

A Medical Debate in Nineteenth-Century English Canada: Ovariectomies

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In the late nineteenth century a major division developed among medical practitioners over the question of gynaecological surgery. This was occasioned by two significant changes which had come about in mid to late nineteenth-century medicine: first, the emergence of gynaecology as an important medical specialty, and second, the advances that medicine had been able to make as a result of anaesthesia and, more particularly, of antiseptics. As operating procedures became safer, operations became more frequent, bringing the whole question of gynaecological surgery into prominence. As the medical profession divided into opposing camps, with general practitioners on one side and specialists on the other, their debate exposed another question, seldom discussed: the question of female sexuality.

À la fin du dix-neuvième siècle, le problème de la chirurgie gynécologique divisa profondément la profession médicale. Pour expliquer ce phénomène, il faut remonter aux deux changements de grande importance qui avaient marqué l'histoire de la médecine dans la seconde moitié de ce siècle : premièrement, l'émergence de la gynécologie en tant que spécialité médicale importante; deuxièmement, les progrès médicaux réalisés grâce à la pratique de l'anesthésie et, plus encore, à celle de l'antisepsie. Au fur et à mesure que l'amélioration des techniques entourant les opérations avait diminué les risques de complications, le recours à la chirurgie était devenu plus fréquent, projetant ainsi à l'avant-scène du monde médical toute la question des interventions chirurgicales en gynécologie. En plus de la scission du corps médical en deux camps — les tenants de la médecine générale et les spécialistes —, cette controverse nous livre aussi les opinions de l'époque sur un sujet rarement abordé publiquement : la sexualité féminine.

In the mid to late nineteenth century, gynaecology emerged as a major medical specialty in Canada and elsewhere. Physicians increasingly intervened in the functioning of the sexual/reproductive system of women, and gynaecological surgery was the ultimate form of this intervention. Hysterectomy, salpingectomy, hysteropexy, ovariectomy, excision of the cervix, and colporrhaphy were only a few of the operative procedures in use. However, not all physicians agreed with either the medical or surgical direction gynaecology was taking. From the late 1880s, there was increasing criticism of the intervention. It was argued that too much stress was placed on the reproductive/sexual system of women, and that too often when a woman was sick physicians looked to the uterus as culprit.¹ What worried such critics most was the degree of major surgical intervention. Perhaps because it was one of the earliest operations to emerge in the gynaecological repertoire, the ovariectomy became a

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1. *The Canada Lancet*, 19 (November 1886): 71; Theodore THOMAS, *A Practical Treatise on the Diseases of Women* (Philadelphia: H. C. Lea and Co., 1868), p. 47; *Canada Medical and Surgical Journal*, 16 (July 1888): 19; *The Canada Lancet*, 24 (November 1891): 92.

major focus of this concern, and the debate on its efficacy represented a wider debate on gynaecological surgery in general which continued into the twentieth century. Opponents of ovariectomy argued that given the severe repercussions of the surgery, it was all too frequent and extreme. They expressed concern about the patients and were especially sensitive to its impact on female sexuality. Both the surgeons performing the operations and their critics acknowledged the existence of female sexuality; the critics worried lest the operations tamper with it. But their discussion revealed that their concern was less for the maintenance of sexuality as such than for procreation. Without the ability to procreate, a woman had no need for sexual feeling; and indeed she was unfit for marriage. Hence any operation that tampered with her ability to procreate had to be regarded cautiously. The charge made against many of the gynaecological surgeons was that they were not cautious enough about their surgery and that although they had mastered the techniques, their judgments of when to operate were not equally expert. This antagonism towards the surgeons was a result of many factors: concern for the patients, concern about the impact of specialization on non-specialists and concern about interventionist medicine.

Historians too have taken part in the debate over surgical intervention. Feminists in particular have sided with the nineteenth-century critics, arguing that due caution was not used. While they do not deny that women suffered from disorders of the reproductive/sexual system, they maintain that much medical treatment of women was a reflection not of limited medical knowledge but of a deep seated hostility to women.² They have tended to treat the medical profession as a monolith despite the fact that most of the criticisms they have brought to bear against intervention were raised by physicians at the time. Underlying their work as well is the belief that middle-class women were the focus of gynaecological surgery. An examination of the Canadian debate refines this feminist interpretation. It emphasizes the division within the profession over intervention and the multi-faceted nature of doctors' motivations; and it suggests that middle-class women were not the only recipients of the surgery. However, it does support the view that physicians saw women not as individuals but predominantly in their social roles, as wives and mothers.

The opinion of physicians and especially their treatment of patients are not always easy to ascertain since most doctors did not leave diaries or patient records. However, in the last decades of nineteenth-century Canada, there were public forums for physicians who wanted to discuss the needs and practice of their profession. These were the medical journals. Together with the medical texts which were used in various Canadian medical schools, they form the major source for the debate over gynaecological surgery. Although both represented the view of the physicians who were writing, and not necessarily that of the profession as a whole, it is possible to assume that the opinions expressed were reflections of wider beliefs. Certainly the texts are authoritative for they indicate what young aspiring physicians in Canada

2. The following is a list of some of the feminist literature which criticizes the medical profession. John and Robin HALLER, *The Physician and Sexuality in Victorian America* (Chicago: University of Illinois Press, 1974); G. J. BARKER-BENFIELD, *The Horrors of the Half-Known Life: Male Attitudes Toward Women and Sexuality in Nineteenth-Century America* (New York: Harper & Row, 1976); Linda GORDON, *Woman's Body, Woman's Right: A Social History of Birth Control in America* (New York: Grossman, 1976); Barbara EHRENREICH and Deidre ENGLISH, *For Her Own Good: 150 Years of the Experts' Advice to Women* (New York: Doubleday, 1978).

were taught and there is no reason to believe that they did not practise accordingly. The case histories published in the medical journals confirm this. Because the journals were numerous and represented a wide body of opinion and differing approaches,³ we can also get a fairly good sense of what the major issues were within the medical profession even if we cannot estimate very accurately the number of physicians supporting any specific view. The journals and the texts also emphasize the international nature of medicine with Canadian awareness of and participation in its major debates. Most of the medical texts used in Canada were written and published elsewhere, and the medical journals republished articles from Europe, England and the United States. Although the discussion over gynaecological intervention and the ovariectomy in particular was international in scope, the sources used in this study reflect the opinions available to Canadian practitioners through medical material used in Canada. More importantly, they reflect opinions expressed by members of the Canadian medical profession itself.

By the end of the nineteenth century, gynaecologists believed they were on the frontier of medical science, witnessing exciting new discoveries which would revolutionize medicine.⁴ Dr. Laphorn Smith, gynaecologist to the Montreal Dispensary stated, "This important department of medicine has made such wonderful and rapid progress and has extended its domain indirectly so much in the human body that the general practitioner must have great difficulty in keeping up with its advances."⁵ Behind such a stance was the notion that each specialty, in this case gynaecology, would be better left to those who specialized in it. Of particular note was the emergence of gynaecological surgery and in the 1870s and 1880s the acceptance of the ovariectomy which "would alone suffice to stamp our age as one of great progress in the treatment of those affections which are peculiar to women."⁶

An ovariectomy refers to the removal of an ovary, ovaries or parts thereof. The first real case was reported in 1809 by Dr. Ephraim McDowell of Kentucky. At that time and until the introduction of antisepsis in the 1870s, it was a very dangerous procedure with a high mortality rate.⁷ Not until 1842 had a successful operation been performed in London, and not until 1862 in Scotland.⁸ In 1856 *The Medical Chronicle*, a Montreal publication, acknowledged the difficulty of the surgery when it reported in a review of *The History and Statistics of Ovariectomy*

3. For a discussion of the medical journals of Ontario in the nineteenth century, see Charles G. ROLAND, "Ontario Medical Periodicals as Mirrors of Change", *Ontario History*, 72 (March 1960); 3-16. For a complete listing of Canadian medical journals, see Charles ROLAND, and Paul POTTER, *An Annotated Bibliography of Canadian Medical Periodicals, 1826-1975* (Toronto: The Hannah Institute for the History of Medicine, 1979).

4. For a general history of gynaecology and its major developments in the nineteenth century, see T. CIANFRANI, *A Short History of Obstetrics and Gynecology* (Springfield, Illinois: Thomas, 1960); Harvey GRAHAM, *Eternal Eve: The History of Gynecology and Obstetrics* (New York: Doubleday, 1951); James RICCI, *The Development of Gynaecological Surgery and Instruments: A Comprehensive Review of the Evolution of Surgery and Surgical Instruments for the Treatment of Female Diseases from the Hippocratic Age to the Antiseptic Period* (Philadelphia: Blakiston, 1949).

5. *The Canada Medical Record*, 19 (January 1891): 73; 16 (November 1887): 25.

6. *Ibid.*, 4 (February 1876): 130.

7. THOMAS, *A Practical Treatise*, p. 566; *Canada Medical Journal and Monthly Record of Medical and Surgical Science*, 8 (September 1871): 98; Walter RADCLIFFE, *Milestones in Midwifery* (Bristol: Wright, 1967), p. 83; GRAHAM, *Eternal Eve*, p. 426.

8. THOMAS, *A Practical Treatise*, p. 49.

that out of 229 attempted operations, 120 patients had died. In all, only 109 ovariectomies had been successful in removing ovarian tumours and having the patient survive.⁹ Despite this, there is no indication that it was viewed differently from any other major abdominal surgery.¹⁰ It continued to be performed, and by 1864 it was estimated that 787 ovariectomies had occurred in the Western world.¹¹ As physicians became more adept at operating and with the adoption of antiseptics which made surgery safer, the number increased. By 1882, Dr. Spencer Wells of London, England, alone had performed 1,000 ovariectomies.¹² In 1886 Dr. Laphorn Smith on his visit to the women's hospitals of New York reported that "ovariectomies and hysterectomies were of daily occurrence."¹³ This reflected the belief that ovarian disease was on the increase.¹⁴

It also coincided with (and perhaps aided) the rise in gynaecology as a medical speciality. Gynaecology was based on the premise that the reproductive/sexual system of women was prone to disease.

It may be affirmed that no severe constitutional disorder can long continue in a woman during the predominance of the ovarian function without entailing disturbance in this function. And the converse is also true, that disorder of the sexual organs cannot long continue without entailing constitutional disorder, or injuriously affecting the condition of other organs.¹⁵

Woman's physiology and life style resulted in uterine disorders.¹⁶ In turn, uterine disorders supposedly caused insanity, sick headaches, morning sickness, neuralgia, chorea, amaurosis and asthenopia and many other pathological conditions of the organs of vision.¹⁷

Such beliefs were not surprising. Gynaecology emerged at a time when the ideology of true womanhood was at its peak. This ideology viewed women as different from men mentally, emotionally, morally and psychologically. In the final analysis these differences were based on the physical differences. Gynaecologists were reflecting the beliefs of their society when they focused on those parts of a woman's body which distinguished her from man and suggested that they were the arbiters of a woman's health. As a result, the ovaries became of major interest.

As with any surgical procedure, there were variations in how the ovariectomy was performed. Two were of particular note. Lawson Tait, an eminent British surgeon, referred to his procedure as removal of the uterine appendages since he removed the fallopian tubes as well as the ovaries.¹⁸ However, the most controversial

9. *The Medical Chronicle*, 4 (September 1856): 260.

10. *Ibid.*

11. THOMAS, *A Practical Treatise*, pp. 563-65.

12. J. A. PRICE, "The Early Ovariectomists, Pioneers in Abdominal Surgery", *The Ulster Medical Journal*, 36 (Winter 1967): 5,8.

13. *Canada Medical and Surgical Journal*, 14 (1886): 108.

14. *Canadian Practitioner*, 9 (September 1884): 274.

15. Arthur EDIS, *Diseases of Women* (Philadelphia: H. C. Lea's Son & Co., 1882), p. 20.

16. *The Montreal Medical Journal*, 25 (March 1897): 682; *Canadian Practitioner*, 9 (December 1884): 363; Henry GARRIGUES, *A Text-Book of the Diseases of Women* (Philadelphia: W. B. Saunders, 1894), pp. 125-29; William GOODELL, *Lessons in Gynaecology* (Philadelphia: F. A. Davis, 1890), pp. 548-71; *The Canada Medical Record*, 17 (February 1889): 98; 19 (January 1891): 74.

17. *Canada Medical and Surgical Journal*, 10 (January 1882): 243.

18. *Canadian Practitioner*, 12 (October 1887): 307-8. For a discussion of Battey's operation, see L. LONGO, "The Rise and Fall of Battey's Operation: A Fashion in Surgery", *Bulletin of the History of Medicine*, 53 (Summer 1979): 244-67. See also PRICE, "The Early Ovariectomists", pp. 1-12.

approach to ovariectomy was the one taken by Robert Battey, a surgeon in Rome, Georgia, who between 1870 and 1890 is thought to have operated on several hundred women and whose procedure was adopted by other surgeons.¹⁹ In the 1870s and early 1880s he referred to his operation as a "normal ovariectomy", i.e., removal of ovaries which were not diseased. Such surgery was called for, he insisted, only

. . . (1) when life is endangered in the absence of the uterus; (2) with obliteration of the uterine cavity or vaginal canal that cannot be surgically restored; (3) in cases of insanity or epilepsy caused by uterine or ovarian disease; and (4) in cases of protracted physical and mental suffering associated with monthly nervous and vascular perturbations.²⁰

Care had to be taken. As the *Canadian Practitioner* pointed out, "The removal of the normal ovaries is always a question in morals as well as in medicine, and cannot be evaded in either relation without evil results."²¹

Because of such concern, Battey tried to make it very clear that he was not advocating removal of healthy ovaries except for the most serious conditions. The purpose of the operation he saw as fourfold:

1. To obviate the effects upon the general system of a vicious ovulation; 2. To obviate the effects of unrelieved menstrual molimen; 3. For the control of exhausting uterine haemorrhages incident to ovulation; and 4. To produce the vascular and nervous revolution which attends upon the change of life.²²

It was an operation designed to bring about premature menopause. Since the aim was the stopping of a physiological function,²³ both ovaries had to be removed.

Because the various forms of ovariectomies were performed in Canada, Canadian participation in the subsequent debate was not simply an academic exercise. As early as 1871 Robert Craik, Professor of Chemistry at McGill University and Consulting Physician and Surgeon to the Montreal General Hospital, expressed concern about the dangers accompanying the operation and made it clear that it should only be performed when the patient's life was unbearable.²⁴ Certainly the operation attracted attention. When Craik himself operated in that same year, a dozen of his medical friends viewed it, which suggests that at that time it was still a rarity in Canada.²⁵ Dr. Trenholme, Professor of Midwifery and Diseases of Women and Children at the University of Bishops College in Montreal, performed Battey's operation in 1876; by 1884 he had performed at least six of Tait's variation.²⁶ By 1886, William Gardner, Gynaecologist to the Montreal General Hospital and Professor of Gynaecology at McGill University, had performed sixteen ovariectomies in private hospitals and 11 removals of uterine appendages. In nine of the sixteen ovariectomies, both ovaries were removed although that decision generally was taken during surgery once the condition of the second ovary had been determined. Gardner was quick to point out that the decision was difficult, especially when the patient was young.²⁷

19. LONGO, "Rise and Fall", p. 252.

20. *Ibid.*, p. 249.

21. *Canadian Practitioner*, 10 (December 1885): 361, quoted from *Medical News*.

22. *Canada Medical and Surgical Journal*, 8 (October 1879): 128.

23. *Ibid.*, 10 (January 1882): 340; 8 (October 1879): 127.

24. *Canada Medical Journal*, 8 (September 1871): 98.

25. *Ibid.*, p. 99.

26. *The Canada Medical Record*, 4 (February 1876): 217-19; LONGO, "Rise and Fall", p. 255; *The Canada Medical Record*, 13 (November 1884): 25-28.

27. *Canada Medical and Surgical Journal*, 15 (1887): 141, 143.

In Toronto Dr. Wright, Professor of Obstetrics at the University of Toronto, claimed that by 1887 at least twenty-four of Tait's operations had been performed by seven different physicians.²⁸

While no Canadian surgeon dominated ovariectomies as Spencer Wells did in England, the number of such operations performed in this country did increase. If it is impossible to be precise about how many were performed at private hospitals whose records no longer exist, the published annual reports of some general hospitals do reveal the degree to which ovariectomies were performed. For example, the Victoria General Hospital in Halifax reported 3 ovariectomies performed in 1894 and 24 in 1899. The Royal Victoria Hospital in Montreal in 1895 reported 4 ovariectomies performed in the surgical department and 14 single and 27 double salpingo-oophorectomies performed in the gynaecological division. In 1901, 2 oophorectomies were performed in the surgical division and 5 double and 27 single oophoro-salpingectomies in the gynaecological. At the Montreal General Hospital, in 1884/85, 4 ovariectomies and 1 oophorectomy were performed; in 1900/01, 6 oophoro-salpingectomies (5 single, 1 double), 4 ovariectomies (3 single, 1 double), 8 oophoro-salpingectomies (6 double, 2 single) and 4 salpingo-oophorectomies (2 double, 2 single).²⁹

The ovariectomy, whether in the form of Battey's operation, Tait's variation or any of the multitude of variations which developed, was a serious procedure. Its seriousness lay in the danger to the life of the patient. Battey's procedure had a mortality rate of about 14 percent; depending on where it was performed, Tait's could go as high as 25 percent.³⁰ The operations also had consequences for the patient's future life, and it was on these consequences that most of the debate centred. In the case of Tait's and Battey's operations, the result was early menopause and the inability to bear children. In the case of the removal of one diseased ovary or part thereof, the possibility of bearing children was lessened. Because of this, physicians agreed that removal of ovaries should be an absolute last resort. When publishing their surgical results, they usually described in detail the suffering the woman had been going through before the operation.³¹

Despite the conviction that such operations should be used as a last resort, there were some patients on whom physicians appeared more inclined to operate. American historians have suggested that much of the gynaecological surgery was aimed at middle-class women and, in the case of Battey's operation, institutionalized women as well.³² There is no doubt that middle-class women were a focus. The reference to the surgery occurring in private hospitals reflects this. However, working women were patients as well. One indication of this is that in general hospitals where many ovariectomies were performed the patients were most likely to be

28. *Canadian Practitioner*, 12 (October 1887): 312.

29. Victoria General Hospital (Halifax), *Annual Report of the Medical Board*, 1894, 1899 (in Nova Scotia, *Journal of the House of Assembly*, 1895, 1900); Royal Victoria Hospital (Montreal), *Annual Report*, 1895, 1901; Montreal General Hospital, *Annual Report*, 1894/95, 1900/01.

30. *Canadian Practitioner*, 10 (December 1885): 361, 12 (October 1887): 312.

31. *The Canada Medical Record*, 12 (November 1883): 25; *The Canada Lancet*, 9 (March 1877): 210; THOMAS, *A Practical Treatise*, p. 563; EDIS, *Diseases of Women*, p. 273; *Dominion Medical Monthly and Ontario Medical Journal*, 2 (December 1895): 672-75; *Canadian Practitioner*, 12 (October 1887): 310; *The Canada Medical Record*, 13 (November 1884): 25.

32. LONGO, "Rise and Fall", p. 256; BARKER-BENFIELD, *The Horrors*, p. 123.

working-class.³³ In addition, some physicians believed working-class women were prime candidates for the surgery. Dr. Trenholme in *The Canada Medical Record* of 1884 described operations for double ovariectomies performed on two young working-class women and indicated that one of the motivations behind the surgery was the fact that both were quite dependent on their own work for a livelihood.³⁴ Working women could not afford to take the time to undergo what was often very lengthy medical treatment to cure some of their uterine disorders. Dr. Alan Wright, Professor of Obstetrics at the University of Toronto, wrote in the 1887 *Canadian Practitioner*, "I feel certain that it would be pernicious to establish the rule that, in all cases of severe dysmenorrhea, or of serious nervous diseases of various kinds, apparently intimately connected with menstruation, the appendages should be removed"; but when it made the patients invalids, it was "a serious matter, but especially is it so in the case of a poor woman who is compelled to earn her living."³⁵ Garrigues in his *A Text-book of the Diseases of Women* agreed: "It is necessary to know something about the financial resources of the patient. In the poor recourse to more radical measures is often imperative, while those who possess adequate means may be benefited by a less vigorous but more protracted treatment."³⁶ Thus while physicians may have been reluctant to take the step of performing operations such as ovariectomies, in the case of working women they felt they had little choice.

However, the concern of physicians who were against such surgery was not the social class of the patients but the effects of the operations. Some argued that the result of enforced early menopause led to the physiological change taking longer to complete than normal, extending the time during which women would have to suffer from hot flashes, perspirations, skin tingling, nerves and gastro-intestinal disturbances.³⁷ When added to other symptoms believed to accompany menopause such as vertigo, fainting, cold hands and feet, constipation, loss of memory, irritability, fear, hysteria, etc., they did not foresee a bright future for the patient.³⁸ Indeed, the litany of menopausal symptoms reflects the low esteem in which physicians held menopausal women. Of special concern was the fear that an early menopause could lead to mental imbalance, that is, morbid brooding, low spirits, melancholy,

33. The Royal Victoria Hospital (Montreal) in 1901 admitted 2,579 patients. Of these 1,254 were non-paying, 904 were public ward patients paying fifty cents per day, and 421 were private ward patients. In the year 1900-01, the Montreal General Hospital admitted 2,823 patients: 2,057 free, 444 paying and 322 private. While the number of paying patients was significant compared to earlier decades, the vast majority of patients would be working-class who either were treated free or paid a minimum fee. Gynaecological surgery may have been performed only on middle-class patients, but until patient files are examined there is no way of determining this; and given the expressions of concern in the medical literature about working-class women, there is no reason to think that this would be the case. Royal Victoria Hospital (Montreal), *Annual Report*, 1901, p. 8. Montreal General Hospital, *Report of the Medical Superintendent*, 1900/01, p. 83.

34. *The Canada Medical Record*, 13 (November 1884): 27-28.

35. *Canadian Practitioner*, 12 (October 1887): 309.

36. GARRIGUES, *A Text-book*, p. 130. See also *Canadian Practitioner*, 9 (September 1884): 273; and Henry MACNAUGHTON-JONES, *Points of Practical Interest in Gyneacology* (London: Baillière, Lindall & Cox, 1901), pp. 69-70.

37. Charles PENROSE, *A Text-book of Diseases of Women* (Philadelphia, W.B. Saunders & Co., 1905), p. 52; *Canadian Practitioner*, 19 (July 1894): 493.

38. John BALDY, *An American Text-book of Gynaecology* (Philadelphia, W.B. Saunders & Co., 1894), p. 84.

suicidal impulses and even insanity.³⁹ *The Canada Lancet* felt that these symptoms could be a result of the nerve shock of the operation coupled with the emotional environment of the patient, especially her fear that she had somehow been unsexed.⁴⁰ Yet it is no wonder that some patients worried. The medical profession itself was not of one mind about this latter issue.

Batthey claimed that his operation left the patient with all her womanly graces and sexual desire intact.⁴¹ William Goodell in his text agreed with Batthey with respect to the womanly graces.

In all other sexual characteristics I have not found in these women any marked changes, either physical or psychic. Their affections seem to remain the same; their breasts do not flatten or wither up; they do not become obese; abnormal growths of hair do not appear on the face or on the body, and the tone of their voice and its quality are not changed. . . . If any change has taken place, it has been in the direction of old-maidhood.⁴²

Other physicians were not so sure. According to Dr. Thomas's *A Practical Treatise on the Diseases of Women*, "When the ovaries are removed from a fully matured woman her whole aspect changes. The breasts become flat, the features and voice masculine, and beard appears on the face."⁴³ Certainly some physicians linked the ovaries with women's distinguishing traits. When examining a woman with no vagina or uterus, Dr. Ogden, lecturer on midwifery and the diseases of women at the Toronto School of Medicine, speculated on the presence of ovaries: "From the well developed breasts, the state of the mons veneris, and the occasional experience of strong sexual desires, combined with the usual feminine voice and instincts, one would be inclined to think the ovaries were present *somewhere*."⁴⁴ Even Goodell, who did not think that removal of ovaries affected the physical look of women, recoiled from the operation when faced with one patient: "She was such a splendid specimen of female humanity that I shrank from mutilating her by the removal of the offending appendages."⁴⁵ In an attempt, perhaps, to wend his way through the morass of opinion, Dr. Penrose in an early twentieth century text argued in a way in keeping with modern medical views. Before puberty removal of the appendages would eliminate the development of secondary sex characteristics, whereas after puberty when all the feminine traits were present removal could have little effect.⁴⁶

Concern was also expressed about interference with female sexuality. While the medical profession recognized the existence of a strong sexual drive in women, its members differed as to the importance of that feeling. Goodell in his 1890 text argued that as the ovaries were not necessary for sexual feeling in women, removal of them would not eliminate it: "The seat of sexuality in woman has long been sought for, but in vain. . . . The seat has not been found, because sexuality is not a member or an organ, but a sense—a sense dependent on the sexual apparatus,

39. *Canadian Practitioner*, 19 (July 1894): 493.

40. *The Canada Lancet*, 26 (January 1894): 141-42; *Canadian Practitioner*, 19 (July 1894): 494.

41. *Canada Medical and Surgical Journal*, 10 (January 1882): 341.

42. *The Canada Lancet*, 26 (January 1894): 143.

43. THOMAS, *Practical Treatise*, p. 509.

44. *The Canada Lancet*, 3 (January 1871): 182, emphasis mine; Alexander SKENE, *Medical Gynecology, A Treatise on the Diseases of Women From the Standpoint of the Physician* (New York: D. Appleton & Co., 1895), p. 18.

45. *Canadian Practitioner*, 19 (July 1894): 497.

46. PENROSE, *A Text-book*, p. 52.

not for its being, but merely for its fruition." His proof was that women experienced sexual desire after menopause when the ovaries were not performing any function and that women had been known to masturbate before puberty, before the ovaries had come into operation.⁴⁷ However, he did not hold that view long.

In an 1894 article reprinted in the *Canadian Practitioner* and *The Canada Lancet*, this same physician argued that "castration" in a woman (referring to the removal of ovaries) was not analogous to castration in a man, but rather to menopause in a woman which meant that the sexual feeling would lessen and eventually deaden.⁴⁸ "My own experience would lead me to the conclusion that in the majority of women who have been castrated the sexual impulse soon abates in intensity, much sooner than after a natural menopause, and that in many cases it disappears."⁴⁹ He felt that this was all for the good since, if sexual feeling remained after menopause, women would not be able to obtain sexual satisfaction after the death of their husbands. It was as if menopause was nature's way of preparing women for eventual widowhood. However, the problem for many women undergoing ovariectomies was that they were still young and had their lives ahead of them, and Goodell recognized that "castration" could lead to domestic unhappiness.⁵⁰ Not all women would be able to emulate one of his patients who, although she found sexual intercourse painful after she had been castrated, "with true womanly devotion . . . has studiously kept her husband in ignorance of these facts."⁵¹ Thus it was not the removal of female sexuality per se that bothered Goodell, but rather the consequences of its removal for the marriage relationship. If that was not enough, Dr. James Ross, who lectured at the Woman's Medical College in Toronto, claimed removal of the ovaries would lead in some cases to an interference with a woman's intellectual capabilities. Unlike some, he did not feel it was important for a marriage whether a woman had sexual desire. For her husband, however, "It is very important that her companionship should be unimpaired by any loss of mental vigor."⁵²

Other physicians echoed Ross in playing down the importance of sexual feeling in women. They were more concerned about the interference with a woman's ability to give birth. Dr. Hingston of Montreal viewed the elimination of the childbearing abilities of women as "a crime against society" and interference "with the interests of the state."⁵³ The 1885 *Canadian Practitioner* criticized those who frowned on Battey's operation on the grounds that it lessened sexual desire. Women, the article maintained, were not creatures of lust but rather of procreation. The problem with the operation was not that it lessened sexual desire but that it left women without the ability to become mothers, and without that sex within marriage made them analogous to prostitutes. It went on to argue that an unmarried girl who had her ovaries removed had no right to enter into marriage.⁵⁴ Goodell agreed.

The majority of physicians and all laymen look upon women deprived of their ovaries as unsexed. Just as castration in the male, so castration in the female is deemed a sexual

47. GOODELL, *Lessons*, pp. 410-12.

48. *Canadian Practitioner*, 19 (July 1894): 494-95; *The Canada Lancet*, 26 (January 1894): 141-45.

49. *Ibid.*, 26 (January 1894): 143.

50. GOODELL, *Lessons*, p. 413; *Canadian Practitioner*, 19 (July 1894): 496.

51. *Ibid.*, 19 (July 1894): 495.

52. *Ibid.*, 15 (November 1890): 513.

53. *Ibid.*, 9 (September 1884): 272.

54. *Ibid.*, 10 (December 1885): 360.

mutilation to which common consent attaches a stigma. No woman would marry a eunuch, and few men would wed a woman deprived of her ovaries.⁵⁵

When one considers the importance the nineteenth century attached to motherhood as a woman's primary role, these views become more understandable. As Skene pointed out in his *Medical Gynecology*, woman's function was to be a wife and mother and if she lacked man's mental power she made up for it in that role.⁵⁶ Deprived of that role, little remained for her.

While much of the hostility towards the ovariectomies stemmed from physicians' concern for their patients, it was concern for women in their social roles and not for them as individuals. They feared the physical repercussions of the operation in that it brought with it the many uncomfortable symptoms that they believed often accompanied menopause. They were also worried about the effect that removal of the ovaries would have on a woman's sexual nature. Some feared it would lessen it and in doing so would remove a vital part of a woman's life and lead to marital strife. Others feared that without the possibility of conception a woman became functionless to the point that she should not marry. For these physicians, sex without the possibility of conception appeared immoral and associated with those considered to be the lowest stratum of society, prostitutes. Concern about female sexuality was not a concern for the individual pleasure of women but for their marital/procreative role.

Critics of ovariectomies were anxious not only about the effects of the operation on the patient, but also about what it meant for the practice of medicine. They believed that surgeons were not living up to their own expressed need for caution and were too desirous of practicing interventionist medicine. Such a criticism reflected the increasing surgical conservatism among some physicians which occurred in the late nineteenth century.⁵⁷ In the early 1880s this criticism may have reflected the relatively few ovariectomies that had been performed in Canada and the belief that the operation was still on trial. Certainly by 1884 this was the feeling of Dr. Temple, Professor of Obstetrics and Diseases of Women and Children at Trinity Medical College in Toronto, and of Dr. E.H. Trenholme, despite the fact that the latter physician had performed ovariectomies including Battey's variation.⁵⁸ The fact that even by the 1890s physicians were not agreed on the repercussions of the operation on female sexuality lent credence to the claim that caution was still needed. In addition, it appeared that medical knowledge about the function of the organ being removed was not established. In 1898 the *Dominion Medical Monthly and Ontario Medical Journal* claimed that "the advantage of conservatism does not lie merely

55. *Ibid.*, 19 (July 1894): 495-96.

56. SKENE, *Medical Gynecology*, p. 85; THOMAS, *A Practical Treatise*, p. 497; GOODELL, *Lessons*, p. 570.

57. Surgical conservatism refers to the nature of intervention and not the quantity. Surgical intervention was increasing greatly throughout the late nineteenth century; however, the nature of that intervention was coming under attack. Those espousing conservatism meant resorting to surgery *only* when all else failed and if surgery was undertaken, to mutilate the patient as little as possible. *Canadian Practitioner*, 19 (July 1894): 500; see also W. MITCHINSON, "Historical Attitudes Toward Women and Childbirth", *Atlantis*, 4 (Spring 1979): 31, and "Gynecological Operations on Insane Women: London, Ontario, 1895-1901", *Journal of Social History*, 15 (Spring 1982): 467-84.

58. *Canadian Practitioner*, 9 (December 1884): 364-65; *The Canada Medical Record*, 13 (November 1884): 25.

in the possibility of conception, but . . . it is *probable* that the ovaries, like the liver and thyroid gland, modify the blood circulating through them, and add to the blood some peculiar product of their metabolism."⁵⁹ As well there was confusion about the relationship of ovaries to menstruation.⁶⁰

Despite the lack of medical consensus on the repercussions of the operation on female sexuality and incomplete understanding of the purpose of the ovary, surgeons still seemed anxious—too anxious in the eyes of some critics—to operate. “A craze seems to have taken hold of the profession. The axiom seems to have become: ‘If a woman has indefinite pains or pelvic symptoms that you cannot account for, take out her ovaries.’”⁶¹ Of particular concern was the vagueness of surgeons about the symptoms indicating the necessity of operating. *The Canadian Practitioner* worried that in some cases surgeons “do not observe sufficient care in their discrimination of the cases which actually require this radical cure.”⁶² This was especially true of Battey’s ovariectomy. Battey himself by the latter part of the century felt that his operation was being performed too frequently, particularly in American insane asylums.⁶³ Certainly ovariectomies were resorted to for the cure of mental disorders and were supported for such purposes by doctors such as Battey, Goodell and Tait.⁶⁴ However, such surgery was open to abuse. Dr. Hingston of Montreal expressed his fear of this in *The Canadian Practitioner* of September 1884 arguing that the subjective symptoms of hysterics should not be trusted as indicators for operating.⁶⁵ Dr. Trenholme disagreed and argued that the removal of ovaries and tubes could prove of benefit in cases “where the activity of the sexual organisation dominates the mental powers, [and] may we not hope that the cessation of this controlling force will be followed by a calm and such a change in behaviour as the results of castration in the lower animals would lead us to expect.”⁶⁶ In fact he looked forward to such surgery after operating successfully on a woman with mania. “There is still much to be done in this line, and I am anxious to see what may be achieved in the way of castration of insane male subjects.”⁶⁷ While most were not willing to go that far, in gynaecological surgery on the female insane, Canadian physicians such as Ernest Hall in British Columbia and R.M. Bucke in Ontario led the field. Indeed, the work of the latter stirred up much controversy within the Ontario public asylum system and the medical journals of the late nineteenth century.⁶⁸

In addition to operating too frequently, and on non-consenting patients, i.e., the insane, gynaecological surgeons, according to their opponents, were too radical

59. *Dominion Medical Monthly and Ontario Medical Journal*, 11 (November 1898): 225, emphasis mine.

60. LONGO, “Rise and Fall”, p. 266.

61. *Canadian Practitioner*, 15 (November 1890): 513; *Canada Medical and Surgical Journal*, 13 (1885): 227; *Canadian Practitioner*, 12 (October 1887): 309; 19 (July 1894): 500; *The Canada Medical Record*, 16 (November 1887): 25.

62. *Canadian Practitioner*, 11 (October 1886): 322. In the final analysis the article believed the advantages outweighed the disadvantages.

63. LONGO, “Rise and Fall”, pp. 249, 263.

64. GOODSELL, *Lessons*, p. 413; *Canadian Practitioner*, 9 (September 1884): 273.

65. *Ibid.*, 9 (September 1884): 272.

66. *Canada Medical and Surgical Journal*, 13 (1885): 175.

67. *The Canada Medical Record*, 13 (November 1884): 26.

68. See MITCHINSON, “Gynecological Operations”, pp. 472-74, for a discussion of the criticisms of such surgery with respect to the asylum in London, Ontario.

in their approach. The *Canada Medical and Surgical Journal* noted that one physician recommended the removal of both ovaries even if only one was diseased, maintaining that the normal one would be predisposed to disease as well.⁶⁹ Even Battey acknowledged that he had erroneously referred to his operation as a normal ovariectomy. Soon after introducing it, he apparently decided that many of the ovaries which he had removed must have been diseased although not enough to interfere with ovulation. The change of perspective on Battey's part may have been a desire to offset criticism which the term "normal ovariectomy" was attracting.⁷⁰ Dr. Gardner, Professor of Gynaecology at McGill, vacillated between admitting that not all ovaries slightly enlarged and cystic would develop tumors, and not being sure.⁷¹ Dr. Ross, Gynaecologist to Toronto General Hospital and Surgeon to the Woman's Hospital, Toronto, argued the difficulties of diagnosing diseased ovaries and the tendency of many physicians to assume any apparent abnormality as the cause of disease when much of the perceived abnormality was in fact harmless.⁷² With reference to one patient operated on in November 1885, Dr. Adam Wright, Professor of Obstetrics, University of Toronto, admitted: "The left ovary was large, and, I think, more cystic than it should be, although, I must confess that I am frequently unable to draw the line between a diseased and normal ovary."⁷³ This lack of diagnostic ability provided support for those who questioned the extensive nature of the surgery and who felt that often gynaecological surgeons did not know what a normal woman should look like and seized on any abnormality as an excuse to operate. This uncertainty could only lead to unnecessary surgery. Supporters of a less interventionist approach argued that, owing to childbirth, many women had abnormalities in the pelvic area that were minor in nature but that once in the hands of "meddlesome gynecologists" they were convinced that an operation was necessary.⁷⁴

To counter the tendency to operate, opponents argued that in only a minority of cases of ovarian disease was surgery indicated. The "fatality of chronic diseases of the appendages is greatly overrated" and "far more women perish from the operation of removing the tubes and ovaries than from their diseases themselves."⁷⁵ They maintained that neurotic women often exaggerated their ovarian pain, so that pain should not be used as the only criterion for operating.⁷⁶ In this case, sympathy with the patient's distress was not a prime consideration. They insisted that non-surgical procedures often worked and that before any operation those procedures should be tried.⁷⁷ If they failed and removal of the ovaries was indicated, only one ovary should be removed or if both were diseased then if possible a healthy fragment

69. *Canada Medical and Surgical Journal*, 12 (1884): 26; 10 (1882): 340; *Manitoba and West Canada Lancet*, 6 (August 1898): 34.

70. *Canadian Practitioner*, 12 (October 1887): 308; *The Canada Lancet*, 8 (February 1876).

71. *Canada Medical and Surgical Journal*, 15 (1887): 143-44; 14 (1886): 214.

72. *Canadian Practitioner*, 15 (November 1890): 514.

73. *Ibid.*, 12 (October 1887): 308.

74. *Ibid.*, 23 (October 1898): 581; 19 (July 1894): 497; *Canada Medical and Surgical Journal*, 14 (1886): 716.

75. *Canadian Practitioner*, 19 (July 1894): 496; *The Canada Lancet*, 26 (January 1894): 143; *Canadian Practitioner*, 10 (December 1885): 361.

76. *Canada Medical and Surgical Journal*, 10 (January 1882): 342.

77. *The Canada Medical Record*, 16 (January 1888): 80; *Canadian Practitioner*, 19 (July 1894): 497; *The Canada Medical Record*, 16 (November 1887): 26; *Canadian Practitioner*, 10 (December 1885): 361; 12 (October 1887): 311.

be left.⁷⁸ As William Goodell put it, "Reform is here needed. . . . It signifies conservative gynecology, a golden mean between let-alone methods of the old school and the too hasty and too radical interference of the new school."⁷⁹

Some physicians even followed what today has become a feminist interpretation and argued that the fact that the patients were women encouraged the gynaecological surgeons to pursue their expertise.

The change of name from "testes muliebus" to "ovaria" or "ovaries" has hindered the conservative treatment of female pelvic disorders, for had the older name "testes" been retained operative surgery would not have gone so far, as the conservatism with which the male organs are treated would have been reflected upon the gynaecological field.⁸⁰

There was a definite feeling that these surgeons were somehow hostile to women and less caring of them than they would be of their male patients. Such a criticism also suggested that the speciality of gynaecology was somehow spurious and developed for reasons other than the physiological needs of women.

By the end of the nineteenth century a less interventionist movement within medicine was gaining strength, perhaps in reaction to the amount of medical intervention occurring not just in obstetrics or gynaecology but also in general surgery. Much of the criticism represented a difference in philosophy or approach to medical care. It also represented a desire to protect one's own area of expertise, for some of the criticism came from gynaecological surgeons themselves who worried about surgery being performed by those with little training. In 1893, *The Canada Medical Record* supported the idea of increased training for gynaecological surgeons and pointed out that too much surgery was being performed by inexperienced and unskilled practitioners.⁸¹ Supporters of this view wanted to protect their area of specialty from intruders and the best way of doing so was to emphasize the need for expertise.⁸²

Ironically, their criticisms joined those of doctors who disliked such specialization. Surgeons were becoming the new élite within the profession and as they expanded their territory they could not help but infringe on the preserve of other physicians. This led to an attack on the surgeons and on specialists in general. The non-specialist accused the gynaecologist of always finding something wrong with the women who came in to see him. As the *Canadian Practitioner* put it, "The danger of all specialism is to warp the judgment and contract the mental horizon within the range of its own narrow field of operation."⁸³ It was noted that surgeons were taking over the domain of the general practitioner. "The diseases of women are now treated by operations almost exclusively, and general practitioners, whose patients are pretty comfortable without such radical measures, must conclude that the uterus is made the scapegoat for the shortcomings of all other organs."⁸⁴

78. *Canadian Practitioner*, 19 (July 1894): 499-500; *Canada Medical and Surgical Journal*, 14 (1886): 716-18, 214; *Dominion Medical Monthly and Ontario Medical Journal*, 12 (June 1899): 280; 5 (December 1895): 674.

79. *Canadian Practitioner*, 19 (July 1894): 500.

80. *Dominion Medical Monthly and Ontario Medical Journal*, 11 (November 1898): 225.

81. *The Canada Medical Record*, 22 (October 1893): 18.

82. *Ibid.*, 16 (November 1887): 25; 19 (January 1891): 73.

83. *Canadian Practitioner*, 23 (October 1898): 579; *Canada Lancet*, 16 (August 1884): 384.

84. *Dominion Medical Monthly and Ontario Medical Journal*, 12 (June 1899): 280-81; *Canada Medical and Surgical Journal*, 15 (1887): 570-72.

The motives of the gynaecologist and the surgeon especially were being called into question. The gynaecologist was at times pictured as the newcomer, "a smart chap from all points of the term, slick at most things, and five times out of eight a money maker."⁸⁵ He is a man who soon learns that "the public loves the marvellous, and the intelligent patient pines for distinction as the heroine of an operation. . . . The admiring public accordingly seeks his office for advice about everything from a headache to a bunion."⁸⁶ These "pseudo-gynecologists may be considered in three classes: the fellows who repair lacerations, those who take out ovaries and those who take out everything."⁸⁷ The scenario for the future was of a specialty which would take over all others. No one would be immune from gynaecological surgery. As one general surgeon put it:

I see a vision in the future of the special organs belonging to the male in the ruthless and sacrilegious hands of the ubiquitous gynaecologist, who is continually like Alexander seeking new worlds to conquer. Then alas! will come the deluge, for testicles will be much easier to remove than ovaries.⁸⁸

The hostility was strong. After all, the general physicians were seeing their patients attracted elsewhere. Their livelihood was at stake. For these physicians it was not the ovariectomy per se that they were criticizing but its frequency and degree. In becoming accepted as a normal procedure, it helped epitomize the specialization of medicine and reminded many of what that could mean for their economic survival.

On both sides of the issue, access to patients was the common denominator. Specialists wanted exclusive control and expressed concern for patient safety in order to justify it. Non-specialists and those who believed in moderating the interventionist direction medicine was taking argued patient safety as well. Concern for the patient, however, had its limitations. It was restricted by the social roles acceptable to the society of the time. It left little room for the acceptance of women as functioning sexual beings in their own right, but rather focused on them as beings whose sexuality existed for a social purpose—motherhood.

The debate over ovariectomy which occurred in late nineteenth-century medicine and which was engaged in by Canadian practitioners reveals a dynamic and internally contentious profession. The concern over the frequency of surgery reflects important changes which had occurred in medicine such as the emergence of gynaecology as an important medical specialty and the strides medicine had been able to make as a result of anaesthesia and particularly of antisepsis. The latter increased the safety of operating and consequently the frequency of surgery, gynaecological surgery joining the increasing list of medical specialties. As surgeons became more technically competent and surgery more frequent, a debate developed around the consequences of the operation, its frequency and its degree. The discussion of consequences exposes opinions on female sexuality, a topic seldom addressed in the late Victorian period in Canada. It reveals a recognition of female sexuality, not for the pleasure it could provide the individual woman but rather for its relationship to her primary social role—maternity. The controversy concerning ovariectomies also reveals that they were not limited to middle-class women as previous historians have suggested.

85. *Maritime Medical News*, 10 (October 1898): 337; *Canada Lancet*, 16 (August 1884): 384.

86. *Dominion Medical Monthly and Ontario Medical Journal*, 12 (June 1899): 278.

87. *Ibid.*, p. 279.

88. *Canada Medical and Surgical Journal*, 15 (1887): 570.

Working-class women by the demands of their economic position were in fact a focus of attention. In addition, the opinions expressed about the surgery's frequency and its radicalism reflects a medical division between specialists and others whom they considered incompetent to participate in their area of expertise. The "incompetents" responded in turn and exposed the problems of specialization within medicine and how it narrowed the focus of physicians to the detriment of patients and non-specialists alike. On both sides of the question, access to patients was a major concern. The controversy over the ovariectomy, then, was one of means, not goals.