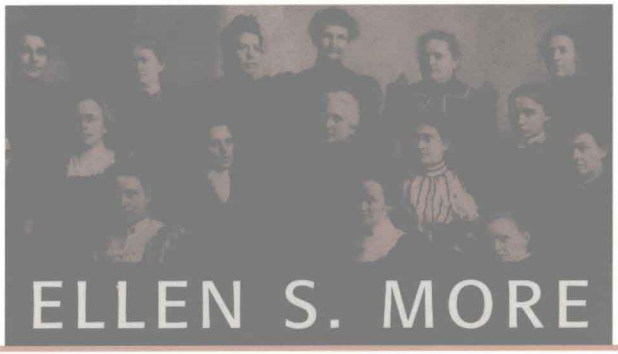

ELLEN S. MORE

RESTORING THE BALANCE

Women Physicians and the Profession of Medicine, 1850–1995

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WOMEN PHYSICIANS AND THE
PROFESSION OF MEDICINE, 1850–1995

ELLEN S. MORE

HARVARD UNIVERSITY PRESS
Cambridge, Massachusetts
London, England

Printed in the United States of America

Second printing, 2000

Library of Congress Cataloging-in-Publication Data

More, Ellen Singer, 1946–

Restoring the balance : women physicians and the profession of medicine, 1850–1995 / Ellen S. More.

p. cm.

Includes bibliographical references and index.

ISBN 0-674-76661-X (alk. paper)

ISBN 0-674-00567-8 (pbk.)

1. Women physicians—United States—History 19th century.
2. Women physicians—United States—History 20th century.
3. Women in medicine—United States—History 19th century.
4. Women in medicine—United States—History 20th century.
I. Title. [DNLM: 1. Physicians, Women—United States.
2. Feminism—history—United States.
3. History of Medicine, 20th Cent.—United States.
WZ 80.5.W5 M835r 1999]
R692.M645 1999
610.69'52'0820973—dc21 99-38185

This book is dedicated with love to my husband, Micha Hofri, and to my daughter, Betsy More. Without their love and support—and humor—I surely would have lost my own sense of balance. I dedicate it, too, to the memory of my parents, Ben and Dorothy Cooperman Singer.

Acknowledgments

This project was intended to be a small, highly focused study of the professionalization of women physicians in one region of the country, upstate New York, during the years between 1880 and 1920. It was inspired by my students' persistent questions about women in medicine during an experimental seminar on the history of the American medical profession, given at the University of Rochester in 1978. Dr. Edward Atwater's generous tip that the Edward G. Miner Library at the University of Rochester medical school held the extraordinary, forty-year correspondence of Dr. Sarah Dolley and her son sent me into the archives in Rochester and at the Medical College of Pennsylvania. (This was just the first of many acts of generosity by Ed and Ruth Atwater over the years, for which I am immensely grateful.) An unexpected telephone call from Dr. Leah Dickstein (whose New York accent made me nostalgic) to my office at the Institute for the Medical Humanities at University of Texas Medical Branch in Galveston resulted in an invitation from the American Medical Women's Association to research the history of AMWA. At that point, my "focused" study began to expand. Regina Morantz-Sanchez, whose works have illuminated so much of our understanding of nineteenth-century American women physicians, read my original book prospectus and presciently advised me to expand my perspective and, particularly, to incorporate the history of African American women into my narrative—excellent advice.

I am grateful to the National Endowment for the Humanities for two grants for Travel to Collections (Nos. RV-21087-85, FE-22611-88); to the Susan B. Anthony Center for the Study of Women in Society; to the National Institutes of Health National Library of Medicine for a two-year Publication Grant (No. 5 RO1 LMO4980-02); to AMWA for research support; to the Office of the Dean of Medicine, UTMB, for research support; and to the Institute for the Medical Humanities and its director, Ronald A. Carson, for that most important resource, dedicated research time.

Among the many librarians and archivists who provided crucial assistance, I wish to thank specifically Philip Maples of the Baker-Cederberg Archives of Rochester General Hospital; Christopher Hoolihan, Lucretia McClure, and Janet Brady Joy, currently or formerly of the Edward G. Miner Library at the University of Rochester School of Medicine and Dentistry; Karl Kabelac and Mary Huth, Rush Rhees Library Department of Rare Books and Special Collections, University of Rochester; Sandra Chaff, Margaret Jerrido, and Jill Gates Smith, formerly of the Archives and Special Collections on Women in Medicine of the Medical College of Pennsylvania (now MCP Hahnemann University); Adele Lerner, Dan Cherubin, and Stephen Novak of the New York Hospital–Cornell Medical Center Medical Archives; and the archival staff at the Schlesinger Library of Radcliffe College. The archivists at the University of Pennsylvania library, the Rochester Public Library, and the National Archives Research Center all provided excellent help. Closer to home, the reference librarians at the Moody Medical Library of UTMB regularly resolved bibliographical mysteries and tracked down wayward sources. Linda Zuber of the University of Rochester Alumni Office provided data on medical graduates' employment patterns. I enjoyed the research assistance of University of Rochester and UTMB students Laura Graham, Corinne Sutter (Brown), and Victoria Neidell, as well as research and graphics support from Dr. Kayhan Parsi and Dr. Sara Clausen, respectively. To all of them, I am most grateful.

I want to thank, especially, the many individuals, cited throughout the book, who agreed to be interviewed or to provide uncataloged research materials for this project. They include Mrs. Georgia Gosnell and Dr. Marion Craig Potter (granddaughters of Dr. Marion Craig Potter), Janet Bickel, Phyllis Kopriva, Francesca Calderone-Steichen (daughter of Dr. Mary S. Calderone), Eileen McGrath, and Drs. Sally

Abston, Mary Ellen Avery, Judith M. Cadore, the late Mary Steichen Calderone, Leah Dickstein, Suzanne Hall, Ruth Lawrence, Eugenia Marcus, Carol Nadelson, Bertha Offenbach, and the late Mary Saxe.

The following journals allowed me to make use of materials previously published: *The Bulletin of the History of Medicine*, *American Quarterly*, *Journal of the American Medical Women's Association*, and *Rochester History*. I am grateful to them for this courtesy. Archival materials, including photographs, have been used with permission from the following sources: Edward G. Miner Library of the University of Rochester School of Medicine and Dentistry; Baker-Cederberg Archives of Rochester General Hospital; the Rochester Public Library; the Department of Rare Books and Special Collections, Rush Rhees Library, University of Rochester; the Schlesinger Library, Radcliffe College; New York Hospital–Cornell Medical Archives; the Archives and Special Collections on Women in Medicine of MCP Hahnemann University; and the National Archives Research Center.

The following family, friends, and colleagues read and provided useful criticism of all or part of the manuscript: Micha Hofri, Tom Cole, Chester Burns, Ron Carson, Steve Peitzman, Kenneth Ludmerer, Regina Morantz-Sanchez, Gert Brieger, and Warren Carrier. (Unfortunately they refuse to accept any responsibility for mistakes.) Many of my graduate students, including Laura Kickleiter, Toni Schossler, Heather Campbell, David Stevenson, and Craig Klugman, also read the manuscript and gave insightful critiques.

The editorial staff at Harvard University Press has been a pleasure to work with. I have particularly benefited from the professionalism of Editor-in-Chief Aida Donald, my acquiring editor, and Ann Downer-Hazell, editor/diplomat extraordinaire. Copyediting by Julie Ericksen Hagen has greatly strengthened the manuscript although (again) whatever mistakes remain must be credited to the author.

At the Institute for the Medical Humanities, crucial secretarial assistance was provided efficiently and sympathetically by Donna Vickers, as was expert editorial guidance, by Sandy Sheehy. I extend my deep appreciation to my colleagues at the IMH, who have always provided the rich, multidisciplinary environment needed to sustain intellectual risk. But my deepest, most profound gratitude is reserved for my husband and daughter, who have contributed to this book in ways that cannot be cataloged.

Contents

Introduction: Restoring the Balance?

> In all departures of health of body, mind, or spirit, I believe there is a loss of balance. [Though] we may have other terms, harmony, equilibrium, etc., the point and principle of getting righted . . . must be to restore that balance.
>
> *Sarah Adamson Dolley, M.D., 1896*

> If we women can be more honest in dealing with conflicts between family and career, we can lead our male colleagues to also be more open and flexible in balancing personal and professional lives.
>
> Anonymous quotation in Association of American Medical Colleges Project Committee Report, *Increasing Women's Leadership in Academic Medicine*, 1996

FROM DRS. BERNADINE HEALY, Frances Conley, Antonia Novello, Joycelyn Elders, Ruth Kirschstein, Vivian Pinn, Susan Love, Joyce Wallace, and Nancy Dickey to *Dr. Quinn, Medicine Woman*, American women physicians were a notable public presence during the 1990s.[1] As government officials, researchers, clinicians, and reformers, women physicians appeared prominently in media coverage of the medical profession. This is a far cry from the mixture of public condescension and admiration accorded the nineteenth-century pioneer Dr. Elizabeth Blackwell, or the anger and resentment directed at so many of her successors until well into the 1970s.

Not all cultural indicators of women's progress in medicine are so encouraging, however. For women struggling to succeed in the medical professions, indeed in all fields, books and articles about sexual harassment, the "mommy track," and the "second shift," as well as the persistence of sex stereotyping, glass ceilings, unequal pay, and unreliable day care, indicate that much work remains to be done. Women in medicine

today, like their predecessors, still must work hard at balancing the many demands of their composite role: woman/physician.

It took me a long time to recognize that the theme of "balance" winds through the entire history of women in medicine. Most cultures find it difficult to reconcile equality and difference, and ours is no exception—especially in the domain of gender. For more than a century and a half, American women physicians have grappled with the dilemma of how to be a woman and a physician, how to be different from yet *equal to* their male colleagues. Legal scholar Martha Minow framed the problem as the "dilemma of difference."[2] The many achievements of women doctors have been accomplished in the face of this long-standing problem. The ideal of balance has been a virtue and a conscious goal throughout their history in the American medical profession, the hoped-for solution to the dilemma of difference. Indeed the metaphor of balance that binds together my account of their history not only has maintained currency during the past century and a half but also has taken on additional layers of meaning, resonating powerfully with the realities of life for women in medicine today—as for women in the workforce in general.

Like my fellow historians, I am acutely aware of both the ethical and the epistemological importance of the ideal of objectivity in the construction of narrative. Yet scholars from Wilhelm Dilthey to Paul Ricoeur, Evelyn Fox Keller, and Joan Scott remind us of the limited reach of our truth-seeking ambitions. Historians frame questions according to their own lights, guided (self-consciously, one hopes) by the social, psychological, and historiographical moment in which they find themselves. As I began the process of shaping this narrative, I could not help but acknowledge that, as a woman, a professional, a wife, and a mother, I was writing about women whose values and concerns were in many cases much like my own. When Amelia, the pediatrician-protagonist of Dr. Perri Klass's novel *Other Women's Children*, finds herself unbearably stretched between responsibilities to her family and her profession, she agonizes: "This is a moment when things are badly out of balance for me. How can I go back and forth, how can I hold these two realities in my mind at the same time?"[3] I recognize this dilemma. When I first encountered similar accounts in the historical record, I felt as if I'd uncovered an ancient, partially encrusted mirror. Rather than obscuring the underlying significance of such accounts, or distorting my historical

perspective, my own experience has deepened my awareness of the meaning of my sources.

Women physicians, of course, like women in general, are no less diverse than their male colleagues. Many, for example, have forgone childbearing; some live alone, while others live with a same-sex partner. Still, in the face of what philosopher Iris Marion Young termed humanity's "inexhaustible heterogeneity," generalization can be a tool of understanding as well as prejudice.[4] Thus the metaphor of balance—balancing work and home, family and career—although it appears in many guises, nevertheless recurs throughout the history of women physicians. With the title of this book, *Restoring the Balance*, I highlight three facets of the balance metaphor: first, the process by which American women physicians fought for professional equality in medicine; second, their steadfast resistance to a one-dimensional conception of professionalism by pursuing a judicious balance of personal, community, and professional interests; and third, the attentiveness of many women physicians to interactions among the psychological, social, and physiological dimensions of their patients' lives.

Although it is well known that women have practiced as healers and midwives since the days of ancient Greece, it is less commonly recognized that they have also practiced as full-fledged physicians since ancient times. Women may have practiced medicine and surgery—not midwifery alone—at least from the fifth century B.C.E., a tradition extending through the fifteenth century, when Costanza Calenda of Naples became the first woman known to have received a doctorate in medicine. In England, some women practiced as surgeons, licensed and unlicensed, well into the seventeenth century.[5] As historians are discovering, however, female participation in the profession was increasingly suppressed between the Renaissance and the nineteenth century when, first in the United States and soon afterward in Europe, women were finally readmitted to medicine's formal educational and professional institutions.[6]

This book takes up their history with a close reading of the life of one pioneering nineteenth-century medical graduate, Dr. Sarah Adamson Dolley, and then examines the various strategies employed by succeeding generations to balance professional equality and feminine difference. With the exception of a few glittering tokens, female physicians were consigned to the margins of the profession until quite recently.

Only since 1970, in the wake of complex social, political, and legal changes, have significant numbers of women doctors been able—and willing—to move toward the center of professional authority in the United States. If access to the profession was the major obstacle confronting the pioneer generations—something that previous historians have written about extensively and well—the challenge for their successors has been to solidify their standing, and to flourish on their own terms.[7]

Even during the centuries when women were absent from the roster of medical doctorates, however, they made signal contributions to the practice of medicine. From the earliest years of the American colonies, women such as New Englanders Martha Ballard and Joanna Cotton served their communities as skilled midwives and healers. During the early nineteenth century, when the role of physician began to supplant that of midwife, a few women, such as Harriot Hunt of Boston, completed apprenticeships and enjoyed successful careers as physicians. Yet it was not until 1849 that Elizabeth Blackwell became the first woman in America to graduate from a college of medicine. In the second half of the nineteenth century women won gradual acceptance from male colleagues and the general public, primarily as physicians to women and children. By 1920 women represented approximately 5 percent of American doctors.[8]

Prior to the American Revolution, African Americans—medicine's *other* minority—also participated in the healing arts, primarily as informally trained slave practitioners, herbalists, and midwives but also, in rare cases, as apprenticeship-trained physicians (like most white physicians). By the nineteenth century, according to historian Herbert Morais, "Negro women engaged in the general practice of medicine were frequently listed in plantation inventories as 'Doctor.'"[9] Plantation practitioners used the same techniques of bleeding, blistering, purging, and emesis as their freeborn colleagues. Morais also found that a "handful of free Negroes" practiced in the northern states before the Civil War. Some were largely self-taught; some had trained as apprentices. A few, like Dr. David J. Peck, who graduated from Rush Medical College of Chicago in 1847, were graduates of a college of medicine.[10] By 1860 at least nine northern medical colleges had begun to admit African American men. The first African American woman received a degree from a college of medicine in 1864. That year, Dr. Rebecca Lee gradu-

ated from the New England Female Medical College; three years later Rebecca J. Cole graduated from Woman's Medical College of Pennsylvania. (By the end of the nineteenth century, a total of 12 black women had graduated from Woman's Medical College.) In 1890, according to historian Darlene Clark Hine, 909 black physicians were in practice, including 115 women.[11]

White and black, most female physicians mainly treated women and children. But by World War I, women's medical schools, medical societies, hospitals, dispensaries, houses of refuge, and settlement houses—the institutional settings of the nineteenth-century "woman's sphere" in medicine—began to decline. The growth in numbers of women enrolling in medical school and the increasing proportion of female physicians nationwide also lost momentum in the early years of this century. African American women may have been affected even more than white women; compared with the 3,885 black male physicians listed by the U.S. Census for 1920, only 65 black women were listed as practicing medicine (just 1.6 percent of all women physicians). More than two-thirds of them are estimated to have graduated from Howard University and Meharry Medical College; 9 others were graduates of Woman's Medical College of Pennsylvania.[12]

The proportion of all physicians who were women did not exceed the modest level of 7 percent until 1970. Since then the number has continued to rise. Women comprised 11.6 percent of the profession in 1980, 16.9 percent by 1990. This represents an increase of 92 percent, although the overall rate of increase in numbers of physicians during the same decade was 32 percent. By 1995 women physicians numbered more than 149,000: 20.7 percent of doctors were women. By the year 2010 they are expected to represent nearly 30 percent.[13]

Statistics reveal less progress, however, in achieving racial and ethnic diversity. African Americans accounted for 5 percent of medical graduates in 1975; by 1995, they accounted for just 6.6 percent. As for social class, women physicians of all races and ethnic categories, like men, are still predominantly middle to upper-middle class in origin. From the beginnings of women's formal medical training in the late 1840s, most white women medical graduates were from the middle class; often they had spent some years as a teacher to earn the money for their medical education. The first generation of African American women physicians, too, were the daughters of prominent black families or had acquired

middle-class standing on their own as teachers or civil servants in post-bellum Washington, D.C., prior to matriculating in medical school. Not all, however: for example, Dr. Virginia Alexander (1899–1949), a leading African American physician in Philadelphia, was able to attend the University of Pennsylvania and Woman's Medical College through the help of scholarships and by working twenty hours a week.[14] As one recent study commented, "Considering the economic ramifications of medical school attendance, it is not surprising that the major changes have not been in social class but in gender; it appears that the daughters of the middle and upper middle classes are joining their brothers in medical school in greater numbers."[15]

The careers women doctors are constructing, however, do differ in important ways from those of their male colleagues. The differences result both from personal agency (choice) and sociocultural imperatives (necessity). For example, recent research on the career patterns of contemporary women physicians suggests that the majority willingly combine the multiple responsibilities of work, family, and community involvement.[16] Women's specialty choices continue to cluster in fields that largely are defined as primary care medicine, a trend that dates from the nineteenth century. As of 1991, more than one-third of women residents had trained in internal medicine or pediatrics. About one-fourth of the remainder specialized in obstetrics-gynecology, family practice, or psychiatry. These choices result from their own interests and because, in settings such as health maintenance organizations (HMOs), physicians in these fields have the opportunity to structure reasonably regular work hours during their years of child rearing—something many women doctors consider important. In addition, certain specialties, such as orthopedics and neurosurgery, have only recently begun admitting more than token numbers of women into residencies. The question of specialty choice is a complex one, however. Within fields like internal medicine and pediatrics, many more women are entering and practicing subspecialties such as oncology and hematology. In their professional style and setting, these practice areas afford doctors the opportunity to combine aspects of primary care and subspecialty practice.[17]

To understand the evolving situation of women in the medical profession, I have found an explanatory model developed by sociologist Rosabeth Moss Kanter particularly useful. Kanter describes the effect

of what she terms "skewed" sex ratios on the internal dynamics of occupational groups. She argues that the status and prestige of a minority subgroup, in this case women, will vary according to its level of representation in the group. In groups with a *skewed* sex ratio, defined as female representation of at most 15 percent, the majority overwhelms the minority. Under such circumstances members of the minority, often seen as "tokens," will have virtually no opportunity to shape the group's culture. In groups with a *tilted* ratio, Kanter hypothesizes, where women constitute no more than about one-third of the membership, they have more opportunity to form alliances and affect decision making. (A group that is *balanced* would be composed of approximately equal numbers of the subgroups.)[18]

Although Kanter was primarily interested in the movement of women into corporate leadership, her hypothesis also helps describe the evolving status and prestige of women in the American medical profession. At the outset of the nineteenth century the profession's sex ratio was entirely *uniform*—in other words, all male. From the 1850s to 1985, fewer than 15 percent of American doctors were female (a skewed sex ratio), and those women generally occupied the margins of professional power. Since 1985, as women have become a more visible presence in the profession, their number has risen to more than 20 percent, a sex ratio that Kanter's model would characterize as tilted. The profession will reach balance, according to this model, when the proportion of women approaches 40 percent—something not projected to occur for decades.

What Kanter's model describes, historians must attempt to explain: Why is it taking so long for women physicians to reach the higher levels in their profession, both in numbers and in power? Having finally moved beyond tokenism since the 1970s, will women capitalize on their increasing numbers by moving into leadership roles that reshape the profession to reflect their perspective? Here the work of historians and sociologists of science, such as Gerald Holton and Gerhard Sonnert, offers insight by pinpointing two possible explanatory models. One, which they label the "deficit model," presumes that women have been the targets of external, structural, formal and informal mechanisms of discrimination that kept their numbers down. I refer to this dynamic as "necessity." A second explanatory model claims that differences in women's preferences and values persuade many to choose

scientific or medical career paths with fewer opportunities for major success. This they label the "difference" model, what I refer to as "choice."

Detailed historical investigations of the careers of women in American science and medicine by Margaret Rossiter, Regina Morantz-Sanchez, and others do not fully support either model by itself. As this book will argue, both necessity and choice, social deficits and individual preferences, have shaped the majority of women physicians' career opportunities and selections. Probably the answer lies closer to what Sonnert and Holton, following sociologists Jonathan R. Cole and Burton Singer, call the "kick-reaction" model, or what I, following Harriet Zuckerman, term the model of "cumulative advantage or disadvantage," according to which individual careers are shaped both by external social forces (especially early on) and by the individual's response to those factors.[19]

So, what cultural forces, professional traditions, and individual values have informed the experiences of women in American medicine? I interpret their history as a careful attempt to fulfill expectations that originally were characteristic of mainstream professional culture in nineteenth-century medicine. As historian Judith Leavitt has observed, the majority of nineteenth-century American practitioners combined general medical practices with the routine details of domestic, agricultural, and small-town life. Unavoidably, "they wove together their domestic experiences with their perceptions of their own medical practices . . . [T]hey saw the parts as an integrated whole."[20] Not the least of women physicians' achievements was their ability to sustain into the twentieth century this traditional professional culture, firmly situated in the context of community life, by exploiting its many points of congruence with feminine gender norms.

Although all physicians, male and female, are charged to be both empathic and expert, the historically dichotomous identity imputed to women physicians in Western culture—to be womanly as well as scientific—has complicated this challenge, while situating it at the center of their professional life. Furthermore, the duality of their own experience, particularly the intersection of professional and feminine cultures, has fostered a continued appreciation for the complicated interplay between a patient's mode of life and state of health. Throughout their history, women physicians have attempted to integrate professionalism with civic and personal life, to sustain an older model of "civic profes-