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Wendy Mitchinson

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WENDY MITCHINSON

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SEEKING TO UNDERSTAND WHAT COULD BE the essence of an era, historians attempt to find patterns or consistencies in the lives and actions of peoples in the past.¹ The recent focus on diversity and the recognition of the dangers involved in essentializing large numbers and groups of people has meant that the search for patterns has come under scrutiny and questions have been raised about the distortions resulting from such a search.² The result has been a concentration on specific groups that share some commonality, be it race, religion, gender, occupation or other features. But no matter how small the groups, whether marginal or not, there is always a danger that diversity within them will be ignored. In my own work, I have focused on how the medical profession treated women patients. The generalizations called for with respect to practitioners means that the nuancing of differences among them is sometimes lost. The writings of one 20th-century physician, Harold Bengé Atlee, illustrate how at some times individual practitioners could differ from the general

1 I would like to acknowledge the financial assistance of the Social Sciences and Humanities Research Council of Canada, Associated Medical Services through the Hannah Institute for the History of Medicine and the Rockefeller Foundation. I would also like to thank Janice Dickin, who read an early version of this paper and the anonymous readers for their helpful comments.

2 Perhaps the area most sensitive to the dangers of essentialism has been the postmodern sensibility within women's history. See Lesley Doyal, *What Makes Women Sick: Gender and the Political Economy of Health* (New Brunswick, New Jersey, 1995), p. 4. For a critique of this approach see Susan Bordo, "Feminism, Postmodernism, and Gender-Scepticism", in Linda J. Nicholson, ed., *Feminism/Postmodernism* (New York and London, 1990), pp. 133-56 and Elizabeth Fox-Genovese, *Feminism Without Illusions: A Critique of Individualism* (Chapel Hill and London, 1991). A thoughtful examination of such issues is Franca Iacovetta's "Post-Modern Ethnography, Historical Materialism, and Decentering the (Male) Authorial Voice: A Feminist Conversation", *Histoire sociale/Social History*, 32, 64 (November 1999), pp. 275-94. An awareness of diversity and the problems of generalizing is not new. See Daniel Clark, *Mental Diseases: A Synopsis of Twelve Lectures Delivered at the Hospital for the Insane, Toronto, to the Graduating Medical Classes* (Toronto, n.d.). In Canadian history, the most trenchant critic of the reluctance to generalize has been J.L. Granatstein in his *Who Killed Canadian History?* (Toronto, 1998), especially Chapter 3, "Professing Trivia: The Academic Historians", pp. 51-78. Critiques of Granatstein which attempt to put his concerns in context and to incorporate a new way of acknowledging diversity within a broader overview are numerous. Of special note are the flurry of articles in the *Canadian Historical Review*: A.B. McKillop, "Who Killed Canadian History? A View from the Trenches", *CHR*, 80, 2 (June 1999), pp. 269-300; Bryan D. Palmer, "Of Silences and Trenches: A Dissident View of Granatstein's Meaning", *CHR*, 80, 4 (December 1999), pp. 676-86; Ken Osborne, "'Our History Syllabus Has Us Gasping': History in Canadian Schools — Past, Present, and Future", *CHR* 81, 3 (September 2000), pp. 436-51; and Ian McKay, "The Liberal Order Framework: A Prospectus for a Reconnaissance of Canadian History", *CHR*, 81, 4 (December 2000), pp. 617-45.

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thrust of medical practice and at others be part of it. The argument is not that Atlee was unique among physicians but rather that in his complexities and contradictions he embodied the dynamic inherent in medical practice.³

Harold Bengé Atlee was Chief of Obstetrics and Gynaecology at Dalhousie Medical School from 1922 until 1958. Born on 24 November 1890 in Pictou County, Nova Scotia, Atlee was the eldest child and only son of Alfred Atlee and Sarah Gunn. Following a childhood mostly spent in Annapolis Royal, he entered Halifax Medical College when he was 16, graduating at 21, the youngest person to do so. He practised general medicine for a very brief time, before travelling to London, England for post-graduate study. When war broke out he joined the Royal Army Medical Corps and afterwards returned to Britain to take specialist training in obstetrics and gynaecology at the Queen Charlotte Hospital in London. In 1920 he became a Fellow of the Royal College of Surgeons in Edinburgh, at which point he returned to Halifax, where he was appointed Professor and Chairman of the first combined Department of Obstetrics and Gynaecology at Dalhousie University and Chief of Service at Victoria General Hospital. As part of his appointment, he completed a year of further study in London during which he married his long-time love Margaret Ross. He then returned to take up his various positions, including that of University Clinician at Grace Maternity Hospital. Although well educated, Atlee did not have extensive practical experience in the field of obstetrics and gynaecology when he began his medical work in Halifax, but his positions gave him both tremendous influence over students and platforms from which to speak and write, neither of which he was averse to doing. Between 1922 and 1925 he also found the time to write a column in the *Halifax Chronicle* on a wide variety of non-medical issues and until the 1940s he also wrote and published fictional stories, many starring his detective hero, Kent Power. In 1958 he retired but continued to write articles on medical issues until close to his death in 1978.⁴

Atlee is worthy of a full biography, and one has been written.⁵ While somewhat critical, Harry Oxorn's *H.B. Atlee M.D.: A Biography* does not focus on Atlee's ideas and practice or on their significance within the context of medicine. Oxorn acknowledges the inconsistencies of Atlee's thought but tends to view these as flaws.⁶ The contradictions in Atlee's thought, however, tell us not only about him as a person

3 Historians have long privileged the singular voice through biography, although in many cases the voice which was privileged was that of the author and not the subject. In medical history, biography, especially in its hagiographical guise, has long been popular. See the section under biographical listing in Charles G. Roland, *Secondary Sources in the History of Canadian Medicine: A Bibliography* (Toronto, 1984). For a recent discussion on medical biography, see "Constructing History as Biography: A Symposium on *William Osler: A Life in Medicine*", *Bulletin of the History of Medicine*, 74, 4 (Winter 2001), pp. 740-70. In recent years, the postmodern assertion that we can never know the past and that it is always mediated through the present has led some scholars to allow the voices from the past to speak in as unmediated a way as possible. An excellent example of this is Julie Cruikshank, *Life Lived Like a Story: Life Stories of Three Yukon Native Elders* (Vancouver, 1990).

4 For a broader look at Atlee's work, see Harry Oxorn, *H.B. Atlee M.D.: A Biography* (Hantsport, Nova Scotia, 1983). See also Colin D. Howell, *A Century of Care: A History of the Victoria General Hospital in Halifax 1887-1987* (Halifax, 1988), p. 59.

5 See Oxorn, *H.B. Atlee M.D.* .

6 Postmodernism has called into question (or rejects) the expectation of consistency and linear development. But long before postmodernism, biographers had acknowledged the "messiness" of lives. Nevertheless, one of the attractions of biography and history has been the perception that it

and practitioner but also about the profession of which he was a part and the society in which he lived and practised.⁷ Unlike the marginalized in society who are so important to social historians, Atlee had power. His life as a physician crossed the boundaries of the public/private divide. He engaged on a daily basis with the private ills of others and then integrated them into lecture material and/or wrote about them in medical journals. He used his practice, his teaching, and his writing as a stage which he dominated. But the apparent surety of his professional life hid tensions and contradictions within both his actions and writings. Atlee was at times very critical of the profession of which he was a member, especially of the way surgeons were all too anxious to operate. Yet Atlee himself can be accused of setting down indices for surgery that resulted in unnecessary operations. On one level, he appears a man ahead of his time, sensitive to the social inequities which women faced. At the same time, while he believed that society and social mores limited women's lives, he believed women's bodies did so as well and that this could not help but make them limited as people. He attempted to convince his colleagues of the importance of the psychological in health even though he built his reputation on his surgical technique, the swagger with which he operated and his willingness to do so.

But the contradictions and tensions in Atlee's thinking should not be surprising. Medicine, a profession that aligned itself with the certainties of science, as practised by the individual practitioner was full of uncertainties.⁸ Both were reflections of

makes coherence out of chaos. Both present the reader with themes that seem to suggest the possibility of rationality. See Mary Evans, *Missing Persons: The Impossibility of auto/biography* (London and New York, 1999), p. 1.

- 7 Studies of biography offer many reasons to focus on the particular rather than the general. Maurice Mandelbaum in *The Anatomy of Historical Knowledge* (Baltimore and London, 1977) states that "in order for an individual to be of concern to a historian his character and actions must be viewed in relation to the place that he occupied and the role he played in the life of a society or in relation to some facet of culture": cited in William H. Epstein, *Recognizing Biography* (Philadelphia, 1987), p. 173, note 1. As Barbara W. Tuchman has argued, looking at the individual (in the form of biography) allows the writer and the reader to "encompass" the universal. Barbara W. Tuchman, "Biography as a Prism of History", in Stephen B. Oates, ed., *Biography as High Adventure: Life-Writers Speak on Their Art* (Amherst, 1986), p. 94. Susan Mann also has privileged the individual study since it can act as a "laboratory for testing certain generalizations about a given society, a given social movement, the process of social change": cited in R.B. Fleming, "Introduction", *Boswell's Children: The Art of the Biographer* (Toronto and Oxford, 1992), p. xvii.
- 8 In recent years there has been a flurry of feminist writings examining the unscientific nature of science. See in particular: Ludmilla Jordanova, *Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries* (Madison, 1989); Ludmilla Jordanova, *Nature Displayed: Gender, Science and Medicine 1760-1820* (London, 1999); Ruth Hubbard, Mary Sue Henifen and Barbara Fried, eds., *Biological Woman, the Convenient Myth: A Collection of Feminist Essays and a Comprehensive Bibliography* (Cambridge, Mass., 1982); Ruth Hubbard, *The Politics of Women's Biology* (New Brunswick, N.J., 1990); Cynthia Eagle Russett, *Sexual Science: The Victorian Construction of Womanhood* (Cambridge, Mass., 1989); Nelly Oudshoorn, *Beyond the Natural Body: An Archaeology of Sex Hormones* (New York, 1994); Mariana Benjamin, ed., *Science & Sensibility: Gender and Scientific Enquiry 1780-1945* (Oxford, 1991); Ruth Bleier, *Science and Gender: A Critique of Biology and Its Theories on Women* (New York, 1984); Anne Fausto-Sterling, *Myths of Gender: Biological Theories about Women and Men* (New York, 1985); Donna Haraway, *Primate Visions: Gender, Race, and Nature in the World of Modern Science* (New York, 1989); Sandra Harding, *Whose Science? Whose Knowledge: Thinking From Women's Lives* (Ithaca, N.Y., 1991); Sandra Harding and Jean F. O'Barr, eds., *Sex and Scientific Inquiry* (Chicago and London,

changing social and cultural mores. The medical world in which Atlee trained was influenced by the Victorian standards of previous decades. However, the world in which he lived and practised was no longer Victorian, and new ideas and challenges to old ways of thinking emerged. Physicians' views of medicine were changing as well. Increasingly they emphasized its scientific nature as reflected in its technology, its research orientation, its specialized language and its adoption of a more homogeneous model of treatment. Change was the hallmark of scientific progress, but for many physicians, including Atlee, that change underscored the inadequacy of the training they had received. Those in the field comforted themselves that medicine was better than it had been and that new discoveries and therapies were constantly improving their ability to help their patients. At the same time, they worked in a world of tradition and their own experience, both of which could foster resistance to the new.

It is not often that historians of medicine are able to gain insights into the thinking behind physicians' actions or the gap between what practitioners want to do and what they actually do. The writings of Atlee allow that glimpse. Atlee was not unique in his thinking, but he was unusual in teaching and writing about what he did and why he did it. Even more unusual was his willingness to write in a general way about the people who were his patients — women. He had a strong sense of what he wanted medicine to be and what a good physician should do. Unfortunately, the ideal, as with all ideals, remained elusive. In his professional life, Atlee played three roles — teacher, obstetrician and gynaecologist. In all three, he was influential. As a teacher of obstetrics and gynaecology he taught several generations of physicians who would go on to practise in the province of Nova Scotia and elsewhere. He laid the foundation for his students' views of their women patients. His writings in these fields, both professional and popular, extended his sway. His perceptions of medicine and women had real consequences for the women he treated and those his students would see.

Atlee wrote about women, their nature and their problems from both a medical and non-medical perspective. Women fascinated him as they did many practitioners who had them as patients. The medical literature of the time suggests that physicians saw women as qualitatively different from men and that the source of that difference was the female reproductive system in all its complexity. What distinguished Atlee was his willingness to go beyond the physical and to write about women and the lives they led. Atlee approved of the “new” woman who had left the Victorian code of behaviour

1987); Mary Jacobus, Evelyn Fox Keller, and Sally Shuttleworth, eds., *Body/Politics: Women and the Discoveries of Science* (New York, 1990); Evelyn Fox Keller, *Secrets of Life, Secrets of Death: Essays on Language, Gender, and Science* (New York, 1992); Helen Longino, *Science as Social Knowledge* (Princeton, N.J., 1990); Nancy Tuana, *The Less Noble Sex: Scientific, Religious, and Philosophical Conceptions of Woman's Nature* (Bloomington, 1993); Nancy Tuana, ed., *Feminism and Science* (Bloomington, 1989); Lynda Birke and Ruth Hubbard, eds., *Re-Inventing Biology: Respect for Life and the Creation of Knowledge* (Bloomington, 1985); Brian Easlea, *Science and Sexual Oppression: Patriarchy's Confrontation with Woman and Nature* (London, 1981); Londa Schiebinger, *The Mind Has No Sex? Women in the Origins of Modern Science* (Cambridge, Mass., 1989); Londa Schiebinger, *Nature's Body: Gender in the Making of Modern Science* (Boston, 1993); Bonnie Spanier *Im/Partial Science: Gender Ideology in Molecular Biology* (Bloomington, 1995); Carol Tavris, *The Mismeasure of Women: Why Women are not the Better Sex, the Inferior Sex, or the Opposite Sex* (New York, 1992); Barbara Laslett, Sally Gregory Kohlstedt, Helen Longino, and Evelyn Hammonds, eds., *Gender and Scientific Authority: Essays Reprinted from Signs: Journal of Women in Culture and Society* (Chicago, 1996).

behind. At the same time, he had not totally escaped traditional views about women. He evaluated them in terms of their relationships to others and argued that while women were equal to men, they were hampered in fulfilling their potential by their reproductive destiny. The resulting frustration, he argued, could lead to psychological distress and even breakdown.

In 1924, two years after he became head of Obstetrics and Gynaecology at Dalhousie, he wrote an article for the *Halifax Chronicle* entitled “The Flapping of the Flapper”. The article was full of what would become vintage Atlee. He had a unique turn of phrase, wrote in a colloquial manner, and the fact that he wrote for a newspaper suggested his desire to speak out on non-medical as well as medical issues, and to a wider audience. The article described the young woman of the 1920s:

The flapper is the Bolshevik of the feminine world. She has broken down the petty, irritating, rasping claims that have bound women to the wheel of an often time unfair convention for many years. With a jaunty bravado she does just those things which, for countless generations, her mothers were forbidden to do. She displays breezily her maiden charms in public. She draws attention to these charms in a hundred naughty little ways, such as powdering her pretty nose, touching up her saucy lips, and wearing clothes that combine the extreme and the bizarre. What is more she has had the temerity to do in public those things that we, the superior sex, have long claimed as our sole right. She smokes cigarettes with obvious enjoyment, puts her feet on the mantlepiece, and swigs hooch.⁹

Several interesting insights emerge from this article. First, that a 34-year-old, newly married man, and head of a department felt the inclination to comment in the public press on what young women were doing implied his willingness and desire to be a public persona. Second, the content of the article revealed his attraction to women, albeit in a jocular and condescending way, and his admiration for the “new” woman. And third, he recognized that limitations on women’s actions had existed in the past and seemed quite pleased that women were breaking down the barriers that had once held them back. He seemed particularly delighted that they were doing so in such an attractive way. Here were women with whom he could feel comfortable — young, unmarried, attractive and confident.

While Atlee appreciated the freedom young women were experiencing, he never seemed to accept them fully as individuals in their own right. Their importance was connected to being sexual partners of men, future wives and mothers. They were defined by relationships. In all of this, Atlee reflected the period in which he was living. Nonetheless, more than most, he seemed to have given the lives that women led some thought. He appreciated that in early childhood girls quickly learned that they were not considered equal to boys and thus developed what he called a “slave complex” which in later years was difficult to overcome.¹⁰ He also exhibited

9 Oxorn, *Harold Bengie Atlee M.D.*, pp. 151-2.

10 H.B. Atlee, “The Problem of Being a Woman”, unpublished manuscript, p. 7, Oxorn Papers, Dalhousie University Archives [DUA], Halifax, N.S.

sympathy for women who had had careers and found themselves cut off from them because of family obligations. He put forth the rather radical idea that “We have to develop some system that will enable women to have babies without seriously interrupting their careers. Arrangements can and should be made whereby a woman who bears a child would retire from the arena for a matter of months instead of years, so that she would lose nothing in her career from having a baby”. His concrete solutions were day care centres and domestic help.¹¹ In such a scenario, however, the husband seems to be missing. The child was *the woman’s* child whose care was *her* responsibility. Society should change to aid women, but not in a way to inconvenience men. Also noteworthy is the class dimension of his concern. His focus was on those women with careers, not jobs. The fact that the latter might have needed their jobs more than women with careers needed theirs was not an issue. It was not monetary need that concerned him but psychological need. Atlee was not alone in thinking this way. Dr. Marion Hilliard, Chief of Obstetrics and Gynaecology at Toronto’s Women’s College Hospital from 1947 until her retirement in 1957, knew first hand the difficulties of being a career woman. In fact, she wrote publicly about how, in becoming a physician, she had given up the dream of marriage and family.¹² She argued that married women needed to work; it was necessary for their happiness and self-image. And like Atlee, she focused on middle-class, not working-class women; she dismissed the financial necessity of many women who worked in paid employment and instead concentrated on the psychological uplift worthwhile work provided them.¹³ But Atlee and Hilliard were ahead of most of their colleagues who tended to worry about the health and moral consequences of women, especially married women, working.¹⁴

Atlee’s musings on women should not be dismissed as curiosities. His position gave him status and influence. The *Canadian Home Journal* prefaced his 1931 article entitled “Are Women Sheep?” with an admonition to its readers that it was written by “the head of the department of Obstetrics and Gynaecology in a grade A. Canadian Medical School. So, he writes with authority”. The prestige of physicians, especially those who were women’s doctors, was such that they were deemed experts on all aspects of women’s lives, not just the medical. In this article, Atlee berated women for changing their fashions from ones which gave them freedom of movement to ones that returned them to “the old servitude” that they had escaped. He told them that they were failing as mothers because they were allowing the educational system, which was devised for men, to be applied to their daughters as well. Women were different and needed a different form of education, an argument with which many late

11 Oxorn, *Harold Bengé Atlee M.D.*, p. 155.

12 Marion Robinson, *Give My Heart — The Dr. Marion Hilliard Story* (Garden City, N.Y., 1964), p. 131. There is a certain irony in this quote of Hilliard’s since recent research has suggested that she was lesbian. See Valerie Korinek, *Roughing It in the Suburbs: Reading Chatelaine Magazine in the Fifties and Sixties* (Toronto, 2000), p. 295.

13 See Marion Hilliard’s *A Woman Doctor Looks at Love and Life* (Garden City, N.Y., 1957), pp. 104, 109-10, 113 and her *Women and Fatigue — A Woman Doctor’s Answer* (Garden City, N.Y., 1960), p. 72.

14 See *Canadian Journal of Public Health*, 34, 6 (June 1943), pp. 268-9; *Canadian Medical Association Journal*, 50, 4 (April 1944), p. 315; and *Canadian Medical Association Journal*, 35, 5 (November 1936), p. 572 for medical concerns about women in paid employment.

Victorians would have agreed. Childbearing was woman's "destiny".¹⁵ Everything in their lives must be made subservient to it. In this belief, Atlee certainly reflected the few medical commentators who wrote on women's education in the interwar years. Physicians believed the development of the body needed to be privileged over that of the mind, particularly in women, given the centrality and importance of their reproductive role.¹⁶ To counter the problems they faced in a world that did not accept them as equal to men and placed limits on them, Atlee told women they had to group together. At one level Atlee's ideas conformed to those held by his colleagues and others, but at another level he was a proto-feminist, challenging women to use the system in a way beneficial to them. But the berating, coming as it did from a man, seemed too much like nagging, the powerful blaming the less powerful. And in reality, Atlee did not believe that the limitations could be overcome — they were a result of woman's body, her biological destiny.

The social limitations on women created ambivalence in their lives that resulted in ill health. As sick people they were not expected to "bear their burden".¹⁷ As a clinician Atlee's role was to deal with the physical, but experience had taught him, as it had taught many other physicians, that too often there was little he could do for his patients. Unwilling to concede defeat, he focused on the psychological as the way to proceed. Doing so would not only allow physicians to expand their area of expertise but also give them an opportunity to explain the failure of conventional therapies. Unfortunately for patients, this could result in physicians blaming the woman for her own difficulties. Many physicians, for example, believed that menopausal symptoms were more accentuated in women who were emotionally unstable or overly indulgent.¹⁸ Atlee's analysis that social limitations could lead to ill health was similar to that made decades later by early American feminist historians who examined the apparent decline in health among women in the late 19th century.¹⁹ They, like Atlee, focused on the limitations of the lives women lived and the circumstances in which they found themselves; as a way of protest, many women refused to be part of the

15 *Canadian Home Journal* (November 1931), pp. 8-9, 80, 83. What Atlee did appreciate was that "being female" was more than bodily existence. He recognized the psychological, but underlying that was body. Using doctors as experts in areas in which they did not specialize was not unusual. Another example was the April 1948 article in *Chatelaine* on menopause, one of the first on this subject published in a popular magazine. This time the authors were Robert A. Cleghorn and Karl Stern, both deemed experts because they were assistant professors of psychiatry at McGill University. See Beth Light and Ruth Roach Pierson, eds., *No Easy Road — Women in Canada 1920s to 1960s* [Documents in Canadian Women's History, Volume Three] (Toronto, 1990), p. 315.

16 For discussion of women and education see: *Dalhousie Review*, 10 (July 1930), pp. 150, 153; *Dalhousie Review*, 25 (April 1945), pp. 86-7; *Saturday Night*, 62 (28 September 1946), p. 30; *Canadian Medical Association Journal*, 11, 9 (September 1921), p. 619; *Canadian Medical Association Journal*, 46, 1 (January 1942), p. 2.

17 *Nova Scotia Medical Bulletin*, 12, 4 (April 1933), p. 241. See also H.B. Atlee, "The Problem of Being a Woman", p. 236.

18 *University of Toronto Medical Journal*, 27, 2 (November 1949), p. 45; *University of Toronto Medical Journal*, 24, 3 (December 1946), p. 71; Archibald Donald Cameron and Mabel A. Shannon, *Gynaecology for Nurses* (Philadelphia, 1946), pp. 45-6. Cameron and Shannon were Canadians.

19 See in particular Kathryn Kish Sklar, "'All Hail to Pure Cold Water!'" in Judith Walzer Leavitt, ed., *Women and Health in America: Historical Readings* (Madison, Wisconsin, 1984), pp. 246-54, esp. 251.

10 *Acadiensis*

system and so opted out in one of the few respectable ways they could — they adopted the sick role. But whereas feminist scholars suggested agency on the part of such women, Atlee did not.

Atlee worried that in some cases women's alienation from their society could turn into a neurosis. Although not a devotee of Freud, he linked some psychological problems to sexual maladjustment. Like many physicians, he argued that sex, in its broadest sense, was more important to woman than to man because "she mothers the race". In addition, the complexity of her sexual system and its consequent "derangements" could lead to sexual abnormality. That Atlee referred to the "derangements" of the sexual system rather than disorders is, in itself, telling. The former suggests a social/individual origin, the latter, a physiological one. Combined with what he assumed was woman's general ignorance of sexual matters compared to man's at the time of marriage and her often traumatic initiation into sex, it was little wonder that many women were prone to sexual neuroses. Physicians had to begin acknowledging this and other psychological issues in dealing with their patients. Atlee advocated the use of psychologists, recognizing that too many physicians tried to work alone "with no more scientific sanction than the veriest quack". Too often the result was needless surgery.²⁰

Atlee's perceptions of women combined empathy and judgmental pontification. Underlying even his most sympathetic opinions was his belief that women's bodies caused difficulties for them; the society in which they lived added to those difficulties. While he argued that the latter could be altered, the former could not. Atlee was aware that women were socialized in a way that caused them problems. They were told they were equal to men but not treated as equals. As young women grew up, they were inhibited by restraints on their actions. Although Atlee had sympathy for their situation, he disliked the way in which many women responded to it. "We must teach them that tears are a silly weapon in the face of conflict. That all those weaknesses we connote in the word 'womanly' must be replaced by those strengths we connote in the word 'manly'".²¹ Thus Atlee urged women to rid themselves of those aspects of their nature that he found annoying. But did his musings on women really matter? Did they influence his professional practice? In his obstetric and gynaecology practice, he drew on his beliefs about women, which were themselves shaped by his medical experience. In his teaching, he passed both the lessons of his experience and his ideas on to his students.

Little work has been done in the history of medicine on the importance of teaching. Yet medical students learned much of what and how they would practise in the years spent at medical school. Atlee did not see his teaching as a minor aspect of his career but one through which he could influence future physicians. He wanted to ensure that his students received the best training he could provide, training that would prepare them for the future better than he had been prepared. He taught the science of medicine but reminded students about its art. He revealed a sensitivity to his female students and taught all his students to be aware of the needs of their female patients. Nevertheless, students needed to understand that patients and physicians did not

20 *Nova Scotia Medical Bulletin*, 12, 4 (April 1933), pp. 243-4; *Canadian Medical Association Journal*, 32, 5 (May 1935), p. 516; *Nova Scotia Medical Bulletin*, 15, 6 (June 1936), p. 291.
21 *Chatelaine*, 10, 1 (January 1937), pp. 13, 29.

always have the same agenda. Atlee may have admired the independence of the ‘flapper’ but he certainly did not appreciate independence exhibited by patients in their dealings with physicians.

Atlee enjoyed teaching. From interviews with former students, it would appear that he was a good teacher, able to keep his students’ attention and impress upon them the importance of certain maxims.²² His approach was informal: “down to earth” in speech, at times even crude.²³ Teaching appealed to his ego, for, as a teacher, he was on display, performing for a captive audience. But his teaching went beyond this. His concern to make students see and understand what was before them was a result of his own inadequate training as a student at Halifax Medical College from 1907 to 1911.²⁴ A similar sense of unpreparedness appears in many physicians’ memoirs.²⁵ The inadequacy of Atlee’s training stemmed, in part, from having a teacher who had not changed with the medical times. Educated in the Victorian era with its public prudery regarding the female body, Atlee’s teacher, a Dr. Trenaman, continued to teach according to the way he had been taught and the values with which he was comfortable. One of the issues that most disturbed Trenaman was the “new” idea of viewing the female body in birth. He preferred an older system where the physician worked under a blanket which allowed both patient and physician to retain their decorum. In Trenaman’s words, “A woman’s private parts should never be exposed to the male gaze”.²⁶ By the turn of the century, such a stance was antiquated, and the fact that a professor at a medical college could still instruct his students in this manner raises the spectre of time lag in medical practice.

The obstetrical training of medical students in Halifax improved as it did elsewhere in Canada.²⁷ In 1910, the Carnegie Foundation-sponsored study of medical education in North America found the Halifax Medical College wanting and it subsequently closed, with Dalhousie University creating a Faculty of Medicine to take its place.²⁸ As well, in 1919 the Salvation Army, with support from the university, decided to build Grace Maternity Hospital, which opened in 1922. The hospital provided clinical instruction for Dalhousie’s medical students and relieved them of having to go to the

22 Interview with Drs. H. and M., Halifax, 29 October 1993.

23 To impress his students with the importance of the vaginal examination he wrote a long poem entitled the “Moving Finger” which had as a last line to each verse the refrain
Please don’t — Oh don’t — forget to
Stick a finger up her ass!

Oxorn, *Harold Benge Atlee M.D.*, pp. 22-3. This was perhaps his attempt at being “one of the boys” and given the few women in his courses, that phrase should be taken literally.

24 *Dalhousie Medical Journal*, 11, 1 (1958), p. 22.

25 See Wendy Mitchinson, “The Sometimes Uncertain World of Canadian Obstetrics, 1900 to 1950”, *Canadian Bulletin of Medical History*, 17, 1-2 (2000), pp. 193-208.

26 Oxorn, *Harold Benge Atlee M.D.*, p. 200. Only after the mid-19th century did training hospitals allow medical students to view a birth. The Halifax Medical College still did not allow it in 1900, although students were able to attend the maternity ward of the City Alms House. See Rhona Kenneally, “The Montreal Maternity, 1843-1926: Evolution of a Hospital”, M.A. thesis, McGill University, 1983, pp. 19-20; Jo Oppenheimer, “Childbirth in Ontario: The Transition from Home to Hospital in the Early Twentieth Century”, *Ontario History*, 75, 1 (March 1983), p. 41; and “Halifax Medical College Calendar”, 1900, p. 11.

27 See, for example, *Manitoba Medical Bulletin*, 90 (November 1929), p. 7.

28 Howell, *A Century of Care*, pp. 53-4.

12 *Acadiensis*

Poor House which had previously been their source of patients.²⁹ By the 1920s, Dalhousie University medical students were expected to deliver 20 babies, compared to Atlee's four, and to attend five complicated births.³⁰ Atlee was pleased to be part of the new era of teaching. His students would not have to go through what he had and would graduate with a feeling of adequacy based on careful supervision and numerous attendances at childbirth. But that was not to be. Education has difficulty keeping pace with the changing needs of society. Harry Oxorn, one of Atlee's students and his biographer, recalled the training he received in the early 1940s in less than glowing terms. Compared to the training available to students in the 1980s, he saw it as "primitive We did not live-in at the maternity hospital. No medical student was permitted to enter the case room unless a member of the teaching staff was present, and, since there were only three teachers, the opportunity to attend a delivery arose seldom. As a result, we did not see many confinements during our days in medical school".³¹ What Atlee saw as modern instruction was not necessarily the view of his own students. The sense of inadequate training would remain.

Atlee's concern about teaching did not end with improved obstetrical training. He believed a broader issue needed addressing. The training of medical students stressed book learning; yet the practice of medicine was enmeshed with clinical realities.³² He believed that medicine was a mixture of science and art and that if the science was represented by the theory, the art could only be learned through clinical training, the actual practice of medicine. The latter was part of the traditional apprenticeship system whereby students had learned by working with those already in practice. Atlee maintained a healthy skepticism about the claims made in many medical textbooks and that skepticism came from the realities of clinical work. Women's bodies varied tremendously, and the teachings of textbooks could never encapsulate the varying responses they demanded.³³ Clinical practice could teach the need for such responses to students. Atlee believed in the laying on of hands as an important component of teaching practice; only in this way could he make his students good physicians rather than merely competent ones. But doing so was becoming increasingly difficult. He argued, as did some of his colleagues, that specialists, who could not see the wider context in which their patients lived, dominated medicine.³⁴ They certainly dominated

29 Oxorn, *Harold Benge Atlee M.D.*, p. 199. The Salvation Army had been a major participant in providing maternity care, especially among unwed women, and had built Grace Hospitals in several cities in Canada.

30 *Nova Scotia Medical Bulletin*, 11, 4 (April 1932), p. 460; *Dalhousie Medical Journal*, 11, 1-3 (February 1937-November 1937), p. 31; G. Enid MacLeod and Irene M. J. Szuler, "Medical Missionaries of the Early Female Medical Graduates, 1894-1929", *Nova Scotia Medical Journal*, 69, 1 (February 1990), pp. 7-14; and interview with Drs. M. and H., 29 October 1993. The restricted experience of Dalhousie students in the early years of the century was not unusual.

31 Oxorn, *Harold Benge Atlee M.D.*, p. 237.

32 *Nova Scotia Medical Bulletin*, 5, 4 (April 1926), pp. 21-2; see also *Nova Scotia Medical Bulletin*, 15, 7 (July 1936), p. 495 and *Nova Scotia Medical Bulletin*, 19, 6 (June 1940), p. 363.

33 *Nova Scotia Medical Bulletin*, 19, 3 (March 1940), p. 25.

34 H.B. Atlee, "The Problem of Being a Woman", p. 158. Sir William Osler, considered one of the finest teachers of medicine, also focused on the "doing" of medicine. See Michael Bliss, *William Osler: A Life in Medicine* (Toronto, 1999). For concern about specialists see Alton Goldbloom, "The Role of the Physician in the Rearing of Children", unpublished manuscript, p. 2, McGill University Rare Books.

the medical periodical press and teaching. The irony is that Atlee was a specialist, but one who believed he had a broader perspective than most.

Atlee's appeal as a teacher was his ability to connect to students. Unlike many in the profession, Atlee did not have difficulties accepting women as professionals, and some of his female medical students remember him fondly. Other professors at best tolerated them, but they believed that Atlee truly accepted them. Such acceptance was important since women physicians remained a small minority. In 1931 only two per cent of physicians in Canada were women, rising to 3.2 per cent in 1941 and 4.1 per cent in 1951.³⁵ For Atlee, his women students were representative of the "new" women whose energy and intellect he admired and found attractive. In fact, he was known to tell his women students and others that ultimately women would take over the field of obstetrics, which was all for the good since he believed that only women could understand what other women were going through. He argued that obstetrics was "too much a male-dominated, male-determined specialty".³⁶ He was convinced that women brought a different sensibility to the field. It was part of his general belief in the separateness of the two sexes, not in general abilities but in the specificity of them. He also claimed great respect for his nurses and while he may not have been as willing to grant them increased status vis-à-vis himself, he did not have any difficulty admitting that they often knew more than his interns.³⁷ It is noteworthy, however, that this sentiment regarding nurses was not expressed in his published work addressed to physicians but rather to nurses; neither did he always treat nurses with respect. When working with anyone, he was in charge.

Atlee wanted his students to learn and was enthusiastic about his subject. In his biography of Atlee, Harry Oxorn tells the story of being awakened one night by him to see a woman ostensibly experiencing prenatal eclamptic convulsions. Eventually they discovered that the young woman, who was single and seven months pregnant, had drunk cleaning fluid in the hopes of either inducing labour and abortion or committing suicide. The cleaning fluid, not toxæmia of pregnancy, caused the convulsions. Never daunted, Atlee with his own special form of bravado quickly recouped from his misdiagnosis, declaring "The cause may have been different, but the convulsions *were* typical".³⁸ That Atlee took the time to ensure that Oxorn, no matter what time of day, see a condition that was relatively rare reflects his own enthusiasm for teaching. That he used his error as a teaching tool only reinforced the lesson for his students. Indeed, it was his way of stressing the art and uncertainty of obstetrics. Books could only teach so much. The real test was the clinical side of medicine, and no matter how experienced you were as a physician, you could never be sure about what you would find.³⁹ Atlee was not alone in believing what he did. The tension between the theoretical teachings of medical science and the art of

35 Eva Mader Macdonald and Elizabeth M. Webb, "A Survey of Women Physicians in Canada, 1883-1964", *Canadian Medical Association Journal*, 4 (June 1966), p. 1224. Given the few women, I use the masculine when referring physicians in this paper.

36 *Canadian Medical Association Journal*, 117 (6 August 1977), p. 288.

37 *The Canadian Nurse*, 34, 9 (September 1938), p. 472. See also H.B. Atlee to S., 8. January 1956, Oxorn Papers, DUA and Atlee, *Natural Childbirth* (Springfield, Illinois, 1956), p. 31.

38 Oxorn, *Harold Bengé Atlee M.D.*, p. 116.

39 *Nova Scotia Medical Bulletin*, 10, 12 (December 1941), p. 211.

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medical practice was one that most physicians experienced to a greater or lesser degree. Science seemed to be winning out, but many physicians reminded themselves and their colleagues what would be lost if it succeeded totally.⁴⁰

No problem was too mundane for Atlee to entertain. One of his women students remembers discussing menstrual hygiene with him, telling him about a new method that she had discovered and that he had not heard of. Regarding more conventional products, he apparently was a great supporter of the use of tampons. Released from the regimen of washing out and reusing the rags that had been the norm until the emergence of commercial menstrual pads, many women found that even pads could be uncomfortable and did not provide the security of tampons. Yet some were reluctant to use the latter because of the comparison that could be made between a tampon and a penis being inserted into the vagina. For virgins especially, this could pose a problem. For Atlee that was a tampon's advantage — its use stretched the vagina, which he considered helpful when a woman started to have intercourse.⁴¹ Such a view could be interpreted two ways. It reflected a perspective on women that emphasized their sexual and reproductive destiny, both of which were a result of their relationship with men. It had little to do with women's lives in and of themselves. Yet Atlee's endorsement of tampons was ahead of its time. His lack of concern about the morality of their use reflected his perception of women living their lives no longer restricted by Victorian sensibilities. It recognized women as sexual beings, for whom using tampons could make the transition to sexual activity easier. Certainly the second interpretation does not necessarily negate the first and does coincide with his tendency to support the modern rather than the traditional. Equally modern were his attitudes on birth control. Some of his women students remember him teaching birth control before it had been legalized in Canada. As an obstetrician and gynaecologist he came into contact with women whose health had broken down as a result of too many pregnancies. He railed at his colleagues: "To tell a woman that she should not become pregnant, and then refuse her information as to the means is not only stupid but cruel".⁴² His was a pragmatic approach, not one caught up in the morality of the issue and as such more daring than that of most of his colleagues who remained publicly silent on the issue.

Atlee's support of tampons and birth control was indicative of his sensitivity to women's experience: clearly, he went beyond the medical or the obviously medical. And he wanted his male students to be equally sensitive. He warned them against giving a patient a vaginal examination unless they had a nurse present.⁴³ Today, when public attention has been directed to sexual harassment of patients by some physicians, Atlee's admonition seems sensible and justified. It illustrated his

40 For concern about science dominating medicine, see *Nova Scotia Medical Bulletin*, 13 (October 1934), pp. 513-14, William R. Houston, *The Art of Treatment* (New York, 1936), p. 46; and *Canadian Medical Association Journal*, 31 (August 1934), p. 191. All textbooks referenced in this study were used in one or more Canadian medical faculties.

41 Interview with Drs. M. and H., Halifax, 29 October 1993.

42 *Canadian Medical Association Journal*, 37, 6 (December 1937), p. 552. See also *Nova Scotia Medical Bulletin*, 15, 7 (July 1936), p. 452 and Atlee, *The Gist of Obstetrics* (Springfield, Illinois, 1957), p. 299.

43 Interview with Drs. M. and H., Halifax, 29 October 1993.

awareness that the physician was a gendered being which included a sexual component that no amount of scientific trappings could obscure. While concerned about protecting the reputation of the patient and the physician, Atlee emphasized to his students the importance of giving a vaginal examination. Acknowledging that this was not an examination like others, he argued that it was necessary for the physician to “creep up” on the patient, as he put it. By this he meant that the physician should try to put the patient at ease, by taking a detailed history and completing a general examination before beginning a vaginal. He appreciated the social context in which physicians had to work, recognized that undergoing a vaginal examination was not easy for many women and thus advocated physicians spending time with their women patients if they were going to do their job properly.⁴⁴ Ironically, his biographer and those he interviewed were clear that Atlee’s own actions vis-à-vis his patients were often abrupt, crude and less than comforting.⁴⁵ Whether such actions were a reflection of his own discomfort with the internal examination is unclear.

While Atlee was sensitive on many levels to the concerns of women in his writings, his responsibility was to train physicians, and that meant preparing them for what they might encounter. He was determined that they learn the lessons he had to teach, ones gained through experience. In a 1939 article, he provided a glimpse into his teaching technique. With respect to cancer of the uterus, he had his students so trained that when he began saying “Any woman who bleeds irregularly from the cradle to the grave —” they immediately responded in loud unison: “— has cancer of the uterus until you can prove that she hasn’t”.⁴⁶ It was a maxim he was determined to repeat until it was ingrained in his students’ minds. Otherwise the consequences could be serious. In this scenario, he taught his students to see a woman’s body as guilty until proven innocent, reflecting the fear cancer engendered in both the medical profession and the public. Other physicians were as quick to diagnose, believing that delay would have dire consequences. With respect to breast cancer, many physicians argued that it was best to remove a breast with a suspicious lump even before a diagnosis of cancer could be confirmed.⁴⁷

As well as teaching his students to view patients’ bodies as problematic, Atlee prepared them to deal with patients who, for whatever reason, were uncooperative. Physicians were particularly sensitive about the ulterior motives of women who came in for treatment that could result in a miscarriage if pregnant.⁴⁸ As Atlee acknowledged, a patient could speak outright lies to her doctor “if it is in her interest to do so”. An unmarried woman might want to hide the fact that she was pregnant; even a pregnant married woman might have her own reasons for denying the possibility of pregnancy. Physicians had to be aware and beware of this so that they

44 *Canadian Medical Association Journal*, 32, 5 (May 1935), p. 516.

45 Oxorn, *Harold Benge Atlee M.D.*, p. 209.

46 *Nova Scotia Medical Bulletin*, 18, 10 (October 1939), p. 587.

47 *Canadian Medical Association Journal*, 12, 9 (September 1922), p. 665; *Canadian Medical Association Journal*, 14, 10 (October 1924), p. 921; *Canadian Medical Association Journal*, 40, 3 (March 1939), p. 233; *University of Toronto Medical Journal*, 1, 5 (April 1924), pp. 8-9.

48 Harry Sturgeon Crossen and Robert James Crossen, *Diseases of Women* (St. Louis, 1930), pp. 86-7, 11, 831; William A. Brend, *A Handbook of Medical Jurisprudence and Toxicology* (London, 1941), p. 120; *Canadian Journal of Medicine and Surgery*, 79, 1 (January 1936), p. 11.

could help their patients and protect themselves. Atlee warned students that patients would not always volunteer pertinent information unless specifically asked. Some topics were simply not easy for many women to discuss. Thus, if the physician needed to know what the sexual history of the patient was, he should not interpret silence as meaning that sexual relations were fine.⁴⁹ The relationship between physician and patient was sometimes an adversarial one and was always one of power. The physician was dominant in that he controlled the kind of treatment suggested to the patient, his expertise was being sought and the patient was vulnerable because of illness. Nevertheless, the patient could refuse treatment and, as Atlee recognized, equivocate over what information to provide the physician.

As a teacher, Atlee tried to prepare his students for the reality of practice, what he deemed the art of medicine. His own sense of inadequate training was an important motivation in doing so. As a clinician, he knew the gulf that existed between medical theory and the everyday world practitioners faced. He was not afraid to broach sensitive topics with his students and to encourage sensitivity in them vis-à-vis their patients. Especially significant was his awareness of the gendered nature of society, as reflected in his understanding of both the problems his women students faced as professionals and the problems his male students faced in being doctors to women.⁵⁰

When Atlee took up his posts as Professor and Chairman of the Department of Obstetrics and Gynaecology at Dalhousie, Chief of Service at Victoria General Hospital and University Clinician at the Grace Maternity Hospital, many women still gave birth at home, although over the years Atlee saw this change. Increasingly women gave birth in hospitals. But whether at home or in hospital, until the very late 1930s maternal mortality remained high. Even when the rates dropped, they remained too high for most practitioners. Losing a mother in childbirth was an experience that few physicians forgot, and its fear was ever present. Prenatal care became the medical response. Atlee believed in prenatal care with its emphasis on the centrality of birth in women's lives. Like most of his colleagues, he inundated women with advice and in doing so generalized women in terms of what they needed and how he viewed them. His pregnant patients were to put themselves under his care and control, for no longer were their lives their own. Pregnancy had changed them into different beings — physically and emotionally. They were soon-to-be mothers, defined by the future relationship with their child and by the present reality of their pregnancy which determined what they should and should not do. Atlee differed somewhat from his colleagues in rejecting some fads and in publicly endorsing abortion. His view of the vomiting of pregnancy underlined his belief in the importance of the psychological, his willingness to take a minority position and his desire to remain central and in control of whatever treatment he provided to his patients. Like many of his colleagues, he was concerned about “meddlesome midwifery”, but unlike most had specific suggestions about how to lessen it. Lastly, compared to most practitioners, he was more willing to address the needs of women after childbirth.

49 *Canadian Medical Association Journal*, 32, 5 (May 1935), p. 516.

50 At a time when social historians are searching for agency among the marginalized, Atlee's experience with women patients reminds us that from the perspective of a physician, patient agency could be a two-edged sword.

Like most physicians in the interwar years, Atlee believed strongly in the importance of prenatal care. Physicians in Canada faced the reality of high maternal mortality rates compared to those of other countries in the western world, and in an effort to lower the rates and to justify their patients' belief in medical science, they looked to prenatal care as a solution even when statistics on such care did not always confirm its value.⁵¹ The prenatal care envisioned by most Canadian physicians involved supervision of the pregnant woman throughout her pregnancy. She was to look to her physician for guidance and not listen to other women, no matter how authoritative they might appear. Atlee believed that the modern woman was accustomed to getting and taking advice and so was primed to receive it. The problem was to ensure that her physician was her only source of information.⁵² Underlying the emphasis on prenatal care was the implication that women were unable to bear children as well as they once had.⁵³ The notion that civilization had weakened women physically became widespread belief in the late 19th and first half of the 20th centuries. To some extent Atlee subscribed to this view. Modernity had impaired women's ability to perform a natural function as well as they once had and, in placing limits on women, had made it impossible for them to help one another.⁵⁴ Thus the "new" woman, when facing childbirth, was more needy than her mother and grandmothers. Childbirth was an experience where the modern woman lost her independence. Her body was in charge and determined her need for advice and care.

The supervision of the prenatal months reminded women that while pregnant they were dependent on the care and monitoring of a physician. What such monitoring

51 Maternal mortality in 1925-26 was 6.4 deaths per 1000 live births, which meant that 4 women died every day. It did not decline significantly until after 1937, and by 1946 it was 1.6 per 1000 live births. See *Census 1901*, volume 4, p. 235; National Council of Women, *Yearbook* (1923), p. 60. For 1926 rates see *Canadian Medical Association Journal*, 17, 12 (December 1927), p. 1434; *Manitoba Medical Bulletin*, 79 (March 1928), p. 8 and *Canadian Nurse*, 24, 4 (April 1928), p. 180. For rates in 1937 and in the 1940s see Florence H.M. Emory, *Public Health Nursing in Canada* (Toronto, 1953), p. 184; *Canadian Medical Association Journal*, 46, 1 (January 1942), p. 1; and Cynthia R. Comacchio, "Nations are Built of Babies": *Saving Ontario's Mothers and Children, 1900-1940* (Montreal and Kingston, 1993), p. 233.

52 Dependency on the physician was given added weight by various levels of governments which in their prenatal literature emphasized the importance of medical advice. When coupled with the shift in women's culture that led to young women not learning from their mothers in the same way that they had in the past, it is not surprising that many women did see their physicians as advisers on a vast array of issues. See *Canadian Medical Association Journal*, 37, 6 (December 1937), p. 550.

53 For references to doctors believing women gave birth easier in the past see: *Canadian Medical Association Journal*, 7, 5 (May 1917), p. 405; *Dominion Medical Monthly*, 23, 5 (November 1904), pp. 324, 326; *Dominion Medical Monthly*, 28, 3 (March 1907), p. 116; *The Canada Lancet and National Hygiene*, 63, 1 (July 1924), pp. 1-2; *Canadian Medical Association Journal*, 45, 6 (December 1941), p. 539; Egbert H. Grandin and George W. Jarman, *A Textbook on Practical Obstetrics* (Philadelphia, 1901, 3rd ed.), p. 245; *The Western Canadian Medical Journal*, 1, 11 (November 1907), p. 500; Clark, *Mental Diseases*, p. 90; *Manitoba Medical Review*, 14, 6 (June 1934), p. 3. See also Charles E. Rosenberg, "Pathologies of Progress: The Idea of Civilization as Risk", *Bulletin of the History of Medicine*, 72, 4 (Winter 1998), pp. 714-30.

54 *Canadian Medical Association Journal*, 37, 6 (December 1937), p. 551. See also H.B. Atlee, "Medical Lecture Notes — Gynaecology", p. 8, Oxorn Papers, DUA; *Canadian Home Journal* (November 1931), pp. 80, 83; *Canadian Medical Association Journal*, 33, 2 (August 1935), p. 144.

consisted of could vary from one physician to another, but the goal was to ensure that pregnant women stayed within the medically defined limits of a normal pregnancy. How those limits were defined was never clear. For example, Atlee expressed the opinion that a woman should not put on more than 20 pounds during her pregnancy, due to the danger of developing toxæmia.⁵⁵ But how did the 20-pound figure emerge? Little discussion existed in the medical literature of how women differed one from another, or of the possibility that 20 pounds for one was overweight and for another was not. While Atlee may have stressed to his students that the needs of women were variable and that their specific contexts had to be considered, the need for guidelines in both teaching and practice led to the creation of normative standards. In another example, Atlee admitted that “While the average pregnant woman can indulge in fairly violent forms of exertion without aborting there is no doubt that these do threaten the life of the fetus in a considerable number of cases, and for that reason should be advised against for all pregnant women”. Walking, golfing and simple calisthenics were fine but long automobile rides were problematic. Atlee had had several patients lose their babies as a result of long journeys, and he was unwilling to take the risk for any other patients.⁵⁶ The logic of Atlee’s position is clear. Because physicians could not predict which individual woman might have difficulties, they treated all women as if they would have difficulties. However, the consequence for pregnant women as a group was to generalize them as vulnerable and to see pregnancy itself as an abnormal state. Physicians became more focused on the complications of pregnancy than on its normalcy.

As indicated in Atlee’s attitude toward long automobile rides, he was very much influenced by his own experiences in practice, as were most physicians. It did not always matter what the medical literature said or what the reports on various therapies claimed. If a physician had had a case that seemed to go against the findings, the likelihood was that he would believe the one case that he had seen rather than reports of many cases which negated his own experience. Medicine is somewhat like law, in so far as the physician’s experience with a patient becomes part of case-medicine just as a legal case becomes part of case-law. But in the physician’s situation, case-medicine is more individualized. Case-medicine creates a history of the patient which is orderly and coherent but which differs from the case-histories of others in its details. Physicians in their treatment of patients share general approaches but in the specifics vary greatly. As a clinician, Atlee drew conclusions based on both his own observations and his own intuition.

Not only did physicians generalize the activities it was safe for pregnant women to engage in, they generalized the women themselves. The activities listed suggest a middle-class woman. Seldom did Atlee or other physicians address the problems of working-class women. One of Atlee’s rare acknowledgements of the particular needs of working-class women revolved around the anemia of pregnancy. Unlike some of his colleagues who thought it a universal condition, he believed that it largely existed in working-class women because of their poor diet. The solution — give them extra iron.⁵⁷

55 *Canadian Medical Association Journal*, 37, 6 (December 1937), p. 547.

56 *Canadian Medical Association Journal*, 37, 6 (December 1937), pp. 550-1. See also *Nova Scotia Medical Bulletin*, 15, 7 (July 1936), p. 447.

57 *Canadian Medical Association Journal*, 49, 5 (November 1943), p. 378.

Although Atlee conformed to the general prescriptions of prenatal care, at times he was willing to question and even reject convention. When a specific test for diagnosing pregnancy was devised, he remained skeptical of its claims for accuracy.⁵⁸ In the 1940s he opposed hormonal treatment for women threatened with miscarriage. Equally suspect in his eyes was the use of Vitamin E. In his wonderfully irreverent way he expounded: “Vitamin E is napoooh. Use Wheat Germ Oil for your salad dressing, to lubricate your sewing machine, or to rub into your sore back — but you’ll stop no woman aborting with it”.⁵⁹ He refused to get on the bandwagon. Neither did his words suggest restraint when he felt he was right about something. He believed that women had the right to have abortions performed by skilled physicians. The issue for him was not morality but life — the life of the woman; he had seen too many young women butchered by incompetent abortionists or by their own efforts to self-abort.⁶⁰ He might not agree with what they were doing, and he had refused to help some women abort, but he understood that they were not going to stop because of morality or the law.

Another example of Atlee’s willingness to go against medical convention was grounded in his belief that psychology could be a useful tool in obstetric care. Nowhere was his belief more evident than in the treatment of the pernicious vomiting of pregnancy, a condition that could result in the death of the mother. Physicians were rightly concerned about what caused it and how to treat it. In the early years of the interwar period there seemed to be two schools of thought. The first was that most cases were physiological in nature, a result of some form of toxæmia of unknown origin. The second was that the cases were neurotic in origin and necessitated psychological handling. Most physicians espoused belief in both types, although they argued that cases of the former were more numerous than those of the latter. Atlee disagreed.⁶¹

Atlee had a strong belief in the significance of the psychological element in people’s lives, espousing the view that the people’s emotional life was as central to their health as their physical life and that the one could influence the other. Indeed, he consistently urged his colleagues to take the psychological element into consideration when treating their patients. In treating pernicious vomiting, he isolated the patient, encouraging her to look only to him for assistance. He insisted that she would get well but would refuse to indulge her or let anyone else do so.⁶² In taking this approach, Atlee knew he was out of step with his colleagues and tried to explain why he favoured the neurotic

58 *Nova Scotia Medical Bulletin*, 28, 10 (October 1949), p. 238.

59 *Nova Scotia Medical Bulletin*, 28, 10 (October 1949), pp. 238-9; Oxorn, *Harold Benge Atlee M.D.*, pp. 122-3.

60 Oxorn, *Harold Benge Atlee M.D.*, pp. 123, 158. See Patient Records: patient E.R., patient no. 1650, register no. 1527, admitted 18 February 1931, discharged 2 March 1931; patient M.M., patient no. 600, register no. 514, Surgical Department, admitted 15 November 1930, discharged 21 November 1930; patient Mrs. M.D., patient no. 1024, register no. 957, Surgical Department, admitted 10 December 1930, discharged 4 January 1931; patient M.M., patient no. 1205, register no. 1087, Surgical Department, admitted 9 January 1931, discharged 20 January 1931, Victoria General Hospital Archives, Halifax.

61 *Canadian Medical Association Journal*, 15, 4 (1925), p. 388.

62 *Canadian Medical Association Journal*, 15, 4 (1925), p. 389; Oxorn, *Harold Benge Atlee M.D.*, p. 115.

explanation of vomiting rather than the toxæmic. First, he argued that vomiting associated with pregnancy had been successfully treated using many types of therapy based on “widely differing pathological concepts”. Thus he implied that because the ailment was susceptible to so many different kinds of treatment, it could not be physiological or specifically toxic in origin. This logic assumed one ailment, one treatment. Second, the vomiting of pregnancy could not be of toxic origin since it was known to occur in the husbands of some of these women. Thus he was arguing that because it occurred in the husband, where there was obviously no toxic origin, its existence in the wife was equally suspect. Again there is the sense that the vomiting had to be the same for all. Third, “so many cases of persistent vomiting of pregnancy present clear evidence of psychological conflict”. Given his policy of patient isolation, it is unclear who, other than Atlee, was making this judgement about the psychological conflict. Many women experience ambivalent feelings about having children, but most do not experience the pernicious vomiting of pregnancy. Nonetheless the third factor reflects Atlee’s conviction that the mind affects the body and in cases where a specific physiological cause was unclear, his orientation was to look to the mind as the origin of the distress. With respect to women, he may also have been appealing to the strong cultural belief that women were more emotional than men and, during pregnancy, were even more so. Fourth and last, his method worked.⁶³ It was a method, however, that could not be tested scientifically. The purpose of detailing Atlee’s arguments here is not to bring his work into disrepute. Rather it is to understand how he came to support the kind of treatment he did in the face of a profession that was going in another direction. Atlee started with a belief and seemed to find some evidence in his own practice that confirmed that belief. He then thought of more rational justifications for it and in doing so believed that he had found the “scientific” logic for it. We all do this in our thinking, but what it really represents is a confirmation of our own predilections, not science as we understand it to be.

While present day critics of medicine would not be sympathetic to Atlee’s view and treatment of the vomiting of pregnancy, they would be more supportive of his concern about increasing intervention in childbirth.⁶⁴ His solution to “meddlesome midwifery” was multifaceted. First, women should be trained in the art of childbirth. Modern society had to be refashioned so that the preparation for childbirth would be part of every woman’s experience. Like many others, he believed childbirth was natural. However, it was not instinctual, and so training was necessary since modern women had become separated from what he and many physicians saw as their destiny. In his views on childbirth his support of greater freedom for women collided with his conviction that they could not escape the consequences of their destiny — biologically, socially and emotionally. Less conventional was his second suggestion — women should take over obstetric practice. He argued that societal discrimination had created a vacuum that male midwives had filled. But men in obstetrics was not necessarily a good thing for women. Yes, they had advanced the field, but he argued

63 *Journal of Obstetrics and Gynaecology of the British Empire* 41 (1934), p. 753. See also Atlee, *The Gist of Obstetrics*, pp. 66-67.

64 Oxorn, *Harold Bengé Atlee M.D.*, pp. 22-3, 200-201; Atlee, “Grace Maternity Hospital, 1922-1972”, unpublished manuscript, p. 3, Oxorn Papers, DUA.

that men were too impatient, unwilling to give nature the chance to direct the birth.⁶⁵ The sexes were different. He never stopped to consider that perhaps men could learn to be patient. Apparently, they, too, were limited by an inherent destiny. Atlee's third remedy was to separate obstetrics from gynaecology. Gynaecology had become a surgical specialty and aligning obstetrics with it had increased the willingness of obstetricians to intervene.⁶⁶ That childbirth was increasingly taking place in hospitals only accentuated the attitude that women who were giving birth were somehow ill. Staff treated them as patients and passive rather than agents in their own right.⁶⁷ Hospitals also provided an atmosphere in which intervention was encouraged.

One intervention that Atlee questioned was induction of labour. He pointed out to his students that pregnancies varied in length, something that many texts did not acknowledge. Consequently physicians should not be too quick to assume that a pregnant woman was overdue.⁶⁸ Atlee argued that the use of an enema and pubic shaving, which had become the norm in hospital births, were both unnecessary and did not make delivering the child any easier. Like most of his colleagues, however, he accepted the lithotomy position (woman on her back with her knees bent and feet in stirrups) despite admitting that some women disliked it. The convenience it provided to the physician outweighed the opposition of patients, although in his 1956 book, *Natural Childbirth*, he acknowledged that his conscience was not comfortable with his stance.⁶⁹ One of his most adventuresome challenges to traditional childbirth was his attack on anaesthesia and the way it left women feeling insignificant in the birthing experience. He made an analogy between childbirth and mountain climbing. Under heavy sedation a woman "is often not present at the supreme moment of birth". He asked, should she be? And answered: "Suppose that a mountain climber could take a drug, just before the last desperate push to the summit, that would remove all awareness of pain and danger. He could still climb, but he would return with no memory of having stood on the roof of the world . . . Who would want to mountain-climb under such circumstances? What kick would be left in it?"⁷⁰ Perhaps because of this, and his concern about the meddlesome nature of obstetrics that he saw around him, he became a devotee in the 1940s of natural childbirth, the painless birth espoused by Grantly Dick Read.⁷¹ Natural childbirth had many appeals for Atlee. It reminded the physician that birthing was a natural, physiological function and placed the woman in a more central position. While giving her agency, the kind of coaching needed for it kept the physician central as well.⁷² Atlee saw the latter as a lesser form

65 *The Canadian Nurse*, 34, 9 (September 1938), pp. 474-5.

66 *Canadian Medical Association Journal*, 117 (August 6, 1977), p. 287. See also Atlee, *Natural Childbirth*, p. 24.

67 Atlee, *Natural Childbirth*, pp. 35-9.

68 Atlee, *The Gist of Obstetrics*, pp. 72-3.

69 Atlee, *Natural Childbirth*, pp. 41, 47.

70 Atlee, "The Problem of Being a Woman", pp. 94-5. See also Atlee, *Natural Childbirth*, p. 19.

71 Grantly Dick Read (1890-1959) was an English physician. See his *Childbirth Without Fear: the Principles and Practice of Natural Childbirth* (New York, 1944). Read's theory was that fear caused tension and tension resulted in spasm of the cervix which induced pain. Doctors were to encourage women not to fear childbirth or its pain.

72 Atlee, "Grace Maternity Hospital, 1922-1972", p. 5, Oxorn, *Harold Bengt Atlee M.D.*, p. 265. See also Atlee, *Natural Childbirth*, pp. 17-19, 21.

of control compared to doctors' use of instruments. But Atlee was never an extreme proponent of natural childbirth. He distinguished between "feeling" pain and "bearing" it. Natural childbirth could encourage the latter. Little could eliminate the former except anaesthesia.⁷³

The image of Atlee as someone who questioned the degree of intervention that was occurring in childbirth and was willing to entertain so-called natural childbirth should not distort our view of his medical practice. His view of pregnancy and labour could have led to the meddlesome midwifery he deplored. For instance, he argued that during pregnancy women became less emotionally stable and referred to labour as "a cataclysmic process" in which "one-tenth of a woman is literally torn from her".⁷⁴ The pregnant woman was at the mercy of her body. Pregnancy and labour were fraught with problems. He deplored needless intervention but what was needless? Concerned about the loss of life during the Second World War, he advocated deep episiotomies (incision of the perineum) in order to ease the birth of premature babies. "A dead baby is a dead Canadian", he wrote. "Better a perineum through which you can drive a coach and horses, than a baby that dies or grows up to inhabit a home for the feeble-minded".⁷⁵ His willingness to perform a deep episiotomy was extended to conventional episiotomies for normal births. If the deep one could help ease the entry into the world of a premature baby, then a more moderate one could do so for a full-term baby.⁷⁶ In Atlee's mind there was intervention that he agreed with and that which he did not. In the case of episiotomies, he conformed to medical convention.

The management of childbirth and the prenatal care that preceded it was the focus of obstetricians during the first half of the 20th century. But Atlee made one of his most important contributions with respect to postnatal care. In 1928 he began an early rising regimen, claiming the Grace Maternity Hospital was the first North American hospital to adopt it. The regimen consisted of mild exercises in bed, sitting in a chair a day after delivery and beginning to walk for short periods thereafter.⁷⁷ From today's perspective, when women leave the hospital within 24 hours, this may not appear particularly innovative. But before Atlee introduced it, the norm was to keep women in bed for at least ten to 12 days.⁷⁸ Atlee knew he was challenging conventional therapy but was convinced that such challenges were necessary in medicine. Physicians should question why they did the things they did and not blindly follow wisdom that had been passed down. And it was not simply the postnatal rest period he was challenging; it was the philosophy that underscored it. If childbirth was pathological, if birthing was akin to surgery as many physicians were arguing, then it only made sense for the postnatal period to be a medically supervised recuperative period. But if birthing was physiological, then the possibilities for a different kind of care were possible. Atlee saw how tired women were on rising, how little energy they

73 Atlee, *Natural Childbirth*, p. 9.

74 Atlee, *The Gist of Obstetrics*, p. 20.

75 *Canadian Medical Association Journal*, 49, 5 (November 1943), p. 381.

76 Oxorn, *Harold Bengé Atlee M.D.*, pp. 119, 113. See also H.B. Atlee, "Grace Maternity Hospital, 1922-1972", p. 3.

77 Oxorn, *Harold Bengé Atlee M.D.*, p. 117. See also H.B. Atlee, "Grace Maternity Hospital, 1922-1972", p. 5.

78 *Canadian Medical Association Journal*, 33, 2 (August 1935), p. 144.

had and how unhealthy they looked. Even if childbirth had some pathological aspects, recuperation should not be a trial. Early rising had been tried in previous decades by others but Atlee wanted to push it further.⁷⁹ Nevertheless, he still believed women should remain in hospital. Only what he “allowed” them to do while there had changed.

As an obstetrician, Atlee exemplified the tension existing between belief and reality. Like most physicians, he extolled the value of prenatal care, even when statistics did not bear that out. His attitudes to his patients exhibited tension as well. He believed that he knew what was best for them. He accepted the view that modern women had difficulty giving birth; he argued they should listen to doctors like himself and not to one another; he dismissed pernicious vomiting of pregnancy as a physiological condition and argued it was primarily neurotic in origin. At the same time, he advocated more participation of the birthing mother in the miracle of childbirth, encouraged early rising after birth and was sympathetic to the importance of the psychological in the healing process. He accepted medical convention — prenatal care, limits on weight gain and prenatal activities and episiotomies — but also challenged it in his support for abortions, his attack on meddling midwifery and his adoption of early rising. Seldom was his admiration of the “new” woman reflected in his obstetric work. Pregnant women were timeless; they called attention to a biological destiny that faced obstetricians in an immediate way. It was a destiny, however, that Atlee and many physicians perceived as problematic.

The third area of Atlee’s expertise was gynaecology, a specialty that focused on the most private parts of a woman’s body. In practising gynaecology, physicians had to take care that their actions not offend their patients, challenge social conventions or call their own reputation into disrepute. Atlee excelled in the surgical practice of gynaecology though, and nowhere was the tension between what he wrote and what he did more evident. He criticized the tendency of other surgeons to operate too frequently, yet his own predilection was for action. The premise underlying gynaecology was the problematic nature of women’s bodies, a far cry from the independent women so admired by Atlee. Gynaecologists also made decisions based not solely on need but also on the social role expected of women. Thus the nature of surgery often depended on whether the patient was still capable of having children.

Because theirs was a specialty that involved the most intimate parts of a woman’s body, gynaecologists had to take special care in approaching their patients. Atlee discussed one of the fundamental things a physician should look for — the presence or absence of a vaginal hymen. In his description some of the themes already discussed emerge — the problem of trusting women’s statements, the difficulty of interpreting what could be observed, the willingness to generalize despite that difficulty, the problematic nature of women’s bodies and the way both women’s bodies and their social role should determine treatment:

⁷⁹ For descriptions of early rising in the early decades of the century see: *Montreal Medical Journal*, 37, 1 (January 1908), p. 33; *Canadian Practitioner and Review*, 35, 2 (February 1910), pp. 88-9; *Dominion Medical Monthly*, 38, 6 (June 1912), p. 202; David Berry Hart, *Guide to Midwifery* (London, 1912), p. 544; *Montreal Medical Journal*, 31, 10 (October 1902), p. 774; *The Canada Lancet*, 43, 2 (October 1909), pp. 122-3; *Montreal Medical Journal* 38, 8 (August 1909), p. 491; *Canadian Medical Association Journal*, 33, 2 (August 1935), pp. 145, 149.

The total absence of a hymen, or its replacement by hymenal caruncles would suggest that the patient was not a virgin, and should certainly be set against a denial of coitus. I am not so sure that it proves coitus absolutely, since I have seen two or three young women, whose word I felt I could trust fairly implicitly, in which a definite hymen was not present and upon whom a vaginal and speculum examination could be made without the usual virginal distress and difficulty But *the presence of a distinct virginal hymen does not rule out pregnancy*. I have seen four cases in which girls with very definite virginal hymens were pregnant. In all four there had been no penetration, but a history of “laying about” was obtained. Nevertheless impregnation without penetration is a comparatively rare phenomenon, and it is reasonably safe to conclude that a woman with a virginal hymen is unlikely to be pregnant in either the uterus or the tubes.⁸⁰

Atlee and his fellow physicians recognized that they had to take care not to give a false diagnosis of pregnancy and in so doing sully a woman’s reputation and their own medical expertise. They also had to beware of women who denied pregnancy in the hopes of convincing a physician to perform a procedure that would result in an abortion.⁸¹ Even if not deliberately lying, patients could not always face up to what was happening to them and fashioned a “truth” about themselves with which they were comfortable. Patient M.D. was an obvious example. She entered the Victoria General Hospital on 30 December 1930 after having taken pills to bring on her periods. While willing to admit this, what she could not admit was that she had had gonorrhoea and syphilis for some time. For whatever reason, the presence of VD raised issues about her own or her husband’s activities which she would or could not acknowledge.⁸²

In gynaecology, Atlee excelled as a surgeon. He was the first surgical gynaecologist in Halifax and, indeed, the province.⁸³ As a surgeon, he represented the direction that gynaecology had taken since the late 19th century. He did not advance the field in any specific way; rather, his contribution was to challenge his students and other gynaecologists to think more about what they did. More than most, at least in what he wrote, he was willing to accept the limits of medicine. In 1935, in an article on spasmodic dysmenorrhoea (painful menstruation), he began by admitting that the cause of the condition was vague. While this causal vagueness suggested “exhibition of a neurosis”, he was willing to entertain the idea of “some subtle physical derangement”. The usual course of treatment for women with spasmodic dysmenorrhoea varied: use of emmenin, hygienic measures such as exercise, relief of constipation, use of sedatives and the use of suggestion. If after all these the patient still experienced pain, then the alternatives became limited. A standard treatment was

80 *Canadian Medical Association Journal*, 32, 5 (May 1935), pp. 518-19.

81 For concern about diagnosis see interview with W.H., 11 August 1993; J.S. Fairbairn, *Gynaecology with Obstetrics: A Text-Book for Students and Practitioners* (London, 1924), p. 94; *Canadian Medical Association Journal*, 17 (December 1927), p. 1469.

82 Patient records: patient Mrs. M.D., patient no. 1024, register no. 957, admitted 30 December 1930, discharged 4 January 1931, Victoria General Hospital, Archives.

83 Arthur L. Murray, M.D. to Harry Oxorn, 4 March 1980, Oxorn Papers, DUA.

dilatation of the cervix.⁸⁴ More extreme was to perform “an old maid’s hysterectomy”, a reference to the removal of the reproductive system of women who were not going to reproduce. Women’s role in society was to procreate — that is what separated them from men. If they were not going to become mothers then their reproductive system was of no use to them. Such an attitude was very instrumental in its logic. Reflected in this entire discussion of spasmodic dysmenorrhoea was the uncertainty of medicine, leading to a variety of attempts to cure, sometimes appearing to be hit and miss. Historians of medicine have often referred to the early and mid-decades of the 19th century as the period of “heroic” medicine, when physicians resorted to bleeding and purging patients in an attempt to bring the various humours of the body into balance. The “heroic” aspect referred to the severity of the results for the patient. What Atlee was suggesting was that the “heroic” period of medicine had not really disappeared but had simply been replaced by a different type of “heroic” treatment. The patient was still the material on which to experiment.

Criticism of the willingness of gynaecologists and others to resort to surgery became one of the strongest themes in Atlee’s published works.⁸⁵ In a 1936 article on chronic iliac (intestinal) pain, he commented on the tendency to remove the appendix all too quickly, before other causes of the pain were entertained.⁸⁶ In 1942 and 1945 he returned to the same theme, pointing out that women were undergoing surgery with no benefit and in some cases the surgery made their conditions worse. To explain what was happening, Atlee went to the heart of what he saw as a fundamental trend in medicine — the growing inability to see the patient, to listen to the patient and to think reflectively about the issue at hand. He wanted physicians to consider the complete woman — her body and her life. He painted a profession in which the surgeon had become the “conquistador”. For decades surgery had extended the limits of medicine in a positive way, with the justifiable result that the highest accolades were given to the surgeons. But as Atlee asked, “I wonder if we should continue much longer to do so, for with surgery as with geography the last frontiers have been opened up, the last body cavities explored, and further surgical advances will probably be mainly along the lines of improved technique”. Whereas once surgery had been the domain of those specifically trained and skilled in it, its technique had become so standardized “that any fresh medical graduate possessed of a modicum of courage, a nearby hospital and a textbook on operative surgery, can set himself up as a surgical glamour-boy”. The result was too much unnecessary surgery for which women paid the price. Atlee described the pattern he saw emerging. For chronic right-sided pain, remove the appendix. When that did not work send the patient to a gynaecologist.

84 *Canadian Medical Association Journal*, 32, 1 (January 1935), p. 55. See also Atlee, *Chronic Iliac Pain in Women* (Springfield, Illinois, 1954), p. 3.

85 This is ironic. When Atlee was appointed to the Victoria General Hospital, it was standard procedure for general surgeons to perform gynaecological surgery. Atlee’s predecessor did not do surgery. Thus it is not perhaps surprising that there was some opposition to Atlee insisting that he and not the general surgeons should do the gynaecological procedures. See Howell, *A Century of Care*, p. 59. Perhaps for this reason he was adamant about territorial boundaries in surgery and protective of his own. He argued that too often physicians and other surgeons saw surgery as the first line of defence rather than the last.

86 *Nova Scotia Medical Bulletin*, 15, 6 (June 1936), p. 291.

After all, if it was not her appendix that was the problem it must be a retroverted uterus or an ovary. The result was “a partial or complete resection of her ovary, or a suspension of her uterus”. When this still did not remove the pain, more diagnoses followed — adhesions, constipation, irritated caecum (first part of the large intestine) — with other extreme treatments.⁸⁷ Atlee was damning in his criticism. Too much unnecessary surgery was occurring. Too many physicians felt that they had to be seen to be doing, and since surgery was the most prestigious form of “doing”, the temptation to cut was difficult to resist.

Too many physicians had a perception of the female body as faulty. Atlee used the issue of sterility as an example. More often than not, practitioners focused on the woman as the source of the problem, even to the point of performing surgery when it was really the husband who was at “fault”.⁸⁸ He accused his colleagues of removing too many ovaries compared to testicles “largely because of the location of the organs and not because they are less sensitive to pain than the ovary”.⁸⁹ He further noted that physicians were gendered beings and even as professionals could not avoid being so. It was not a new accusation and had been made in the late 19th century with respect to ovariectomies.⁹⁰ Neither was Atlee alone in his concern about the degree of surgery taking place. Many physicians were extremely critical about their profession. But Atlee went beyond critique — he made suggestions about how the profession could overcome its love affair with surgery. He thought that surgery should be deglamourized, that the profession needed to “relegate the operator to the rewards and status of the plumber”. If that was going too far, which Atlee certainly knew it was, he suggested that before surgery (except in emergency situations) a surgeon “should justify his proposed intervention before a group of his colleagues, consisting of — among others — an internist and a psychiatrist”. The latter, of course, picked up one of Atlee’s favourite themes, the psychological aspect of disease causation. He also recommended considerable follow-up after surgery. Too often a physician sent his patient home in the belief that surgery had been successful and had little knowledge of what happened to her afterwards. If follow-ups were done for a year after surgery, a different picture of surgical success might emerge.⁹¹ Atlee was raising an important issue: how were hospital cure rates determined, and would a patient and a physician or hospital have the same criteria of success?

The irony of Atlee’s condemnation of excessive surgery is that he could be criticized for the same fault. He saw women’s bodies as problematic in the complexity of their reproductive system. Atlee had long trained his students to see post-menopausal bleeding as a sign of cancer until proven otherwise. Moreover, Atlee was

87 *Nova Scotia Medical Bulletin*, 21, 3 (March 1942), pp. 148-54 and *Canadian Medical Association Journal*, 53, 2 (August 1945), pp. 122-8. See also Atlee, *Chronic Iliac Pain in Women* and Atlee, *Acute and Chronic Iliac Pain in Women: A Problem in Diagnosis* (Springfield, Illinois, 1966 2nd ed.).

88 *Nova Scotia Medical Bulletin*, 28, 10 (October 1949), p. 237; Atlee, “The Problem of Being a Woman”, p. 59. For a general look at infertility see Wendy Mitchinson, “Infertility: Historical Overviews of Medical Perceptions in Canada”, in *The Prevalence of Infertility in Canada: Research Studies of the Royal Commission on New Reproductive Technologies*, 6 (Ottawa, 1993), pp. 1-59.

89 Oxorn, *Harold Bengé Atlee M.D.*, p. 136.

90 Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* (Toronto, 1991), p. 270.

91 *Canadian Medical Association Journal*, 53, 2 (August 1945), p. 128.

not always willing to wait for the proof. In a 1949 article, he referred to vaginal hysterectomy, claiming that “We do the operation in every woman who bleeds from the cavity of the uterus after the menopause, and we teach our students that this is a good thing to do, with the result that we are getting post-menopausal bleeders sent in to us much earlier than used to be the case”. This statement is extraordinary in what it is suggesting. All post-menopausal bleeders were operated on — surely an incitement to surgery? And what constituted post-menopause? Given the variety of women’s experience in the menopause and the differing lengths of it, determining its end was problematic in and of itself.⁹² In another article the same year, Atlee made it clear that for such women he removed their uteruses and *then* tested them for cancer.⁹³ The attitude seemed to be that since such women were unable to have more children the reproductive system had now outlived its usefulness; removing it did not pose a problem. When faced with the possibility of cancer, caution disappeared. Atlee was not alone in this.⁹⁴ It was better to err on the side of “safety”, even if the woman turned out not to have needed the surgery. The tragedy of Atlee’s push to save women was that many were operated on unnecessarily. Yet when vaginal hysterectomy on “all women who bled after the menopause” was eventually found “not productive”, he changed his mind, and decided that curettage, once the focus of his disdain, was the better route until laboratory tests confirmed a diagnosis of cancer.⁹⁵

Atlee seemed himself to be the “conquistador” of surgery that he belittled.⁹⁶ While he could criticize what he saw as the excessive surgery being done, the reality was that he had made his reputation doing surgery: that was in large part the measure of the man. It is also telling that while he looked forward to the day when women doctors would take over obstetrics, he did not foresee them taking over gynaecology. Surgery was a man’s terrain. The perceived differences between the sexes would be reflected in medical specialities. Add to this belief confidence in his ability to diagnose and you have a recipe for the “conquistador”. His actions in surgery support this — Atlee was known for throwing dull or worn out instruments around the operating theatre in fits of pique.⁹⁷ His biographer tells the following story, which represents the epitome of what Atlee was arguing against even as it illustrates his own actual practice:

On one occasion, finishing a hysterectomy, he noted that the gall bladder was full of stones. He didn’t hesitate, closed the original incision, made a new one in the upper abdomen, and removed the gall bladder. As the second incision was being sewn together, the intern asked Atlee if he was aware that

92 *Canadian Medical Association Journal*, 60, 5 (May 1949), pp. 452-3. See also *Nova Scotia Medical Bulletin*, 18, 10 (October 1939), p. 587.

93 *Nova Scotia Medical Bulletin*, 28, 10 (October 1949), p. 239. See also *Nova Scotia Medical Bulletin*, 18, 10 (October 1939), p. 602 and interview with Drs. M. and H., Halifax, 29 October 1993.

94 *Canada Medical Record*, 30, 6 (June 1902), p. 265; *Saskatchewan Medical Journal*, 2, 3 (March 1910), pp. 75-6; Thomas H. Cherry, *Surgical and Medical Gynecologic Technic* (Philadelphia, 1929), pp. 600-01.

95 Oxorn, *Harold Bengt Atlee M.D.*, p. 133. For another example of Atlee’s excessiveness in surgery, see Murray to Oxorn, 4 March 1980.

96 *Canadian Medical Association Journal*, 60, 5 (May 1949), pp. 452-3. See also *Nova Scotia Medical Bulletin*, 18, 10 (October 1939), p. 587.

97 Howell, *A Century of Care*, p. 59.

there was a lump in the patient's breast. Atlee examined the breast, decided that the lesion was malignant, and did a Halstead operation, a radical mastectomy.⁹⁸

What such a description reveals is the enormous self-assurance of a man who does not need to wait for confirmation by tests to support an on-the-spot diagnosis. It reveals, too, what could happen to a woman in a period before law suits were prevalent and before the concept of informed consent was widely accepted. It may also reflect Atlee's early experience in surgery, at a time when a good surgeon was one who could operate fast and limit the amount of time a patient was under anaesthesia. Medicine had changed, but when trained under one system, it was not easy for physicians to adjust behaviour to fit the new. One can only imagine the trauma of his patient awakening to find that she no longer had a uterus, gall bladder or breast.

As the above examples indicate, Atlee was not immune to seeing the female body as problematic, despite his encouragement to his colleagues not to do so. He was quick to jump to conclusions. In a discussion of uterine cancer in the mid-1930s, Atlee, in his own words, "dogmatically" insisted that "any woman, of any age who, having at any time been pregnant (whether the pregnancy terminated at full time or in a miscarriage) who bleeds irregularly between her periods, or bleeds after coitus, after hard work, or while at stool, should be handled as a case of carcinoma of the cervix *until she has been proved not to have that dread disease*".⁹⁹ Such an attitude did not give women's bodies any benefit of the doubt, and, with the rate of cancer deaths being high, his attitude is understandable. But he saw even normal processes such as menstruation as stressful for most "civilized" women.¹⁰⁰ In this view he conformed to much of the profession.¹⁰¹ Normal did not mean without difficulty. He tried to argue that despite the stress of menstruation, most women could continue their usual routine, but they had to be vigilant and not become over tired. The end of menstruation was also a difficult time. A woman could not help but be upset, faced "with the unmistakable evidence that she can no longer fulfill [her] physiological destiny, pregnancy".¹⁰² At the same time he perceived women to be at the mercy of their bodies, he saw it as his responsibility to be an advocate for them. One patient, Mrs. M.T., a young Mi'kmaq woman, entered the Victoria General Hospital on 17 April 1931. She had had a ventral fixation in 1925 but had not been well since. As she had already given birth to five children, four of them living, Atlee wrote on her record "Might be a good idea here to undo ventro fix & remove body of uterus. She has 5 children & does not want any more". While some might suggest a racial element in his willingness to sterilize this young woman, it also has to be noted that Atlee's

98 Oxorn, *Harold Benge Atlee M.D.*, p. 129.

99 *Nova Scotia Medical Bulletin*, 13, 9 (September 1934), p. 450 [Atlee's emphasis]. See also *Canadian Medical Association Journal*, 32, 5 (May 1935), p. 523; Atlee, "The Problem of Being a Woman", p. 200.

100 H.B. Atlee, "Medical Lecture Notes - Gynaecology", p. 8.

101 See *Public Health Journal*, 10, 11 (November 1919), p. 491; Carl Henry Davis, ed., *Gynecology and Obstetrics, Volume 1* (Hagerstown, Maryland, 1935), Chapter 2, p. 5 and *The Hospital World*, 22, 5 (November 1912), p. 187.

102 H.B. Atlee, "Medical Lecture Notes - Gynaecology", pp. 8-12.

conscious sympathy was with his patient who had already gone through five births, did not want any more children and was suffering from a chronic condition of the uterus.¹⁰³ Certainly one of his patients appreciated his taking control. In a letter to his biographer, Mary M. Joudry explained that in 1945 she was a patient of Atlee's. She needed a hysterectomy but was Catholic. To avoid causing her distress, Atlee went behind her back and consulted with her family physician and then went to her priest. Once assured that there was no religious impediment in her case, he faced Joudry with the decision. She concluded, "For a busy and prominent [gynaecologist] and a self-professed atheist I believe Dr. Atlee acted 'above and beyond the call of duty'".¹⁰⁴ Joudry's response reflects the kind of security Atlee provided to his patients and is a reminder that the doctor/patient dynamic in the past was different than it is today. The control doctors had over their patients was often not questioned and indeed expected.

As a gynaecologist, Atlee's career highlights the internal tensions and even the contradictions within the man and the profession. An outspoken critic of excessive surgery, he was a surgeon whose philosophy at times could only encourage what he claimed to abhor. The dangers of cancer loomed so large that they overcame his desire for surgical restraint. He was a doer, not a patient man, and reacted to the need to engage the cancerous enemy. He was an advocate for his patients and willing to act in their interests against dominant morality if he deemed it warranted. But his advocacy had a paternalistic element to it, perhaps motivated by his belief that if women were not weaker than men, their bodies certainly were.

R.B. Fleming, in an analysis of the biographical approach, claimed that "biography makes history complex".¹⁰⁵ Certainly an examination of one doctor and his public writings has made viewing the practitioner less straightforward than many critics of medicine have suggested. Harold Bengé Atlee was a complex individual. In looking at his professional thinking, ambivalence and contradiction emerge. He criticized the tendency of physicians to operate more than they should, yet he was an aggressive surgeon. He tried to introduce the importance of the psychological and yet his training and expertise were as a clinician. At the same time, taking the psychological element into account seemed for him to consist of exerting his own personality over that of his patient. He admired women, especially the "new" woman of the interwar years. He exhibited tremendous sympathy for women and a willingness to analyze the lives some of them led and the problems they faced. In many respects, however, he felt that they were limited beings, confined by bodies and a reproductive destiny they could not escape. He was a physician who tried to go beyond everyday thinking about medicine and in doing so raised crucial issues with which medicine is still grappling. He was concerned about the process of deciding whether surgery was necessary or not. He worried about what the standardization of medical procedure did for the creativity of the clinician. He questioned the meaning of hospital cure rates. Atlee reminds us that individuals are full of contradictions. So too are groups of individuals even when joined by certain commonalities. Generalizations are possible and indeed

103 Patient records: patient no. 2473, register no. 2255, Surgical Department, Mrs. M.T., admitted 17 April 1931, discharged 16 May 1931, Victoria General Hospital Archives, Halifax.

104 Mary M. Joudry to Harry Oxorn, 20 May 1980, Oxorn Papers, DUA.

105 R.B. Fleming, "The Two Solitudes of History and Biography", in *Boswell's Children*, p. 259.

30 *Acadiensis*

necessary, but Atlee's career reveals some of the colour which is lost when the generalizations are not offset by the particular. He reminds the historian of medicine not to be too quick to generalize doctors. They differed from one another and argued amongst themselves. If historians are sensitive about not essentializing the marginalized, neither should we essentialize the powerful or perceived powerful.