

## A Historical Look into Women in Medicine (1890-1930)

In the early decades of the 20th century, female physicians were at the forefront of preventative medicine, particularly in the form of public health initiatives. These efforts were often focused in the crowded environments of urban immigrant communities where infant mortality rates were especially high and outbreaks of infectious diseases such as typhoid were an all-too-common occurrence. Prominent figures such as Dr. Josephine Baker also advocated that physicians actively educate their patients, especially women, about hygiene, infant care, and the prevention of venereal diseases.

In contrast, many male physicians of the era showed little interest in larger-scale preventative medicine, as medical school training focused more on diagnosis and acute care within particular specialties. The prestige of medicine as a profession came from emphasis on cure, not on prevention. In 1909, Rosalie Slaughter Nelson, a New York surgeon and active member of the AMA, commented that she thought it “odd” that “men physicians were just waking up to preventative medicine, while women doctors had for fifty years been stressing the importance of educating mothers in the care of children’s health, in pre-natal care of mothers, etc.” (Morantz-Sanchez 284)

Thus the role of female physicians increasingly became that of patient advocate. As medical schools were being reformed during these years (1900-1920), they also became stricter in their admissions and more advanced in their training. (See table below.) Many physicians (male and female alike) expressed regret that this new emphasis on academic proficiency in “scientific medicine” tended to ignore the humanity of actual patients.

Regina Morantz-Sanchez, a scholar of the history of women in medicine has chronicled these matters extensively in her book, *Sympathy & Science: Women Physicians in American Medicine*, from which a few especially relevant passages might be useful:

The president of the Alumnae Association of the Woman's Medical College of Pennsylvania spoke in defense of the general practitioner in 1901 even as she acknowledged that specialism was the wave of the future. Warning that the phrase "the healing art" should never be spoken of slightly "as though it represented an old-fashioned idea," she worried that “training too exclusively for the laboratory fails by leaving out the human element.” (Morantz-Sanchez 238-39)

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Similarly, M. Esther Harding, a psychiatrist, spoke in 1930 for many women doctors when she wrote to Bertha Van Hoosen, a prominent female surgeon and the founder of the American Medical Women's Association,

“I have been struck recently more than once at the meetings of a Psychotherapeutic Society of which I am a member with a queer little difference between the attitude and approach of the men and the women... to the subject under discussion... Usually the men lead off with scientifically arranged data, followed by statistics and rather abstract

theory. Then presently a woman speaks up and nearly always her voice is raised to remind the group that after all the patient is a human being and not merely the subject of certain symptoms or mechanisms. And this I think is characteristic. We women are more nearly concerned with the human problem presented to us and relatively less absorbed with the collection and classification of scientific material. Let us who write about the intricacies of the human psyche, whether in its normal functioning or in its illnesses and conflicts, remember always that in any final analysis it is the human being that matters. Knowledge of disease and its detailed investigation are not ends in themselves, they are only means to an end, namely that the human being may grow and flourish.”

In agreement with Harding, both Josephine Baker and Emily Dunning Barringer expressed concern that their profession was becoming “less human,” and decried the modern emphasis on “specialism.” (Morantz-Sanchez 239)

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TABLE 9-3 Regular Schools, Male-Female Enrollments, 1890-1928

Year	Women Students	Rate of Change	Men Students	Rate of Change	Proportion Women
1890	648	(+37%)	12,873	(+38%)	4.8%
1895	889	(+20%)	17,771	(+14%)	4.8%
1899	1063	(-21%)	20,338	(+14%)	5%
1905	835	(-31%)	23,177	(-16%)	3.5%
1910	573	(-8%)	19,410	(-21%)	2.9%
1913	526	(NC)	15,393	(-26%)	3.3%
1918	533	(+87%)	11,349	(+38%)	4.5%
1923	995	(-8%)	15,642	(+20%)	6.0%
1928	912	(+16%)	18,734	(+14%)	4.6%

Sources: Records of the Commissioner of Education 1892-1893, 1894-1895, 1904-1905, 1910-1911; *JAMA* “Educational Numbers,” 1913, 1918, 1923, 1928

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In 1915 Dr. William Park, both dean of the New York University Medical School and laboratory director for the New York Department of Health, invited [Josephine] Baker to lecture on child hygiene for a recently developed course leading to the new degree of Doctor of Public Health. Realizing that she did not have an actual degree in the field of public health and would soon be hiring male Doctors of Public Health in her own Department of Child Hygiene, Baker offered to teach in return for the right to earn the diploma herself. Park demurred, arguing that the medical school did not admit women. Baker responded by refusing the appointment, later commenting, "I can hardly be accused of acting unreasonably because I declined to act as teacher in an institution that considered me unfit for instruction." For a year Park searched for an instructor he felt could equal Baker. In the end, the school conceded defeat, admitting Baker to its public health course

and opening it to other women as well, all in order to gain her services on the faculty. Although Baker taught at NYU for fifteen years thereafter, every lecture she gave was greeted by hostile clapping from the male students because she was a woman. (Morantz-Sanchez 313)

## Internal Medicine

During these same decades, the role of internal medicine was being continually redefined. Reforms in medical education, the emergence of professional organizations such as the American College of Physicians, and the ongoing development of subspecialties all influenced the understanding of what it meant to be an internist. The main difficulty in establishing a coherent and commonly agreed-upon definition arose between two tendencies. On the one hand, many internists sought to establish internal medicine as a distinct specialty. The place where they thought it most need to be established was, of course, in medical schools, which were becoming increasingly rigorous. Some internists felt there was a risk that internal medicine would come to be considered nothing more than whatever was left after all the specialties had claimed their territory of expertise.

The difficulty in defining internal medicine as a specialty arose in part from the emphasis of influential figures such as William Osler—who himself advocated in 1895 that “able young men” be trained in “internal medicine as a specialty”—on the unique role that could be played by the internist as a *generalist*. The general internist, however, was to be distinguished from the general practitioner, since the former had received advanced training. Nonetheless, the idea of a generalist-specialist remained a paradox for many.

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By 1925 College [i.e. American College of Physicians] membership was almost 1,000, but leaders of the profession and heads of university departments were conspicuous in their absence. There was an obvious tension, still largely unexamined, between two competing concepts of internal medicine: *that of a consulting body whose stature was so far above the mass that its excellence needed no further organizational definition, and that of a specialty of internal medicine whose needs were not unlike those of surgeons, seeking recognition for their skills in the marketplace.* (Stevens 346, emphasis mine)

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## Connections

Rosemary Stevens’ article, particularly the opening sections, covers this struggle of definition in great detail. Her main thesis is that the idea of the internist as a “super generalist” was hammered out alternately between the university setting of academic medicine in the 1900s and 1910s and then, in the 1920s and 1930s in the setting of actual practice. Internal medicine thereby gradually became a “practice specialty,” though the

irony is that it was the establishment of internal medicine as a specialty in medical schools that allowed it to gradually become less an academic discipline and more a practitioners' specialty. Stevens also argues that as specialties increased in their influence within medicine, the need arose for physicians who could advocate for patients from the primary care setting onward and help them navigate their way through all the specialists. Internists, especially primary care general internists, she argues, were able to fill this role.

The development of internal medicine during the early part of the 20th century parallels the story of female physicians in a few ways.

1. Female physicians during these years were especially focused on primary care issues and dealt with patients most often as general practitioners. Likewise, internal medicine gained much of its stature as a discipline during these years through its generalist emphasis and its applicability to primary care.
2. The roles of female physicians and internists alike were defined in large part through their struggles to find a place within medical schools, which were becoming increasingly influential. It must be said, of course, that internal medicine had an easier time of it.
3. Female physicians in these decades recognized and met the need for patient-centered medicine, the benefits of which the profession as a whole was slow to recognize. Similarly, internal medicine was able to fulfill the need for training physicians at an advanced level on primary care issues.

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Morantz-Sanchez, Regina. *Sympathy & Science: Women Physicians in American Medicine*. Chapel Hill: University of North Carolina Press, 1985.

Stevens, Rosemary. "The Curious Career of Internal Medicine: Functional Ambivalence, Social Success." *Grand Rounds: One Hundred Years of Internal Medicine*. Eds. Russell C. Maulitz and Diana E. Long. Philadelphia: University of Pennsylvania Press, 1988. 339-64.

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