoire of skills.

Obstetrical care did make up a significant portion of Dr. Geggie's medical practice, and many women evidently welcomed him into their homes to aid in the birthing of their children. The strong memory his youngest son has of the call "endormez-moi!" as the doctor arrived suggests that labouring women were perhaps most interested in the pain relief Dr. Geggie could provide, and his almost universal use of chloroform suggests that women expected its analgesic or anaesthetic effects during their deliveries. The medicalization of the labour process was one way to lessen the exhaustion of labour that Dr. Geggie knew would compound the distress in the lives of those already compromised. He perceived pregnancy as being comprehensively linked to women's lives when he pointed out that poverty and overtaxed lives contributed their share to maternal morbidity and mortality. He even went so far as to state, in the days before contraception was easily available, that "until we have adequate birth control methods . . . it is my belief that maternal mortality cannot be reduced to the ultimate minimum desirable."[1]

As long as women continued to give birth at home, they did manage to maintain some form of control over their birthing environments. In Wakefield, pregnant women arranged to have their children born at home, with or without

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[1] H.J.G. Geggie, *The Extra Mile*, 79

family, friends, or the local midwife in attendance. Some negotiated with Dr. Geggie to give birth in a nearby maternity home, while others did not choose him as their attendant at all, but decided to have their baby in one of the hospitals to the south. Nonetheless, once Dr. Geggie was at the bedside, he was apparently the one who decided how the birth would progress. Those who romanticize the 'naturalness' of home births should consider that first, women have not always maintained control over the birthing process just because it has been conducted at home, and second, even home birthing has at times been highly medicalized.

It is perhaps at the bedside in rural obstetrical medicine that the meeting of medical theory and practice is most clearly defined. Dr. Geggie received his training at a time when medical education was undergoing a period of intense reform. As new knowledge from the basic sciences began to contribute to medical efficacy, physician educators were increasingly eager to integrate science into the curriculum, and a wider societal acceptance of a scientific rationale also greatly facilitated these educational reforms. Doctors who graduated in the early part of this century were just beginning to reap the results of the prestige that scientific medicine could then command. But medical education for rural physicians was only the first step in their careers. Removed from the hospital, clinic and both the technical and collegial supports found there, these doctors had to build up their medical practices, with or without their country mentors. Attending women in labour often seemed the

best way to gain acceptance in a community, but at the same time, inexperienced physicians were usually exposed to the harsh judgment of women and their attendants, many of whom had more than a little practical knowledge about birthing. It was at these bedsides that doctors had to adapt quickly, to apply what they had learned in medical school to the realities of medicine often in remote farmhouses many miles away from the nearest consultant.

As the growing literature on clinical records attests, medical and health care historians are gradually becoming more aware of their value in opening up fields of inquiry in social and cultural medical history. While autobiographies and memoirs were useful in this study to give shape to early twentieth-century obstetrics, it was Dr. Geggie's case notes that allowed the details of an actual medical practice to emerge. For historians interested in the history of medical procedures, the records provide concrete evidence of older medical techniques and pharmaceutical preparations, many of which have faded from the physician's repertoire today. Following family names through the years might allow scholars to shed new light on fertility and disease patterns in a local area. The quantity of the case notes themselves and the number of interrupted days and nights that they represent confirm that the lifestyle led by a busy general practitioner was, at best, erratic and at worst, disruptive of any semblance of normal family life. Case notes such as these, then, present medical care from the perspective of one rank and file

physician, and help to provide fresh insight into the provision of medical care by "ordinary" medical practitioners.

These obstetrical accounts also begin to explore the connection between physician and patient. We catch occasional glimpses of the women as they materialize through Dr. Geggie's comments, and while the relationship between patient and doctor is muted, we are nevertheless provided with a sense of the interaction taking place. The stories of the women interviewed provided further definition to the bare outlines already drawn, and though few in number, were therefore integral to this study to offer a balance and depth to the picture of medical care. The difficulties in obtaining women to interview also suggest that it is becoming more urgent to record these stories. The case notes, combined with the information from the daybooks, allowed me to reconstruct women's obstetrical histories. While these findings cannot simply be generalized to women in other rural areas, they nevertheless provide a valuable perspective from which to investigate women's health during the early part of this century.

Records such as these are as yet more easily accessible for the nineteenth century than for the twentieth. While the breadth and depth of the materials preserved from Dr. Geggie's practice may be unusual, sparser accounts may yield more satisfying results as historians make more sophisticated use of them. Obstetrical records such as those that have been used in this study are an invaluable source of historical information about both

the history of medicine and women's history. From these documents we can learn about medical care at the level of its delivery, which can add to or modify our understanding of developments within the wider medical and social context. They allow a glimpse into a medical past that, from the perspective of the late twentieth century, has been both idealized and vilified.

As his sons joined him in practice, Harold Geggie spent more time lobbying "federal and provincial health authorities, municipal and county councils, service clubs, churches, politicians, and anybody who would listen" for a "district cottage hospital."[2] From 1945 onward, the Women's Institute was one of his most ardent supporters, providing financial support as well as the traditional skills of many members to furnish everything from bedding to preserves for the pantry.[3] One of the women interviewed remembered making embroidered bedspreads out of sugar bags. As she remarked, "we worked so hard because Dr. Geggie was so enthusiastic . . . and from the first day it was put there, it was a community effort . . . I mean everybody, French, English."[4]

Dr. Stuart Geggie believes that after its opening, almost all women went to the hospital for their births, although there may have been a few who had

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[2] H.J.G. Geggie, *The Extra Mile*, 130

[3] Norma Geggie, Wakefield and Its People: Tours of the Village (Quyon, Quebec: Chesley House Publications, 1990), 21. See also A.B. Robb, *History of Wakefield Village*, compiled for The Tweedsmuir Village Histories (Wakefield: Wakefield Women's Institute, 1959): 21-22

[4] Interview 15 April 1997, Mrs. S.

home deliveries for awhile longer[5]. The Geggie doctors most likely made it clear that they wanted their patients to deliver in the hospital, but the strong community effort to establish the local facility suggests that it was also welcomed by most women. Once the Gatineau Memorial was a part of the community, a way of life for both pregnant women and their physicians changed forever.

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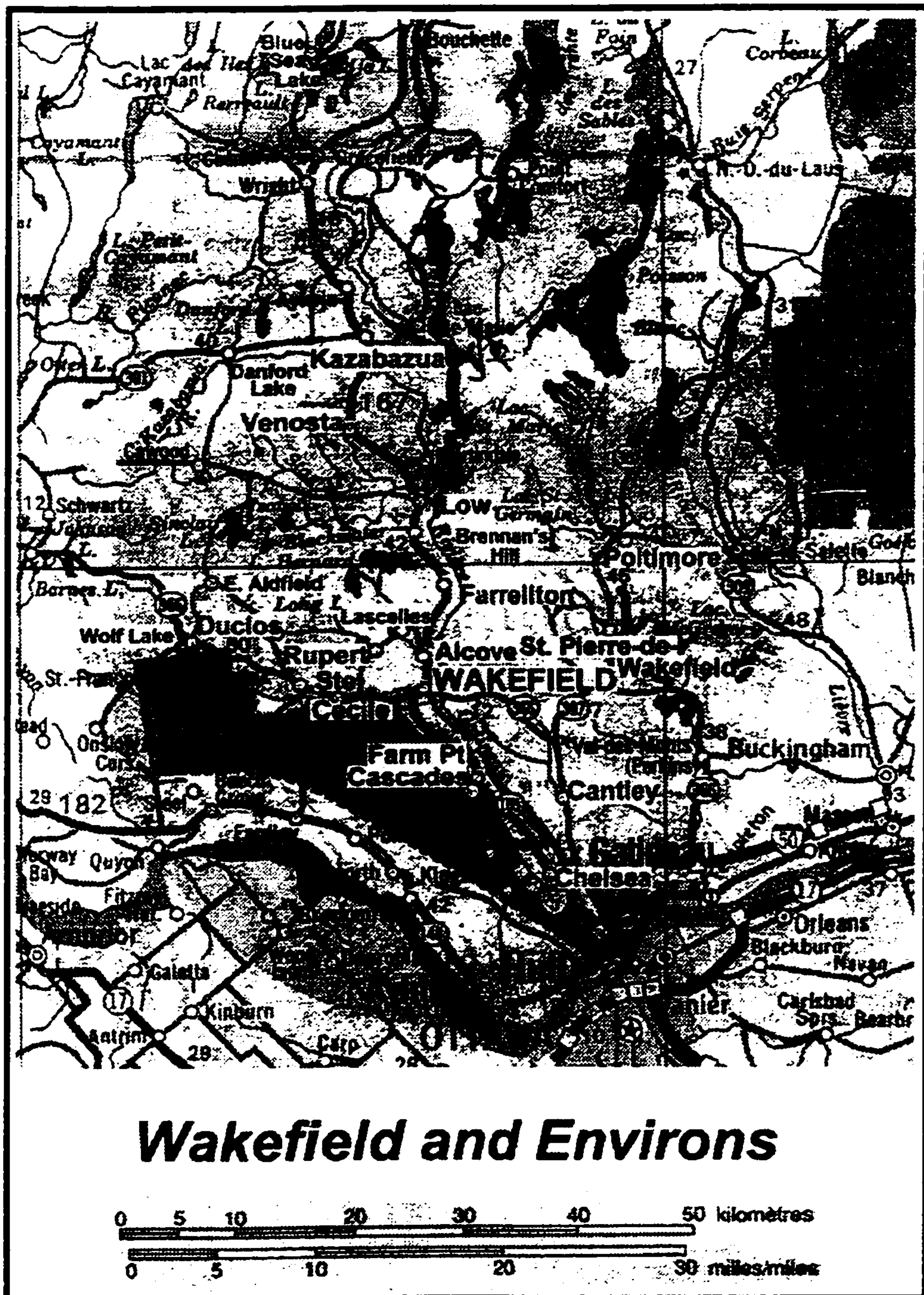
[5] One woman interviewed stated that she "would rather have them [meaning the Drs. Geggie at her home] than the hospital any day." Interview, 19 February 1997, Mrs. T.



Wakefield and Environs

Appendix 2

Table 1

Percentage of Canadian Births Occurring in Hospital

Year	%
1926	17.8
1931	26.8
1936	34.5
1941	48.9
1946	67.6
1951	79.1
1956	88.4
1961	96.9

Source: F.H. Leacy, ed., *Historical Statistics of Canada*, 2nd Edition (Ottawa: Canadian Government Publishing Centre, Stats Canada, 1983), B1-14

Graph 1

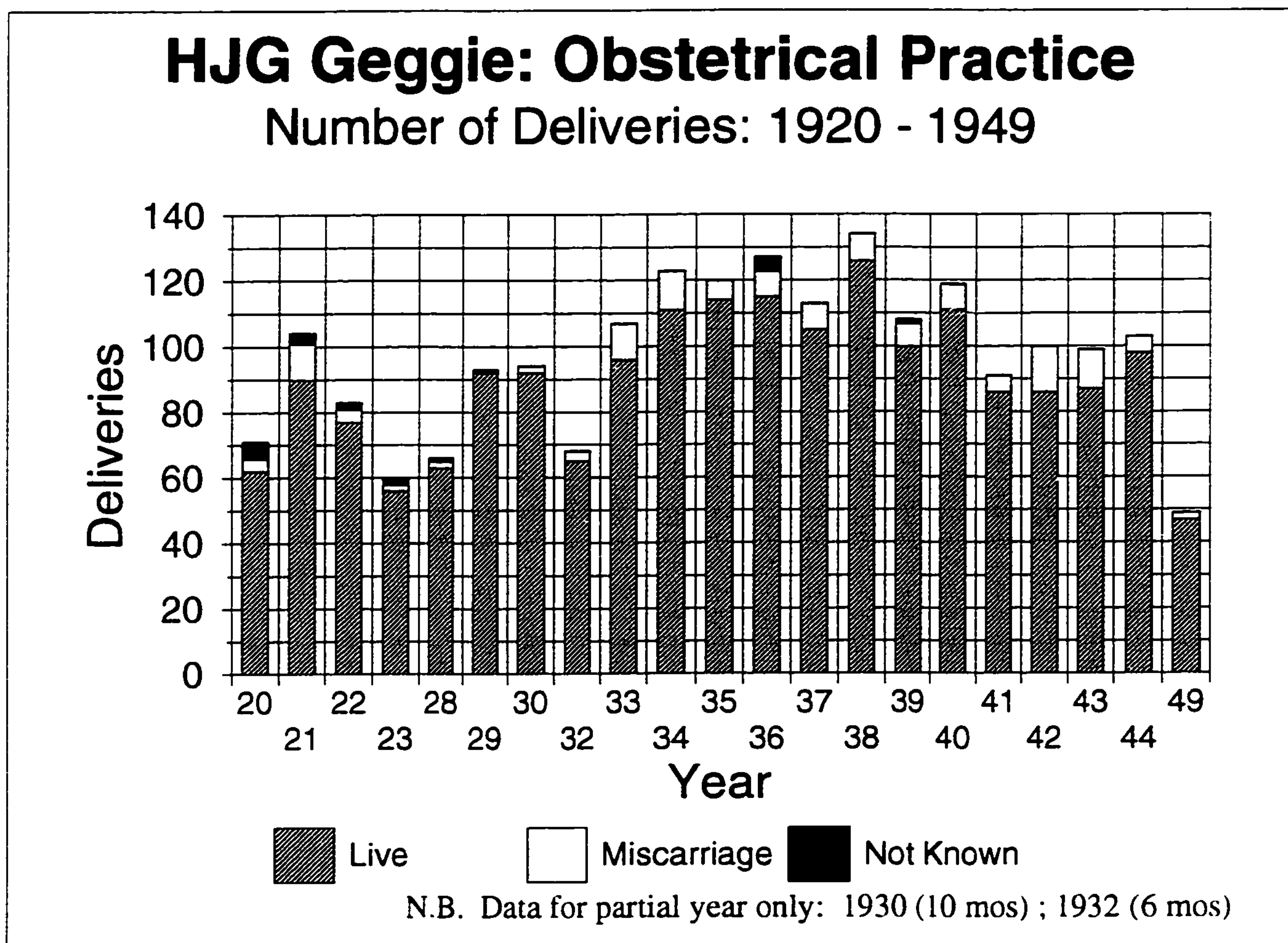


Table 2

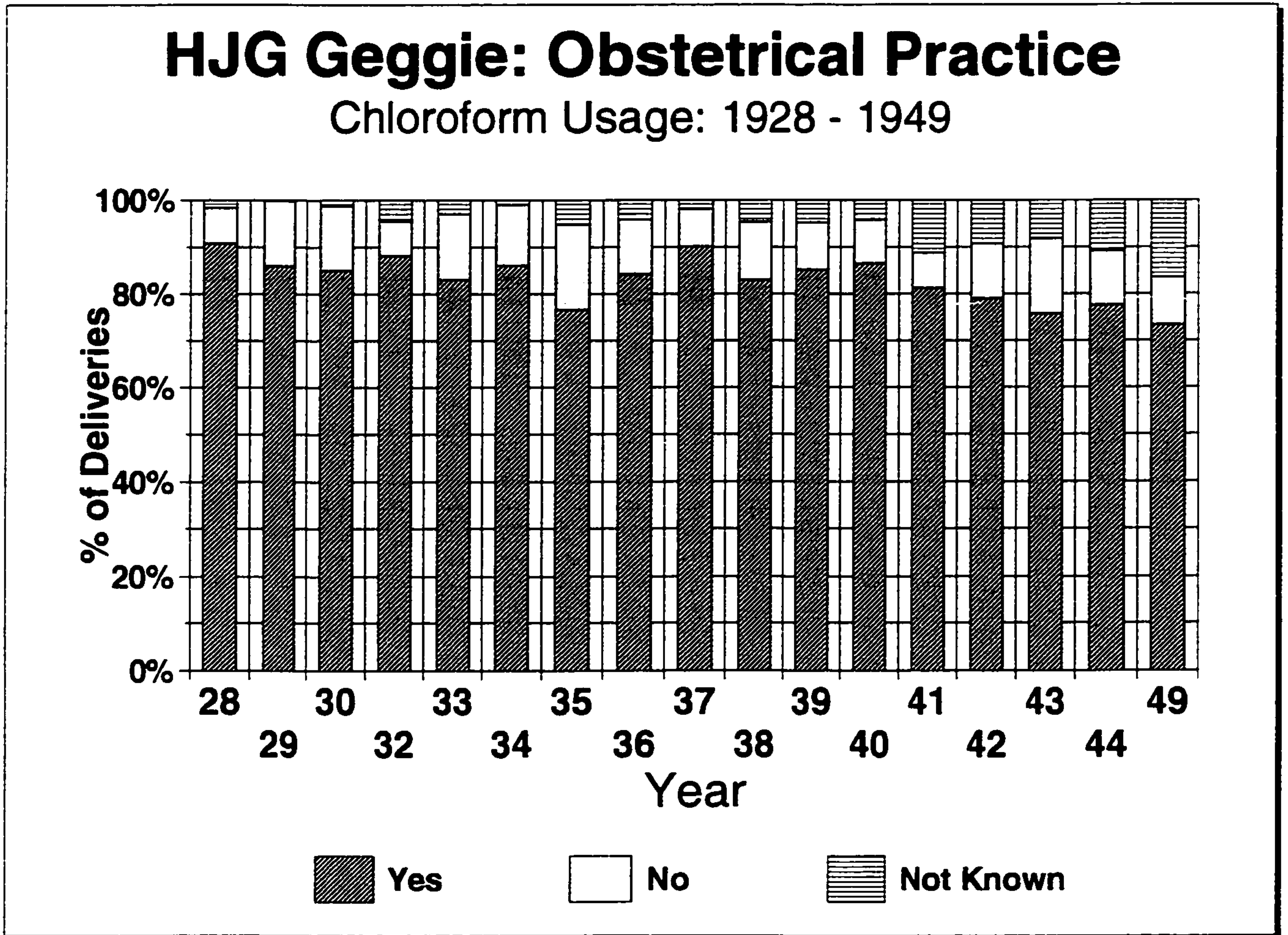
Stillbirths, Neonate Deaths and Maternal Mortality (Canada)

Rates Per 1000 Live Births

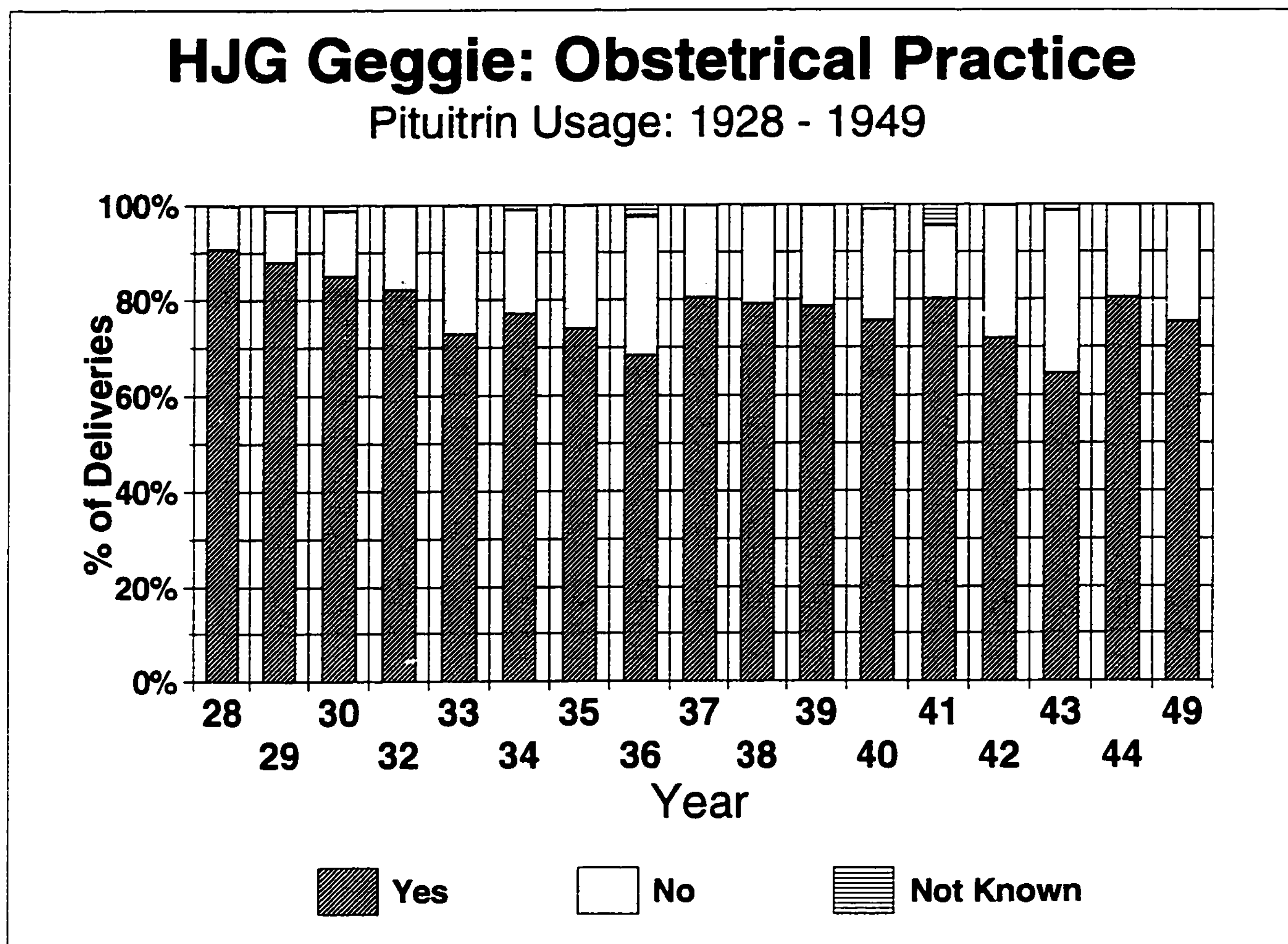
	Stillbirths	Neonate Death	Maternal Mortality
1926	30.2	48	5.6
1931	31.5	42	5.1
1936	28.6	34	5.6
1941	26.9	31	3.6
1946	21.4	27	1.8
1951	18.4	23	1.1
1956	15.5	20	0.6
1961	12.7	18	0.5

Source: F.H. Leacy, ed., *Historical Statistics of Canada*, 2nd Edition (Ottawa: Canadian Government Publishing Centre, Stats Canada, 1983), B51-58

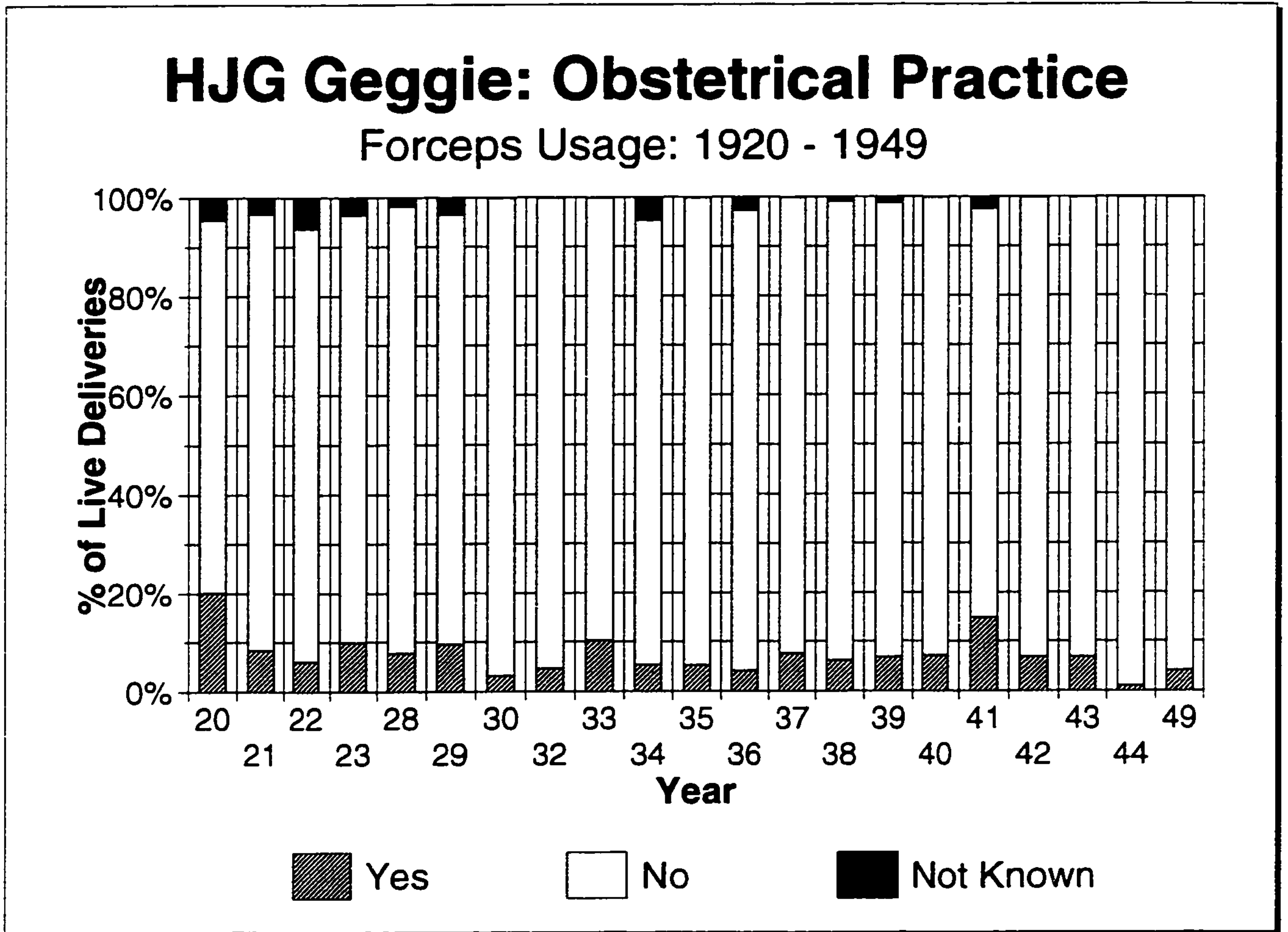
Graph 2



Graph 3



Graph 4



Appendix 3

Example Page From Bedside Obstetrical Notes

IV. Para. [illegible].
Oldest 10; youngest 5 yrs;
4.15 pm. No pains. Irregular
pains this am. Waters
burst? this am. P.R. Head
low [illegible] [illegible] [illegible]
then [illegible]. Memb. in-
tact. Enema. Quinine
Sulph. gr. X. Ol. [illegible] sodium
gr. VI.
4.57 Slight pains. Pit. 1 c.c.
5.12. Severe pains. Dilated
some. Liq. amnii escaping.
5.40 Single boy. Quite a
bit [illegible]. Cried lustily.
No tear. [illegible] 6¼ lbs.
5.47. Placenta expelled
c̄ out pressure. Haem.
5.50 Pit. 1 c.c.
6 pm. OK. Pulse [illegible]
elevated. Awake but
drowsy c̄ [illegible] sodium.
6.45. All OK.

Appendix 4

Graduate Student Proposal for Research with Human Subjects

Procedure:

To complement my M.A. thesis on the delivery of rural obstetrical care in the early twentieth century I plan, during the months of March and April 1997, to interview women in the Wakefield who had their children at home before the hospital opened there in 1952. Names of possible subjects have been solicited from the family of the doctor on whose papers I am working, as well as from members of the executive of the Historical Society of the Gatineau. In the majority of cases, these subjects will have been contacted first by the recruiters to ascertain their willingness to take part in this study. I then will follow up via the telephone to judge their suitability for my project, to confirm their willingness to be interviewed, and to set up a mutually convenient time for an interview. They will be asked if our conversations can be tape recorded, and will at the same time be told about the informed consent they will be asked to sign when our meeting takes place.

Most interviews will take place in the subjects' homes. Once the informed consent is signed, the top half will be left with the informants so that they will have the numbers available if they have any further questions. All subjects requesting anonymity will be assigned a code name, and all efforts will be made to alter particular incidents so that individuals will not recognize themselves or others should they read the final draft.

Jayne Elliott
M.A. Student
Department of History
March 1997.

To the Research Participants:

Thank you for agreeing to participate in this study of rural home births in the Wakefield area. In order to complete my M.A. degree at Carleton University, I am investigating obstetrical care available to women in rural areas during the first half of the 20th century. During our interview, you will be asked for information surrounding your experiences in delivering your children at home, which will include how you prepared for childbirth as well as the type of care you received during and after the actual birth of your children.

This release/consent form is a normal part of doing research, and it is necessary to obtain your permission to use the information discovered through the interview in the ways outlined below. This study has received clearance through the Department of History of Carleton University. You are not required to answer any questions you do not wish to, and all requests for anonymity will be respected. If you have any further questions about confidentiality or about anything else, please contact me or my advisors at the numbers below.

Researcher: Jayne Elliott 738-7414

Supervisor: Professor Deborah Gorham,
Director, Pauline Jewett Institute of Women's Studies 520-6645

Graduate Supervisor: Department of History: Professor Duncan McDowall
520-2834

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In providing information on the topic of home births in the Wakefield area during

the early twentieth century, I ____________________________ hereby grant permission to Jayne Elliott to use the transcript of our tape-recorded conversation in the following ways:

______________________ in her thesis

______________________ in published articles and manuscripts.

My name may/may NOT be used in the final draft.

______________	______________	______________
Interviewer Jayne Elliott	Research Subject	Date

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Primary Source Material

Harold James Gugy Geggie Records and Papers:

These include the obstetrical notes, daybooks, some account books, and miscellaneous papers which were lent to me by Dr. Stuart Geggie and his wife Norma, of Wakefield, Quebec.

Obstetrical notes:

These handwritten notes on which Dr. Geggie kept track of the deliveries and miscarriages he attended are divided by year. Some are unbound pages of a small looseleaf binder, others are written on plain paper.

1926 (incomplete)
1927 (incomplete notes) This year also includes in chart form an abbreviated version of presumably all deliveries for that year.
1929
1930 (10 months only - absent 19 July to 28 September)
1932 (6 months only beginning 1 June)
1933 - 1944
1949

Medical Daybooks:

These include a listing of all patients seen by date, usually with a brief description of signs and symptoms, treatment given and amount charged. They are bound in the following order:

23 November 1919 to 14 May 1921
15 May 1921 to 4 May 1922
5 May 1922 to 31 May 1923
1 June 1923 to 11 July 1923
1 April 1938 to 31 December 1940
1 January 1941 t 30 November 1942
1 December 1942 to 31 May 1945
18 April 1948 to 31 July 1949

Miscellaneous Papers of Harold Geggie:

"Anaesthetics and Analgesics in Childbirth." Article which may have been written for publication, circa 1930

"An Address to the McGill Undergraduate Society." Given February, 1950 by H.J.G. Geggie, M.D.

Letter to Stuart Geggie from Harold Geggie, 7 February 1949

J. Howard Walmsley Fonds

These are held by Queen's University Archives, AArch. 3621.14.
They consist of student lecture notes, including obstetrics, account books and patient records. One notebook from 1921 to 1926 contains patients listed by alphabetical order, and gives detailed descriptions of cases. The patient records have some brief accounts of treatment, but are mainly a listing of visits organized by patient's family name.

Student obstetrics notes, Box 2/3
Notebook, 1921-1926 PR S2, Box 3/3
Patient Records 1921-1926, Series 4; Box. 3/3 (used with permission)
No. 2, A-C
No. 3, D-G
No. 4, H-Mc
No. 5, M-R
No. 6, S-Z

Daybooks, Series 3

No. 10 1 January 1933 to 31 December 1936
No. 12 1 January 1940 to 31 December 1942
No. 13 1 January 1943 to 31 December 1945

Other Manuscript Sources:

Canada Census 1931, Vol. VIII, Table 34
Canada Census 1951, Vol. II, Table
McGill University Archives, Calendars 19108-1909,1910-1911, 1911-1912
McGill University Archives, *Old McGill*, Yearbook, 1911
National Archives of Canada, Conrad Geggie, Unpublished manuscript, MG 55, Box 31, Vol. 4
University of Toronto Archives, Certificate of William James Corrigan, B69- 0003, Box 001

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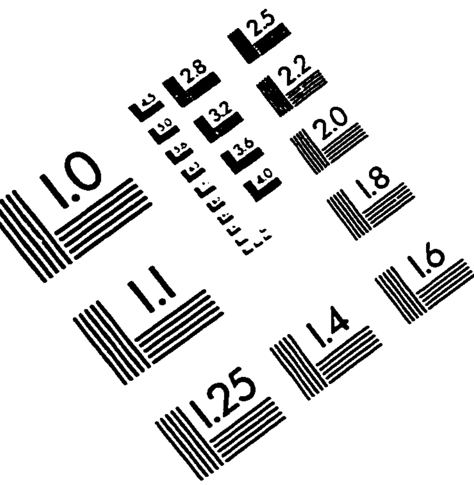
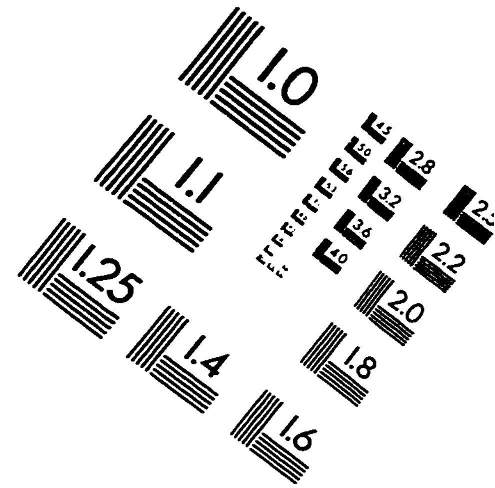
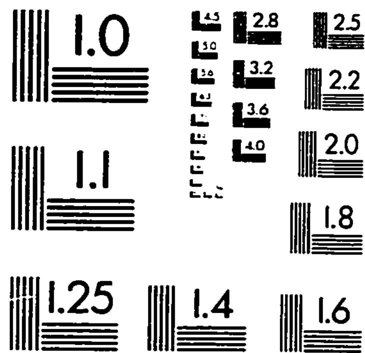
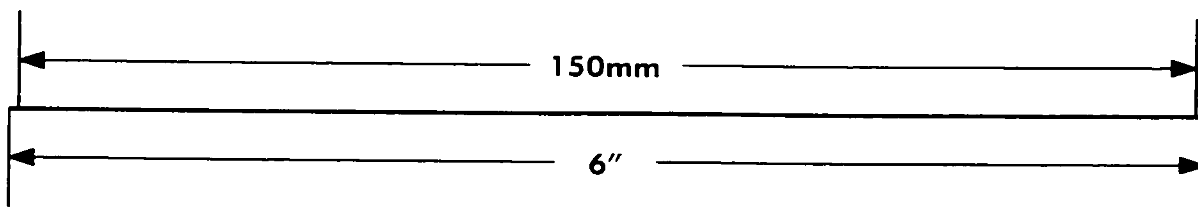

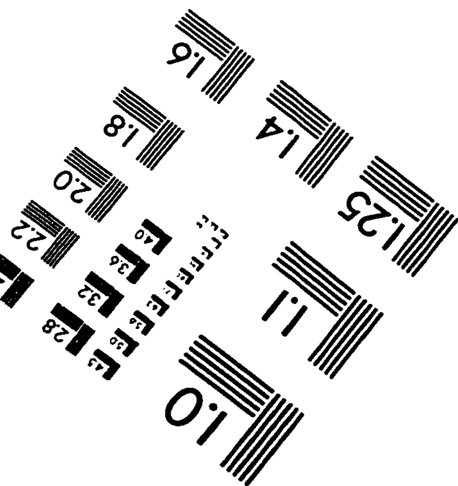

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