



# THE OSLER LIBRARY NEWSLETTER

NUMBER 138 · SUMMER 2023

Osler Library of the History of Medicine, McGill University, Montréal (Québec) Canada

## “Exceptional Women”: The Female Doctors Missing from André Brouillet’s *A Clinical Lesson at the Salpêtrière*



Fig. 1 André Brouillet, *Une leçon clinique à la Salpêtrière*, 1887. Paris Descartes University. Available at: [https://commons.wikimedia.org/wiki/File:Une\\_leçon\\_clinique\\_à\\_la\\_Salpêtrière.jpg](https://commons.wikimedia.org/wiki/File:Une_leçon_clinique_à_la_Salpêtrière.jpg)

By **Adrienne Neufeld**, McGill BA 2023

At the height of first-wave feminism in the 1880s, hysteria was no longer considered the result of a wandering womb, but it nonetheless gained a renewed interest among male doctors

and anti-feminists. Called the ‘father of modern neurology,’ Jean-Martin Charcot is best known for his work on hysteria at the Pitié-Salpêtrière Hospital in Paris. Charcot’s impact on the history of hysteria and medical education is memorialized in André Brouillet’s 1887 painting, *A Clinical Lesson at the Salpêtrière* (Figure 1). Depicting one of Charcot’s weekly lectures, the dichotomy between the male audience and female patient reinforces the historically patriarchal position of male doctors. In the first paragraph of his book on *A Clinical Lesson*, Olivier Walusinski states that the notable omission from the painting is Sigmund Freud, who had studied with Charcot the previous year (Walusinski 2021, 3), but I would argue that the more significant – but perhaps less famous – absences are the female doctors who worked and studied at the Salpêtrière.

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A project we are currently working on at the Osler Library is the cataloguing of the Osler Library's Paris Medical Theses Collection, consisting of over thirty thousand graduate theses from the Faculté de médecine de Paris between 1796 and 1920. I have spent hundreds of hours flipping through 200-year-old books, entering titles and authors into a spreadsheet of over 20,000 rows. Some of the theses have illustrations or diagrams and I like to take photos of the most interesting ones. This 1879 illustration (Figure 2) of a woman with her back arched in a hysteric episode was one that caught my attention (Richer 1879). Since finding that the first thesis written by a female graduate was in 1870, it is always a noteworthy occasion to see a woman represented in the theses (Garret 1870). The introduction of female students into the Faculté's population was very gradual so I have made sure to note the female authors when they show up. In 1888, Caroline Schultze wrote her thesis on "La femme-médecin au XIXe siècle," detailing the early years of women at the Faculté, with a list of every female graduate up to that point (Schultze 1888).

Of the thousands of names in the Paris Theses, the majority have been lost to history. For most, their only mention on the internet is a stub article on French Wikipedia. The length of someone's Wikipedia article is usually a good indicator of how well they are remembered in medical history. Less than one in fifty graduates might have a Wikipedia article and a fraction of those have more than just their thesis in our library. Among the female graduates, however, there is a much higher proportion of names with a digital footprint. Following the example of Caroline Schultze, many publications and databases list the names of all the female graduates (Fontanges 1901, Moulinier 2013) and many of the women have Wikipedia pages detailing their professional accomplishments. Although women were first admitted to the Faculté de médecine in 1866, they struggled for decades to be allowed the same professional opportunities as the men. Many women, like Inès Gaches-Sarraute and Anna Kingsford, are remembered for their medical work, while others are best known for their work in furthering women's access to education. At a time when a woman's ability to practice medicine was still under great debate, any woman who succeeded in medical school, despite all the challenges, would have to be much more exceptional – more inclined to exceed expectations – than her male colleagues, and thus more likely to leave a mark on history.

Among the male students, a few recognizable names can be found amidst the thousands. They include René Laennec (1804), the inventor of the stethoscope, and Georges Gilles

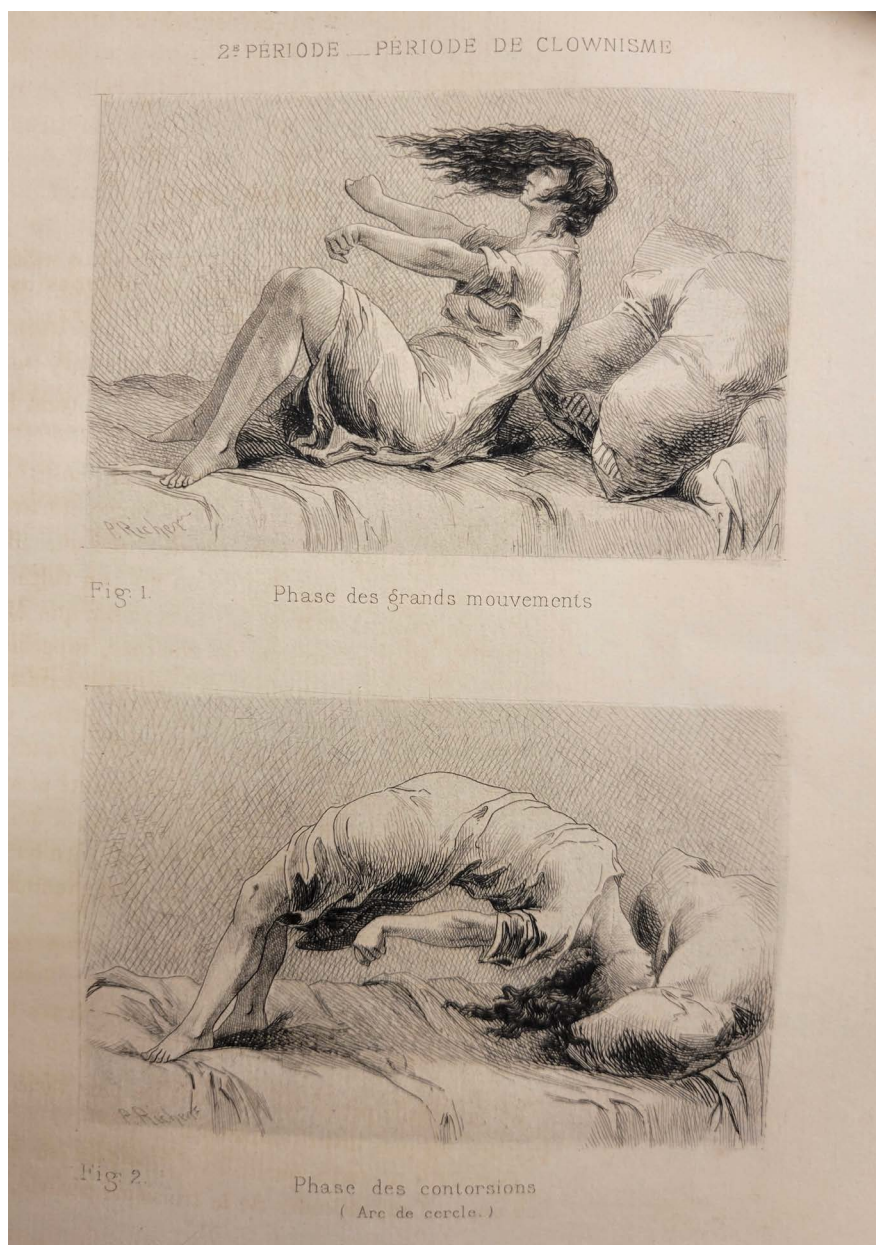


Fig. 2. Sketches of a woman in a hysteric episode. Paul Richer, 1879.

de la Tourette (1885), the namesake of Tourette's syndrome. When looking into Gilles de la Tourette's life story, I saw that he was depicted in André Brouillet's *A Clinical Lesson* at the Salpêtrière two years after his thesis. I had encountered the painting before in a lecture on hysteria, Wikipedia lauding it as one of the most famous paintings in the history of medicine. It turns out that, apart from Gilles de la Tourette, fifteen other doctors and students in the painting are also included in our theses collection. The Pitié-Salpêtrière, where the painting takes place, was a teaching hospital where many students of the Faculté de médecine interned and studied. The 9-foot painting currently hangs beside the entrance to the Museum of the History of Medicine in Paris for all visitors to see and remember its subjects.

Under Jean-Martin Charcot's leadership in the 1870s and 1880s, the Salpêtrière gained a reputation as one of the leading clinics

of neuropsychiatry (Didi-Huberman 2003). As a professor for the Faculté de médecine, Charcot held weekly lectures and demonstrations, but these were not only attended by his students. Rather than purely academic lessons, the presentations were usually centered around a patient's dramatic hysterical episode, a spectacle which drew in high-society actresses, writers and artists. The hystero-epileptic attack would be induced through hypnosis in order to demonstrate its violent movements, which culminated in the arc-en-cercle position (Showalter 1993, 308). In Brouillet's painting, Marie "Blanche" Wittman, one of Charcot's favourite patients, arches her back, mirroring the drawing on the back wall (Gilman 1993, 346). This drawing is the work of Paul Richer, a medical artist who can be seen on Charcot's right with his pencil poised to capture the patient's throes. The drawing of a patient performing an arc-en-cercle is coincidentally the same one that I had noticed months earlier in the thesis of none other than Paul Richer. Based on one of the many photos taken at the Salpêtrière, the drawing reflects the importance of visual culture in the history of hysteria. Charcot and his coterie used photography extensively in their work, to record the patients' behaviour but also to promote the spectacle of hysteria (Hunter, 2016).

Many of the photos they took are compiled in *Iconographie photographique de la Salpêtrière*, where images of female patients are labeled as examples of "Érotisme", "Extase" and "Supplication Amoureuse" (Figure 3) (Bourneville 1878). While Charcot combatted expectation by diagnosing hysteria in men as well, the majority of his patients were women (Micale 1985, 710) and his understanding of hysteria was based around sexual themes. Many of the female patients had experienced sexual trauma and Elaine Showalter refers to Charcot's practice of alleviating the symptoms of the hypnotically triggered episodes by pressing on the ovaries and "hysterogenic points" as a "symbolic rape" (Showalter 1993, 312). Through both the photography and public demonstrations, Charcot and his colleagues captured some of their patients' most vulnerable moments. In Brouillet's painting, Blanche's intimate state of undress is exposed not only to the crowd of medical students but also to the implied viewers of the painting. At the time, Charcot's motives were already being condemned by critics and doctors. Feminist journalist Céline Renooz called his experiments a "human vivisection of women" as he knew neither the cause nor treatment for hysteria (Renooz 1888, 245). Although many diseases had significant etiological revelations in the 1870s and 1880s, hysteria could only ever be defined by its observed symptoms (Micale 1993, 503). Years before Freud's talk-therapy, doctors at the Salpêtrière were not so much interested in the mental factors that contributed to the condition as in inciting the most dramatic symptoms to show during their demonstrations (Showalter 1993, 312).

In the decades after Charcot's death in 1893, hysteria diagnoses rapidly declined throughout Europe. Nowadays, hysteria is no longer a recognized medical condition and its symptoms have been absorbed into other diagnoses, such as epilepsy, anxiety and bipolar disorder (Micale 1993). The perceived prevalence of hysteria in the late 19th century coincided with feminists campaigning for the vote and the right to higher education. Many of Charcot's fellow neurologists noted that hysteria was especially common among more "independent and assertive" women (Showalter 1985, 145), the same kind of women who might dare to practice medicine. Nervous disorders were thought to emerge when women "defied their 'nature'" by engaging in intellectual competition with men (Showalter 1993, 297).

**“ Charcot surmised that female doctors would never be more than an exception in medicine, only fit to care for women and children.**

The argument of women's sensitive nature was also used by Charcot to dismiss the idea of female doctors (Pigeard-Micault 2007). While on the jury of Caroline Schultze's thesis presentation, Charcot rejected her conclusion that women would soon practice equally alongside men in the world of medicine. Although he complimented her beauty and the eloquence demonstrated in her argument, Charcot also admitted that he had not deigned to read her thesis (*Scientific American* 1889). Céline Renooz wrote that Charcot continued with jokes "de mauvais goût" that were more suited for a café-concert (Renooz 1888, 246). Charcot surmised that female doctors would never be more than an exception in medicine, only fit to care for women and children. Historians like to point out Hélène Sosnowska as a female doctor with whom Charcot worked directly, but her thesis specifically focuses on hysteria in children (Goldspiegel 1888; Goldstein 1987; Showalter 1993, 313). She worked at the Salpêtrière in 1887, the year that Brouillet painted *A Clinical Lesson*, yet both she and Schultze are conspicuously missing from the all-male audience. At Schultze's thesis presentation, Charcot said that women should resign themselves to practicing medicine in the country where they will be easily forgotten and leave the glory of city practice to the men (Renooz 1888, 243). The exclusion of these women from the painting is just one more attempt to erase their memory from the history of medicine.

In 1885, Charcot did however add his name to a petition advocating for female students to be able to intern in hospitals (Micale 1985, 710). Internships and externships were mandatory for students of the Faculté de médecine, yet until 1881, women were barred from both. Madeleine Brès, the first French female student, was prevented from applying for an externship in 1871. Although externships were ostensibly permitted as of 1881, Blanche Edwards-Pilliet's



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application in 1882 was opposed by a petition signed by 90 male students. Forced to violate rules that applied to the male students, the female students were also denied the professional experience of working in the hospitals (Schultze 1888, 22). After a successful counter-petition signed by students and professors, including Charcot, Edwards-Pilliet became the first female extern in Paris.

The second female extern was Augusta Déjerine-Klumpke, who externed at the Salpêtrière and attended many of Charcot's lectures (Poirier 2019). Her husband, Joseph-Jules Déjerine, was professor of neurology at the Faculté de médecine and senior doctor at the Salpêtrière. In addition to co-authoring studies with her husband, Déjerine-Klumpke published several scientific articles of her own, even giving her name to Klumpke paralysis. After Charcot's death, Joseph-Jules Déjerine succeeded him as the chair of neurology but faced opposition from within the hospital. In 1892, he provoked a duel with rival doctor, Pierre Marie. When Marie was appointed head chair after Déjerine's death, he swiftly evicted Déjerine-Klumpke from the hospital, allowing her only two weeks to remove everything from Déjerine's office. Pierre Marie sits two chairs away from Richer in Brouillet's painting, yet Déjerine-Klumpke and her husband are excluded.

While ‘Charcot's hysteria’ and ‘female doctors in Paris’ are popular topics for historians, there is very little academic scholarship on the overlap between the two. Olivier Walunsinski's book *Une leçon clinique à la Salpêtrière* contains a chapter for each subject of Brouillet's painting, but there is no mention of the female doctors who were left out. Histories of women's emergence into the medical profession in France often mention Charcot's denunciation of Caroline Schultze's thesis, but they fail to connect it to his treatment of his patients. The women who became doctors in the 19th century were in many ways the same women being diagnosed with hysteria; the ones who spoke out against the patriarchy, who sought to better themselves ‘above their station.’ Some were fortunate, managing to pursue higher education and become practicing doctors, and they are remembered for their accomplishments. Others were detained in mental hospitals, remembered only as the exploited victims of doctors such as Charcot, if at all. Although female doctors may have been an exception in the 19th century, Schultze's hypothesis became fact: women practice medicine in equal numbers to men today. *A Clinical Lesson* depicts 19th century medicine as male-dominated, but it ignores the struggles that women faced and



Fig. 3. Charcot's depiction of hysteria drew upon sexual themes.

overcame to become doctors. The women of that time did not let themselves be easily forgotten, as Charcot suggested, and it is precisely because of their exceptionality that they are remembered.

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# Dosage, Distillation And Deodorants:

## An enigmatic Italian manuscript of the mid-16<sup>th</sup> century

Faith Wallis, Prof. Emerita, Dept. of History and Classical Studies/Dept. of Social Studies of Medicine

In 2021 the Osler Library of the History of Medicine at McGill University purchased a 16th century manuscript from Christie, Manson and Woods.<sup>1</sup> At first glance, this volume looks like a notebook of recipes, and indeed, that is how the dealer described it. But when examined more closely, a rather complicated story begins to emerge – a story about medical alchemy, cures and cosmetics, the Elixir of Life, and what looks like a rather shameless act of plagiarism. And the identity of the compiler and owner is profoundly mysterious.

The volume measures 22 x 15 cm. (8.25 x 6 in.) and now contains 84 paper folios. Originally there were additional gatherings at the back, amounting to about 37 leaves, which have been excised. Whether these leaves also included text is uncertain. Certainly the volume was bound after the surviving gatherings were written, because there are marginalia trapped by the tight contemporary binding. It is written in a single Italic hand throughout, with a few minor additions in other hands of the 16<sup>th</sup> century. There is no title, and no indication of authorship or ownership. Whether the person who wrote the texts also compiled or even composed the material cannot be determined, so I will refer to this individual simply as “the Writer”. The text is largely in Latin, with some Italian passages, and can be dated to after 1554 on the basis of an account of how the Writer cured a patient of anal fistula in 1553, which he identifies as “last year” (*anno preterito*: fol. 71v).

The first part (fols. 1r-30r) is a treatise addressed to students on the subject of pharmaceutical dosage. In fact it is largely copied from Matteo Corti’s *On dosages* (*De dosibus*), first printed in Venice in 1562.<sup>2</sup> Corti, who died in 1542 or 1544, was Professor of Medicine at Bologna. His *On dosages* covers syrups and purgatives (subdivided by the humoral disorder for which they are administered), as well as other types of medications classed by form, e.g. pills, electuaries and so on. However, Corti is never credited as the source. Furthermore, his text has been significantly altered by re-arrangement, abbreviation, omissions

and expansions. The additions and deletions are sometimes subtle, and at other times radically change the text. Our Writer also “improves” Corti by re-arranging his tables into a more consistent head-to-belly order, and tops off his appropriation by adding several supplementary chapters, all imitating Corti’s style. To put it baldly, this text looks for all the world like a bold-faced theft of Corti’s work to serve as the unacknowledged substrate of a new book.

The Writer certainly saw this text as part of the whole manuscript volume, for there is a cross-reference in a recipe for treating colic on fol. 60r to the folios containing the section on enemas adapted from Corti on fol. 21r-23v: “see above concerning the dosage of enemas on folios 21 and 22” (*uide superius de dosi enematum cartibus* 21e<t> 22). But I would draw your attention to a chapter on decoctions which the Writer intrudes into Corti’s text.

To be sure, much could be said here about decoctions because they are continually used in our times. But because I said above that I wished to be brief, I will only state here that there is a great difference between decoctions and distilled waters. Distilled waters are of no, or little, use in medicines. I am not talking about the quintessence, but only of simple distillates in use, and particularly because they are all distilled using lead vessels, whose use in the opinion of experts is so harmful, and I will set these aside for now. Therefore it will rarely happen that you will incorporate these distilled waters into your prescriptions without some decoction, like some practitioners who always tried to spurn the truth of things because of their depraved nature... (fol. 19r-v).

That the Writer so forcefully distances himself from distillation is curious. The “genuine” *On dosages* never mentions distillation. However, Corti frequently complains about the state of modern medicine, so this intrusion at least is made to sound like Corti. Its apparent rejection of distillation is all the more puzzling because the second part of our manuscript opens with some spectacular examples of the wonderful cures that alchemical techniques like distillation can produce.

This second part of the manuscript (fols. 33r-84v) is the collection of recipes. It opens with instructions for preparing an Elixir of Life or *Aqua mirabilis*, followed by some compounds for healing wounds in an exceptionally short time, and a recipe

<sup>1</sup> This manuscript purchase was supported by funds donated by the Department of Social Studies of Medicine of McGill University, to mark the retirement of Prof. Faith Wallis. It has been digitized, and can be viewed at [https://archive.org/details/McGillLibrary-osl\\_in-christi-ni-ami-cupres-junib\\_WZ240IN361550-21429/mode/2up](https://archive.org/details/McGillLibrary-osl_in-christi-ni-ami-cupres-junib_WZ240IN361550-21429/mode/2up)

<sup>2</sup> Mattheus Curtius (Mateo Corti), *De dosibus*, in *Tractationes medicinales Tyronibus Medicis per quam utiles...* (Venice: Apud Vincentium Valgrisium, 1562).



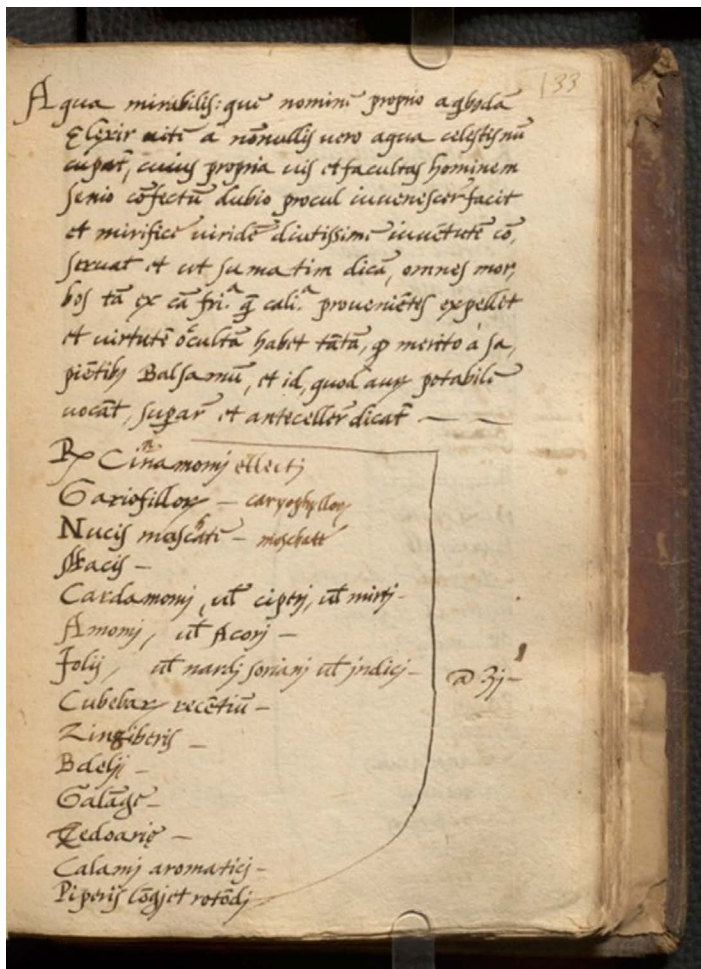


Fig. 1. Beginning of the recipe for the Elixir of Life (fol. 33r).

for Caravita's Oil, a famous universal antidote against poison and remedy for plague. The collection then devolves into shorter and more mundane recipes for problems like toothache, joint pain, and miscarriage, but there is also a recipe for "synthetic" camphor, and a test for determining whether camphor is genuine or artificial. Following a treatment for gout come several for the French Disease (syphilis), all made with guaiac wood imported from the Caribbean. The last part of the collection is devoted to "cosmetics", including deodorants, but also recipes for potable gold, and two non-medical recipes for gilding ostrich feathers and cleaning paintings on wood or canvas.

In the span of this short article, I can only focus on a handful of recipes that hint at a context for this enigmatic manuscript. The first of these, is the Elixir of Life (fols. 33r-35r).

A marvelous water which some call by its proper name Elixir of Life, and others Heavenly Water, whose innate potency and quality will rejuvenate a man stricken with age, and in a miraculous fashion will preserve one in the flush of youth for a very long time, and if I may sum it up, it expels all ailments stemming either from a cold cause or from a hot one, and has such great occult virtue that it is rightly called Balsam by the wise, who say that it surpasses and exceeds potable gold (fol. 33r, see figure 1).

The recipe involves a multi-stage distillation of no less than 77 ingredients, which are mixed with honey, sugar and spirits of wine and distilled in an alembic. To the resulting distillate are added balsam wood, aloes, sandalwood, pearls, white and red roses, amber and musk. These are distilled again. "Then (says our author) <the elixir> will be 'spirited' because all the phlegm extracted from the herbs will be consumed by this second distillation. What remains is spiritual, or rather, Divine potency. From the dregs one can confect many things, for when distilled through ashes one can make from them an oil which the wise call 'balsam', which expels cold diseases. It makes another water whose property is to beautify the face of women and yet another six hundred <applications> which are well known to, and studied by, the wise (fol. 35r)."

Elixirs like this one were extraordinarily popular in Renaissance Italy. The ingredients and structure of our recipe recall three similar recipes in the *Tested Remedies (Experimenti)* of Countess Catarina Sforza of Forlì (1463-1509), composed at least half a century before our manuscript. The third of these recipes is the closest to our *aqua mirabile*: Caterina says we may call this "water of youth" and "water of life" because it will rejuvenate and even resurrect a patient whom physicians have abandoned as incurable. The ingredients match those in the Osler recipe (though they are fewer in number). So are the instructions to pulverize, mix with *aqua vitae* and distill multiple times (five in Caterina's case). Another echo is Caterina's comment that this water can be used to cleanse and beautify the complexion. It is called *aqua celestis* and "balsam" and is "a better secret than the philosopher's stone."<sup>3</sup>

Caterina Sforza's grandson, Grand Duke Cosimo I of Florence, inherited her manuscript book of *Experimenti*, and in 1561 Cosimo's son Francesco I de' Medici (1541-1587) sent to Don Pedro de Luna in Sicily recipes for an elixir of life. Accompanying this recipe was another one, for an antidote against poison in the form of an oil, to which we will return in a moment.<sup>4</sup> Interestingly, the elixir recipe in the Osler manuscript is followed almost immediately by a recipe for a very famous anti-poison oil: Caravita's Oil.

Caravita's Oil was the focus of one of the first recorded experiments to test an antidote for poison on a human subject.<sup>5</sup> In August 1524, the surgeon Gregorio Caravita of Bologna offered this universal antidote for poison to Pope Clement VII (born Giulio de' Medici). Caravita claimed that had been used to good effect on plague patients during the outbreak of 1523.

<sup>3</sup> Catarina Sforza, *Experimenti*, ed. Pier Desidero Pasolini in *Caterina Sforza. Vol. III. Documenti* (Rome: Ermanno Loescher, 1893), 639-41. See also Meredith K. Ray, *Daughters of Alchemy. Women and Scientific Culture in Early Modern Italy* (Cambridge MA and London: Harvard University Press, 2015), ch. 1.

<sup>4</sup> Ed. with French trans. by Rodrigo de Zayas, [Stefano Rosselli], *Mes secrets: A Florence au temps des Medicis, 1593: patisserie, parfumerie, médecine* (Paris: J.M. Place, 1996), 212-3 and 117-8; English translation by Jo Wheeler, *Renaissance Secrets, Recipes and Formulas* (London: Victoria and Albert Museum, 2009) pp. 76-77.

<sup>5</sup> Alisha Rankin, *The Poison Trials. Wonder Drugs, Experiment and the Battle for Authority in Renaissance Science* (Chicago: University of Chicago Press, 2021), introduction and ch. 2.

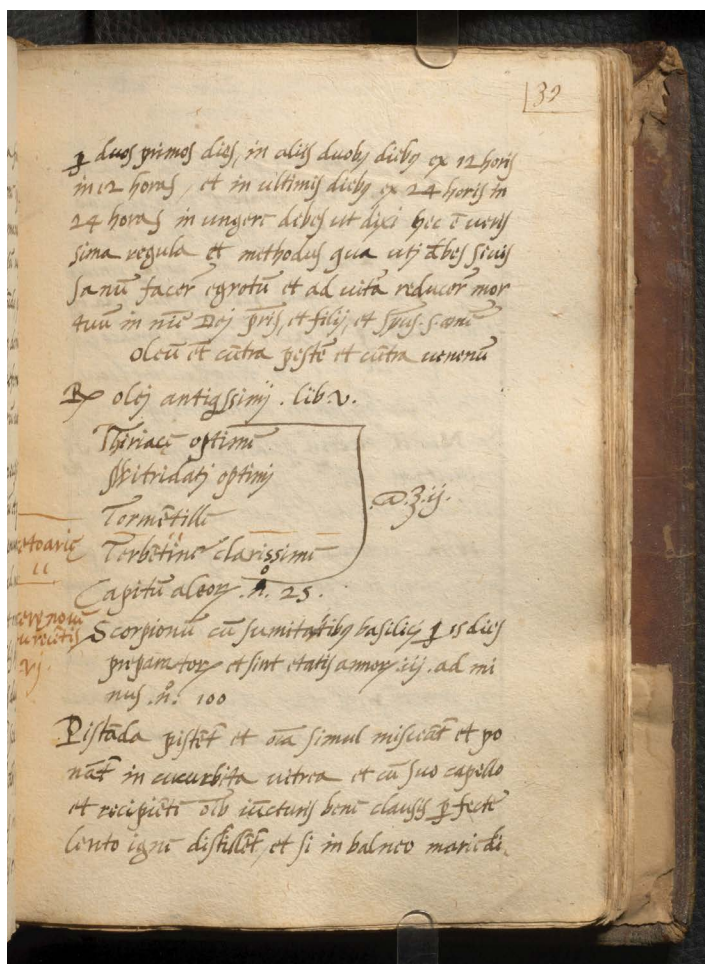


Fig. 2. Fol. 39r, showing part of the recipe for Caravita's Oil.

The Pope ordered it to be tested on two condemned criminals, Corsican highwaymen; both were administered poison, but only one was anointed with the antidote, and he survived. One of the witnesses of the test was Pier Andrea Mattioli (1601-77) who was studying under Caravita at the time. He later described the trial in his translation of and commentary on Dioscorides, first published in Italian in 1544, with multiple Latin and vernacular editions thereafter. Not long after the trial of Caravita's oil, Pope Clement himself lent his name to an antidote oil called the "Oleum Clementis" or "Clement's Oil."

The Osler Library manuscript is one of only two witnesses containing a recipe explicitly claiming to be Caravita's Oil. Indeed, the Writer stresses that this is "the true description of Caravita's Oil", signalling that he was aware that there were alternative formulae. The recipe for the Oil is very complex. It involves steeping herbs in olive oil and *aqua vitae*; boiling the resulting mixture before adding turpentine, earthworms and other substances; boiling again and adding 120 scorpions that are at least three years old, and have been fed on tips of basil (*cum sumitatibus basilici*) for 15 days; boiling again before adding other herbs and seeds as well as theriac and mithridatum (both of these being classic compound antidotes), and boiling yet again before burying the vessel in dung for a month. The vessel is then set in the sun for a month during the hottest season. One is to anoint

the patient over the heart and pulse-points twice a day, "and I say that this is the true rule and method which you should use if you wish to make a sick man well and bring a dead man back to life in the name of the Father, and the Son, and the Holy Spirit. Amen" (fol. 39r, see figure 2).

Our Writer was well advised to insist that his was the *real* Caravita Oil, because there were plenty of scorpion oil antidotes on the market. The only other manuscript located to date which contains a recipe explicitly for Caravita's Oil is the *Book of Exclusive Remedies and Recipes* (*Libro de i secretti con recetti*) compiled between 1536 and 1562 by Brother Giovanni Andrea di Farre of the Order of the Jesuati Friars of St Jerome in Lucca (now Pryce MS E1 at the Spencer Research Library of the University of Kansas).<sup>6</sup> The Jesuati were a religious congregation dedicated to the medical care of the poor, but also deeply committed to alchemical processes (they were nicknamed "the aquavit brothers"). The recipe for Caravita's Oil (fol. 112r) was initially entitled "Oil of Monsignor Pope Clement" (*olio... di monsignore papa clemente*, i.e. *Oleum Clementis*), but Brother Giovanni himself later added in superscript the ascription to Caravita. The recipe bears some likeness to that of the Osler manuscript, but the ingredients list and the order of preparation are different. However, it is worth noting that Brother Giovanni Andrea's manuscript continues with several more recipes for antidote oils based on scorpions, including one ascribed to St Bernardino of Siena (1380-1444; fol. 113r). Incidentally, but perhaps not coincidentally, his manuscript also contains a recipe for the Elixir of Life, advertised as "according to the usage of the University of Bologna" (*secondo l'uso dello studio di bologna*; fol. 128v-129r), as well as a second elixir (fol. 158v-159r) which, while much simpler than the Osler recipe, also promises to cleanse the complexion.

Mattioli, Caravita's student, described the 1524 poison trial in the first edition of his famous *Commentaries* on Dioscorides, in the chapter on aconite in book 4; *napellum*, a form of aconite, was the poison administered to the bandits. In later editions after 1548, Mattioli included in book 6 a recipe for what he called a "most noble" scorpion oil. Mattioli does not claim that this oil is Caravita's though he implies that it is, saying that "this is that oil (*oleum illud est*) which we mentioned earlier in the chapter on scorpions in book 2, and in the book four in the chapter on aconite." However, in the chapter on scorpions, Mattioli claims that the scorpion oil for which he furnishes the recipe in book 6 is his own (*per me factum*), though its virtues are compared to those of Caravita's Oil: "indeed, it should be wonderfully effective ... against the very deadly poison *nepellum* (i.e. aconite) with which the two Corsican highwaymen whose story I told in book 4 were infected in order that a trial might be made."<sup>7</sup>

<sup>6</sup> Digitized at <https://digital.lib.ku.edu/ku-specoll/1729>. For discussion, see William Eamon, *Science and the Secrets of Nature: Books of Secrets in Medieval and Early Modern Culture* (Princeton: Princeton University Press, 1994), 165-6.

<sup>7</sup> Petri Andreae Matthioli Senensis... *Commentarii secundo aucti, in Libros sex Pedacii Dioscoridis Anazarbei De medica materia...* (Venice: Ex Officina Erasmiana, Vincentii Valgrisi, 1558) Book 2 (pp. 187-8), Book 4, c. 73 (p. 539), and Book 6 (p. 762)



Another writer who refers to the 1524 poison trial in Rome is the mysterious “Isabella Cortese”, author of a best-selling volume of *Exclusive Remedies (Secreti)* first published in Venice in 1574. Isabella’s account alters Caravita’s name and profession – he is now “Fra Gregorio Mezzocapo” – but her formula for the oil more or less follows the template of Osler and Mattioli. However, there are no worms, garlic or even scorpions – though with her wonted attention to astrology, Isabella specifies that the Moon should be in the sign of Scorpio.<sup>8</sup> Finally, a similarly pared-down rendition of the antidote, with a mere nine herbs, and only one round of distillation – though this time with scorpions nourished on a diet of basil – is found in the manuscript recipe book of the Florentine apothecary Stefano Rosselli, whose patron was none other than Catarina Sforza’s great-grandson Francesco I de’Medici.<sup>9</sup> In fact, Catarina includes in her *Experimenti* a

“**The recipe for the Oil is very complex. It involves steeping herbs in olive oil and *aqua vitae*; boiling the resulting mixture before adding turpentine, earthworms and other substances; boiling again and adding 120 scorpions that are at least three years old, and have been fed on tips of basil for 15 days; boiling again before adding other herbs and seeds as well as theriac and mithridatum (both of these being classic compound antidotes), and boiling yet again before burying the vessel in dung for a month.**

recipe for a scorpion oil antidote which she ascribes to Pope Paul II (r. 1464-1471). Moreover, the physician and anatomist Gabriele Falloppio in ch. 27 (“*De bubone pestifero*”) of his *On Morbid Swellings (De tumoribus)* furnishes a recipe which he ascribed to “Leo Pontifex Maximus” – possibly Leo X (r. 1475-1521), son

<sup>8</sup> Isabella Cortese, *I Secreti de la signora Isabella Cortese*... Venice: appresso Giouanni Bariletto, 1574), Book 1, ch. 1 pp. 1-3. On Isabella, see Ray ch. 2. “Isabella” may be the invention of the prolific *poligrafo* (“hack-writer”) Girolamo Ruscelli (see below).

<sup>9</sup> Ed. with French trans. by Rodrigo de Zayas, [Stefano Rosselli], *Mes secrets: A Florence au temps des Medicis, 1593: patisserie, parfumerie, médecine* (Paris: J.M. Place, 1996), 212-3 and 117-8; English translation by Jo Wheeler, *Renaissance Secrets, Recipes and Formulas* (London: Victoria and Albert Museum, 2009) pp. 76-77.

of Lorenzo de’Medici.<sup>10</sup> Falloppio’s recipe is fairly close to that of our Writer, and incidentally, the Osler MS contains a recipe ascribed to Pope Leo for a sleeping potion (fol. 46r).

The central part of the Osler manuscripts contains more conventional recipes for preparations of the usual kind, for the usual medical problems. Noteworthy are the clusters of recipes around certain core ingredients (rue, guaiac wood, mummy) and around certain ailments (*e.g.*) colic, gastric issues, uterus, paralysis. Clustering recipes by ingredient immediately suggests that the source was a herbal or manual of *materia medica*. Indeed the rue series seems to be extracted from the chapter on rue in Dioscorides, which Mattioli had recently translated into Latin, and then Italian. After the fashion of a herbal, takes the form of general indications, *e.g.* that rue eaten with nuts and dried fruit is an antidote to poison. However, the slight differences in the names of the same ingredients (*charicis* for *aridis ficis*, *granati mali* for *mali punice*...) suggest that even though the Osler Writer was composing in Latin, he might have been influenced by Mattioli’s Italian translation,<sup>11</sup> perhaps reading it alongside the Latin version.

There is also a cluster of recipes using powdered mummy from Egypt – an unusual, but highly prized ingredient in medieval and early modern medicine, because the preservation of mummified flesh augured well for its powers to resist the corruption of disease. Mummy is not in Dioscorides, but Mattioli discusses mummy in his commentary on Dioscorides’ chapter on bitumen (Book 1, ch. 85), and some of his indications align fairly closely with the Osler Writer’s, *e.g.* the recipe for cough medicine with its distillation on mummy, barley, jujubes and plums. However, here again the Osler manuscript seems to be translating from the Italian version of Mattioli and not copying from his Latin edition. The term *iuubarum* (jujubes) and *sebasten* (plums) echo the Italian (*giuggiole*, *sebasten*) and are quite different from the Latin *zizypharum* and *myxorum* – learned terms for jujubes and plums.

The Osler Writer’s collection of recipes is neither comprehensive, nor rationally ordered. But we can detect a few trends. A good deal of attention is paid to wounds and ulcers, legs and joints, paralysis, digestive and gastrointestinal problems including kidney and bladder stones, as well as to uterine conditions. There are only sporadic remedies for fevers; and almost none to throat and respiratory conditions; there are no cures for morbid swellings (apostemes), cancer, the bites of dogs or venomous animals; and only a few the diseases of children, apart from worms. There is a marked interest in “exclusive” *materia medica* (guaiacum, mummy, potable gold and camphor). Camphor might have been a special fixation; indeed, our Writer actually inserts

<sup>10</sup> Gabriele Falloppio, *De tumoribus*. In *Gabrielis Fallopii Mutinensis medici nostra tempestate clarissimi Libelli duo alter de ulceribus alter de tumoribus praeter naturam* (Venice: apud Donatum Bertellum, 1563). Ch. 27 (fol. 89v-90r) on plague buboes describes antidote oil of Pope Leo.

<sup>11</sup> *De Pedacio Dioscoride Anazarbeo libri cinque Della historia, et materia medicinale tradotti in lingua uolgare Italian da M. Pietro Andre Matthioli ... cum amplissimi discorsi, et comenti*... [Venice], 1544.



camphor into one of Corti's recipes in the first part of the volume.

The last part of the collection is devoted to cosmetics, beginning on fol. 75v. The products include facial washes, treatments to remove blemishes and soften hands; preparations to prevent or stimulate hair growth; hair dyes; and deodorants, both for the armpits and for the feet. Not all or even many of the recipes target women: indeed, one of the hair dyes explicitly refers to dyeing the beard. A rare instance in which we can identify a verbatim match between the Osler manuscript and printed volume, is the recipe in Italian for cosmetic *faccioletti* or "facial wipes" on fol. 76r; this is reproduced almost word for word from the *Secreti* of "Alexis of Piedmont" – another pseudonym of the inventive Girolamo Ruscelli.<sup>12</sup> This can be contrasted with the recipe for "maiden water" (*aqua virginalis*) "to make a woman's face very beautiful", which is in Latin. It requires two separate distillates. The first is composed of ground litharge (a form of lead monoxide) added to white vinegar and distilled until it has reduced by one third. The second is made by crushing and mixing together one part each of plume alum, rock salt, camphor and oil of tartar (concentrated aqueous solution of potassium bitartrate) and two parts each of white frankincense and rose water; distil until reduced by one third. To use, take some of each of these two distillates in your left hand, and mix together before anointing the face and bosom. Finally, our Writer adds a warning: "if you give this water to a woman who wishes to conceive, she will never conceive" – an indication that the author was alert to the toxic properties of lead. One is reminded of the objections to lead distillation equipment in the intrusive chapter on distillates in the first part of this manuscript.<sup>13</sup>

As the reader can appreciate, this quest for sources and analogues is beginning to look like a plunge down a Renaissance rabbit-hole. But I think there is something important to be learned from this exercise – indeed, from its very *failure* to unearth many textual "smoking guns." The Osler manuscript witnesses to the fact that a manuscript was a vehicle not just for preserving medical knowledge, but for shaping that knowledge, even after the advent of print. It was neither the victim nor the enemy of print in this period; indeed, the two media seem almost parasitic upon one another.

A second feature that merits attention is the overwhelming presence of Latin in the manuscript, even when dealing with recipes like *aqua virginalis* which appear mainly or only in vernacular books of secrets. The author may be translating from the vernacular in these cases; indeed, many of the marginalia in the original scribe's hand correct or classicize the Latin orthography. Thus the manuscript encourages us to question easy assumptions that the traffic between learned culture and popular culture flowed in only one direction.

<sup>12</sup> "Secreti del reverendo donno Alessio Piemontese" (Venice: Sigismondo Bordogna, 1555), p. 131

<sup>13</sup> "Isabelle Cortese" provides a recipe also called "*latte uirginal*" (book 4, pp. 144-145) which likewise begins by distilling litharge in white vinegar, then making a second distillate of rock salt, borax, white frankincense and rose water. The treatment protocol also prescribes mixing the two distillates, but there is no mention of its negative side effects.

“ The collection... is redolent of the academic lecture room, but also the surgeon's office, the apothecary's shop, of princely and papal courts, and the alchemist's bench.

A third issue is the elusive context of the collection. It is redolent of the academic lecture room, but also the surgeon's office, the apothecary's shop, of princely and papal courts, and the alchemist's bench. If we cannot pin down what kind of book this is, it is even harder to bring the identity of the Writer into focus. Could he be a physician or surgeon? The reference to specific, named patients is suggestive, but not conclusive. Was our author an apothecary, like Rosselli? Or attached to a convent pharmacy or religious order involved in health care, like Brother Giovanni Andrea. The Kansas manuscript contains remedies for a wide range of disorders, including a significant number for conditions affecting women, and also "cosmetics", particularly hair dyes and skin treatments. But unlike our manuscript, it is carefully indexed, and abundantly annotated, and edited (e.g. a number of recipes are crossed out). In short, the Kansas manuscript belonged to a community, and shows signs of use. We should not discount entirely the idea that the Writer might have been a nun. Female convents were increasingly turning to the pharmacy business in the 16<sup>th</sup> century. Florence alone had six convent-run pharmacies by the middle of the century and many had elaborate distillation equipment.<sup>14</sup> Moreover, the convent of Le Murate in Florence patronized by Caterina Sforza, was also famed for its scriptorium: involvement in pharmacy could also entail with involvement in book production. On the other hand, this might have been the notebook of a *poligrafo* like Ruscelli -- a pillager of other people's writings who produced "content" for the commercial publishing market. The pirating of Corti looks like something a hack-writer might do, but the bombastic self-advertising or disparagement of conventional medicine found in the writings of *poligrafi* is lacking in the Osler volume. Could our manuscript have been created at or for a court -- perhaps the draft of a book to be offered to a prince or patron, or a gentleman amateur's personal notebook? The focus on the health issues of the great and good – wounds, French Disease, stomach problems – as well as the interest in poisons and elixirs of life, and even the recipe for cleaning paintings on wood or canvas, would not be out of place in this context.

In sum, the more we burrow into this volume, the more elusive the Writer and his purposes becomes – and that may just be the point. So I hope that by introducing it to this scholarly community I can encourage others to try their hand at understanding its ambiguities.

<sup>14</sup> Ray, 28-29; Sharon T. Strocchia, "The Nun Apothecaries of Renaissance Florence: Marketing Medicine in the Convent," *Renaissance Studies* 25 (2011):627-647.

# Social Studies of Medicine 4<sup>th</sup> Year Medical Student Selective, “Representation in Medicine”

**Mary Hague-Yearl, Head Librarian**

When 4th-year medical students are nearing the end of their education at McGill, they choose a couple of selectives aimed at bringing together areas of mastery that are central to the medical curriculum. This year, unusually, one of these selectives was offered at the Osler Library.

I chose to organize the library-based selective around the theme of “Representation in Medicine.” Each session included hands-on work with primary source materials from the library’s collections. The class was also treated to a guest lecture on “Representing women in medicine” by Dr. Margaret Carlyle from the University of British Columbia, Okanagan, and Michele Larose-Osler Library artist-in-residence Ana María Gómez López joined us for the summative discussion during the final class.

To get a sense of what students signed up for, this was course summary:

Medicine is a profession in which image plays a key role: the image of the profession, the image of an individual physician, and the image that practitioners have of their patients. This selective will focus on representation in medicine, with an emphasis upon two areas: a) how doctors write about themselves and their profession and b) how marginalized patients appear in medical writings. The selective highlights the role that representation plays in a profession where the intimacy of the doctor-patient relationship demands trust. Students will use a historical lens to discover the deep-seeded nature of the struggles with equity that the profession faces today.

Each week will focus on a different aspect of representation: how the profession (re)presents itself, the representation of race in medicine and medical texts, and representations of women. These three aspects of representation will come together via common questions asked each week and by the inclusion of authors whose work covers aspects of the profession, race, and sex and/or gender.

At the end of the selective, each student submitted a personal reflective essay touching upon the course theme of representation in medicine. I invited a small number of students to share their reflections in the Osler Library Newsletter, believing that our readership would find these young doctors’ words to be instructive and important. Thank you to Drs Sarah Amirali, Nardin Farag, Hamila Hagh-Doust, and Tharaniya Vallipuram for agreeing to share your reflections.

## Reflective Piece

### Hijab – It’s not just a piece of cloth

**By Sarah Amirali, MDCM 2023**

Medicine is a unique field because it sees people during one of their most stressful and vulnerable moments. It is, therefore, crucial as healthcare professionals to ensure that we understand and address the unique health concerns and cultural nuances of diverse communities. Representation in medicine is vital to best meet the needs of an increasingly diverse population, especially in a multicultural city like Montreal. As a hijab-wearing woman, I believe that representation in medicine is especially important for Muslim women, who often face discrimination and barriers in healthcare due to their religious identity.

Islam is the world’s fastest-growing religion, with over 1.8 billion people, and it is projected to be the world’s most-followed religion by the end of the century (Wormald, 2015). Muslims have been increasingly migrating to Europe and North America over the last few decades. Due to the growing number of Muslims in the West, all healthcare providers will undoubtedly encounter at least one Muslim patient in their practice. In the West, the image of the oppressed, veiled woman has been used numerous times to justify a supposed need for Muslim women to be rescued from their practices (Zine, 2006). Due to this, Muslim women in healthcare continue to face various forms of Islamophobia, including discrimination, microaggression, and barriers to accessing healthcare (Khan et al., 2022).

Knowledge of the cultural and spiritual values of Muslims, in particular Muslim Women is vital in providing culturally competent care (Attum et al., 2022). The concept of gender plays an essential role for Muslim women when receiving health care. In Islam, there are certain rulings related to modesty and how women are advised to dress. This is one of the main reasons Muslim women have preferences on who can provide care, specifically concerning the gender of the provider (Nur, 2014). According to a study on the experiences of Muslim women with healthcare providers, many women preferred to be treated by female providers, especially when it comes to pelvic and genital exams such as pap smears. (Simpson & Carter, 2008). If they were seeking basic care that did not involve close contact or in emergent situations, seeking care from a male provider was acceptable.



As a medical trainee, when I was exploring various specialties and deciding on which specialty to apply to, I was told by many of my Muslim friends to go into obstetrics and gynecology. The primary reason for this was the challenge of finding a female gynecologist and the discomfort of being treated by a male gynecologist. Pelvic exams are uncomfortable for most women, but being evaluated by a male gynecologist adds an extra layer of discomfort, especially for Muslim women who greatly value bodily privacy and modesty. This leads to delay in seeking care and refusal of care, leading to delayed diagnosis and treatment (Tackett et al., 2018). It also hinders communication and does not allow them to voice their concerns freely. It is, therefore, important for healthcare providers to understand the gender dynamics in Islam and respect women's modesty during physical examinations. This starts with educating physicians and trainees on the unique needs of Muslim women and implementing strategies to provide more culturally competent care. Some practical tips include deferring breast and pelvic exams when not necessary, attempting to follow their preferences of being treated by a female provider, and, when not possible, ensuring that another female chaperone is present during the encounter.

The Muslim attire has also led to stereotyping and discrimination, creating fear and frustration amongst Muslim women especially post the Quebec ban on wearing religious symbols, including the Hijab.<sup>1</sup> This has led to religious and gender-based discrimination towards Muslim women and the portrayal of Muslims as foreign and not belonging to this society (Alimahomed-Wilson, 2020). Some discrimination I have noticed during my training include offensive and insensitive verbal remarks, especially about Muslim attire, and a lack of respect for privacy. Many Muslim patients feel ignored, not taken seriously, and stereotyped as uneducated, conservative, and backward due to their attire. These harmful stereotypes lead to implicit and explicit biases towards Muslims, in turn leading to poor patient interaction and quality of care.

This is not just prevalent on the patient's side but also on the provider's side. As a hijab-wearing trainee, I carry my Muslim identity with me whenever I interact with a colleague, patient, or family member. When my seniors see my name on their list as 'Sarah' they do not expect a veiled woman behind this name, which has led to many surprised expressions and snarky comments on my first days. The assumption that I have not grown up here or don't speak French are other examples of stereotypes that I encounter on a very regular basis. A colleague once told me, 'I don't know how it is done where you come from, but in Canada, this is how we do it,' implying that I was not from here. My Hijab made my colleague assume that I was ignorant, foreign, and as though I did not belong in this country. Comments like these, whether subtle or blatant, continuously remind me that I will always stand out and am like an 'outsider' due to my attire.

Due to the strict dress code, many Muslims also do not feel welcome or comfortable in the operating room. Hijab-wearing Muslim

women often have difficulty in finding a balance between wearing religious attire and maintaining modesty while also following the operating room regulations. Muslim women are recommended to cover their arms and legs, but in the OR, the scrubs provided are short-sleeved, and undershirts with long sleeves are not allowed due to infection protocol. In my experience, long-sleeved jackets are not always available, making me feel very uncomfortable exposing my arms. When asking for accommodations or long-sleeved jackets, I see the typical eye-rolling and annoyance making me feel like a nuisance. Considering women, especially visibly religious women are a minority in surgery, accommodations must be made to allow women interested in this specialty to pursue it and increase the diversity in these fields.

When the COVID pandemic hit the world, the government quickly provided personal protective equipment to all healthcare staff without realizing that they were not inclusive for those wearing a Hijab or turban. The hospitals provided sterile protective equipment, from shoe covers to hair nets and even beard covers, but no Hijab covers. Due to this, Hijab wearing healthcare staff had to bring their own headscarves and constantly discard them to avoid contamination. Fortunately, various Muslim businesses stepped up and created disposable Hijabs to protect the Hijab wearing healthcare professionals during this worldwide pandemic. Other businesses created hijabs with ear holes for ease in wearing the stethoscope without having to touch the Hijab and contaminate it. It is very heartwarming to see the surge in Hijab wearing women joining the healthcare force and the efforts being made to create a more inclusive environment.

Female Muslim trainees and physicians have and continue to face increasing discrimination in their workplace. A study done by Verdonk et al. (2020) reported that Muslim medical trainees face the 'paradox of being hyper-visible and invisible.' They stand out from their peers due to their attire but are not heard during important decision-making. There have been many stories of female Muslim healthcare professionals being excluded or discriminated against in the workplace, making them feel unheard, unappreciated, and upset. For example, I finished my physiotherapy degree and was applying for jobs around the same time the religious symbol ban policies were being discussed in Quebec. Due to this, I could not find a job in the public sector for close to 6 months despite being qualified as a licensed physiotherapist. All my other colleagues found jobs immediately after graduating, and I was continuously rejected because of my Hijab. I got multiple interviews, but as soon as I walked in, I could see the interviewer's expressions change when they saw my Hijab. This experience made me feel significantly undervalued and frustrated and I often found myself questioning my capabilities and self-worth.

This discrimination, dehumanization, and exclusion faced by Muslim healthcare professionals add to the challenges they are already facing in this field. To mitigate this challenge, equity, diversity, and inclusion training initiatives are crucial in medical training. Misconceptions and dangerous stereotypes perpetuate

<sup>1</sup> Editor's note: this refers to Bill 21, "An Act respecting the laicity of the State," enacted in 2019.

biases toward Muslims, and this must be addressed to bring about meaningful changes in the medical culture. The initial step includes encouraging trainees and medical professionals to reflect on their own biases and beliefs towards visibly religious healthcare professionals. It is also vital to educate the healthcare team regarding the cultural and religious nuances of Islam and how to better support Muslim colleagues and patients. Lastly, promoting and advocating for anti-Islamophobic policies will aid in creating a safe and inclusive environment and increase the quality of care provided to patients.

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## Reflective piece

By Nardin Farag, MDCM 2023

As a final year medical student at McGill University and an aspiring surgeon, I have come to realize the importance of reflecting on my personal experiences in the clinical setting and how they have shaped my identity as a future physician. As a visible minority, I have experienced firsthand the disparities in healthcare delivery and access faced by marginalized communities. This essay provides me with an opportunity to explore and share the different insights I have gained from my reflections on the impact of colonial patterns in medicine and Osler's legacy on modern medical practices, the lack of diversity and representation in medical education, and the crucial need to empower women in medicine, particularly in the surgical field. Through this essay, I aim to contribute to the ongoing discourse

on the need for a more inclusive and equitable healthcare system that recognizes and addresses the unique challenges faced by different patient populations.

## Osler's legacy

During my first two years of medical school, I was heavily exposed to the influential figure that is Sir William Osler. Some of the aspects that were heavily emphasized were his role in clinical teaching, bedside medicine, research, and his role in medical education reform across North America. However, delving deeper into his personal discriminatory views and their impact on medical education, we realize that his ideologies still infiltrate the medical curriculum. While some would argue this is "presentism", and that Osler should not be a victim of criticism due to some of his views that were, on the contrary, widely accepted at that time.<sup>1</sup> I would like to argue that they were only accepted by the higher class of white men who had a platform to share these views.

A recent perspective piece by Dr. Shaheen-Hussain sheds light on some of the negative aspects of Sir William Osler. His critical opinions of Indigenous practices and his desire to make Canada a "white man's country" are among his shortcomings. He normalized a pernicious culture where underrepresented minorities and women should be excluded from the medical field.<sup>2</sup> Osler believed that women were not suited to the practice of medicine and that their involvement in the field would lead to a decline in our profession's standards. In his influential textbook, *The Principles and Practice of Medicine*, Osler wrote that "the practice of medicine is one which demands the exercise of masculine qualities of mind and heart" and that women's "excessive sensibility" and "emotionalism" made them unsuitable for the profession.<sup>3</sup> While most of us today acknowledge his role in creating this culture that is perceived by most as unacceptable, it is undeniable that this is still a reality. Today, visible minorities in hospitals are often assumed to be nurses or janitors, and women face discouragement from pursuing surgical careers to fulfill their "duties" as housewives. These discriminatory views held by Osler have had a lasting impact on the medical profession, contributing to the underrepresentation of women and people of color in medicine and perpetuating biases and inequalities in healthcare.

## A modern view on representation in medicine

The representation of underrepresented minorities in medicine is critically important for several reasons. Firstly, it promotes diversity and equity in the medical field, which is essential to providing the best possible care to all patients, regardless of their race, ethnicity, or background. Research has consistently shown that patients who receive care from physicians who share their racial or ethnic background have better health outcomes, higher satisfaction rates, and are more likely to follow through with recommended treatments. This is because patients tend to feel more comfortable and trusting of physicians who can understand their cultural values, beliefs, and experiences. In addition, being



within a diverse student body can reinforce cultural sensitivity and help promote equity.

Additionally, increasing diversity in the medical workforce can help to address health disparities that disproportionately affect underrepresented minority populations. For example, Black Americans are more likely to suffer from conditions like hypertension, diabetes, and heart disease, but are less likely to receive appropriate care or be prescribed necessary medications than their white counterparts. This is due in part to systemic biases and structural barriers that limit access to quality healthcare. Having a diverse group of healthcare providers can help to mitigate these disparities by increasing awareness and understanding of the unique challenges faced by different patient populations, and by ensuring that culturally appropriate care is provided to everyone, regardless of their background. Finally, promoting diversity in medicine is essential to inspiring and encouraging the next generation of healthcare professionals from underrepresented groups. By providing role models and mentors who come from similar backgrounds, we can help to break down the barriers that have historically prevented individuals from these communities from pursuing careers in medicine. This will not only benefit these individuals personally but will also contribute to a more diverse and inclusive healthcare workforce overall. The representation of underrepresented minorities in medicine is vital for promoting equity, improving patient outcomes, reducing health disparities, and inspiring the next generation of healthcare professionals. It is essential that we work to promote diversity and inclusivity in the medical field, so that everyone can receive the care they need and deserve.

## Neocolonialism in Global Health

One of the most striking aspects of colonialism's impact on Global Health is the way it has reinforced and perpetuated inequalities. While the primary focus of colonial medicine was often on the health needs of Western colonizers, it also served to reinforce colonial power structures by defining indigenous populations as inherently inferior and in need of control and management. As a result, many Global Health (GH) initiatives today continue to center the perspectives and priorities of Western experts and institutions, perpetuating this legacy of inequality.

For example, inputs from experts that are from high-income countries (HICs) is more valued than those from low- or middle-income countries (LMICs).<sup>4</sup> By working towards decolonizing GH, we need to understand the structures of power that lead to the flow of knowledge and funding being unidirectional.<sup>4</sup> Over the decades, we have been left with legacies that result in dehumanization and othering, which are still widely present in GH.<sup>5</sup> Some examples include our racial biases and assumptions that affect the pain management of Black people and characterize Africa as a disease-ridden continent.<sup>5</sup> The importance of decolonization in GH challenges the current depoliticized and ahistorical approach to teaching GH.<sup>6</sup> With

that in mind, it is important to encourage certain reflections among lecturers and students taking part in these initiatives. These reflections should include understanding how systems are rooted in colonial practices and how this perpetuates the experience of health inequities and the delivery of services; reflecting on how colonialism has shaped the way healthcare practitioners define health, illness, healthcare, medicine, well-being and ability in our society; and understanding how current or future healthcare professionals' own experiences of privilege and oppression will affect their practice.<sup>7</sup> Ultimately, understanding the role of colonialism in GH is critical to achieving more equitable health outcomes and dismantling the power imbalances that have been perpetuated by colonialism. By recognizing the ways in which colonialism has shaped healthcare systems and practices, we can work towards a more inclusive and equitable approach to GH that truly centers the needs and perspectives of all people, regardless of their background or origin.

In conclusion, I recognize that as a future healthcare practitioner and an active participant in international collaborations, it is crucial for me to be introspective about my privilege and potential biases. Studying at a top university in a high-income country has endowed me with significant influence, and I must recognize that this power can be wielded in ways that perpetuate inequities. I acknowledge that my medical education has contributed to some of my biases, especially concerning marginalized communities, as the lack of representation in my own cohort has limited my exposure to diverse perspectives. Consequently, it is incumbent upon me to actively engage in dismantling my own implicit biases and promoting greater diversity in healthcare education and practice. We collectively need to advocate for increased representation and work towards creating a healthcare system that is inclusive and equitable for all.

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## Reflective piece

By Hamila Haghigh-Doust, MDCM 2023

Equity, diversity, and inclusivity is a topic that is now at the forefront of discussion in the medical community. Patients are from various cultures, races, genders, ethnicities, sexual orientations, and socioeconomic backgrounds. Having a diverse set of physicians who understand the values of the communities they serve allows for them to engage more effectively with their patients and better advocate for their needs. Over the past few years, efforts have been made to increase the diversity of medical students and provide underrepresented groups with more opportunities, but barriers to entry to medical school, such as the Medical College Admission Test, remain.

A 2018 online survey completed by 1388 medical students found that the socioeconomic characteristics of Canadian medical students differs from that of the general Canadian population.<sup>1</sup> Compared to the general population, respondents were significantly less likely to identify as Black, Indigenous, or to have grown up in a rural area. They also had a higher socioeconomic status, based on parental education, occupation, and income. My experience with representation within my own cohort has been similar. I vividly remember in my first block of medical school, during a small group session, we completed a modified version of the privilege walk, an exercise based on Peggy McIntosh's article on white privilege.<sup>2</sup> In our version of the exercise, we added and subtracted points based on prompts, which demonstrated how race, gender, sexual orientation, and socioeconomic background affected our experiences in life. Successfully reaching a net positive number of points meant you had made your way through life with a certain amount of privilege, and you sat down. At the end, in a group of over 50 students, only a handful of students, including myself, remained standing.

The exercise impacted me deeply: the embarrassment crept in as I felt singled out and out of place. I was shocked that my life experiences had been so different from that of so many of my colleagues. I looked to the other students that remained standing and noticed the ways in which we were similar. My mind was racing with reflections on the identities my standing peers and I shared and how structural barriers could have impacted our path to medical school when I overheard one of my white male colleagues comment to his friends that the exercise was pointless and a waste of time. His easy dismissal of this exercise demonstrated how the privilege that he had held through his life was invisible to him and highlighted his ongoing refusal to acknowledge it. This moment made me realize that many of my privileged peers avoided developing the self-awareness needed as the first step to be able to meet with the particular needs of the diverse populations we serve as physicians. This experience, as well as many others during the past four years, has stressed the need for increasing equity, diversity, and inclusivity in medicine to me.

Many structural barriers limit the demographic diversity of medical students. One of the big barriers to medical school is the standardized Medical College Admission Test (MCAT), which is

required as part of the admission process. Only six schools, including the four Quebec medical schools and two Ontario schools, do not require the MCAT as part of the admission process.<sup>4</sup> It has been identified as a barrier to French and Indigenous students, as testing centres are not available in Northern Canada and are only given in English. Also, the MCAT preparation industry is worth millions of dollars, and students from lower socioeconomic backgrounds have a harder time accessing these extremely widespread resources.<sup>4</sup> Personally, the MCAT would have been an immense barrier to my application to medical school, as I would have been unable to cover the burden of the cost of the exam, tutoring, preparatory material, and travel cost to the testing centre. The MCAT has been a topic of discussion over the past years and reassessing its necessity could address a large obstacle that many medical school applicants from underrepresented communities face. Medical school admission committees are making efforts to increase the acceptance of students from underrepresented backgrounds. For instance, streams for Indigenous, Black, rural, and low socioeconomic status have been put in place at various Canadian medical schools.<sup>3</sup> However, there are limitations to this social accountability, as nationwide demographic data on medical students has not been collected since 1965, though some individual medical schools have been collecting data individually. This makes it difficult to track data as voluntary surveys are at risk of bias and may not be reliable given the low percentage of responders. Overall, more awareness has been brought to these structural barriers and individual initiatives have been taken by medical school admission committees.

Once accepted in medical school, students are introduced to a new and challenging environment to which they must rapidly adapt. Medical mentorship has the goal of providing guidance and advice on the transition into this new setting, as well as tips on research, career planning, and work-life balance. Mentorship programs within medical school and residency have been shown to lead to increased personal accomplishment,<sup>5</sup> career satisfaction,<sup>6</sup> as well as the development of professional competencies such as communication, listening, and research skills.<sup>7</sup> All McGill medical students complete the Physicianship course, a longitudinal mentorship program with the goal of assisting students in their transition from laymen to physicians, guiding them in becoming reflective and patient-centred, and providing a safe environment where they are encouraged to discuss issues arising out of their educational experiences.<sup>8</sup> My group of six students was paired with an attending physician and two senior medical students, with whom we met on a regular basis over the course of four years. Our mentors provided us with valuable insight, advice, and guidance, as we progressed from theoretical classes to the clinical environment, and finally applied to residency.

Medical students from underrepresented backgrounds face additional difficulties beyond those related to the transition into the highly demanding curriculum. They may face hostile environments, microaggressions, as well as overt racism. A recent systematic review of mentorship of underrepresented physicians



and trainees in the USA found 28 mentorship programs that reported high satisfaction, with some reporting improved publications, retention, and promotion.<sup>9</sup> The review highlights the importance of institutional support to improving diversity and inclusion, as it places the responsibility on institutional leadership, rather than on individual faculty members, to put diversity efforts at the forefront of their mission.<sup>9</sup> In Canada specifically, multiple initiatives for support and mentorship of underrepresented communities in medicine have been started. For instance, the nationwide Community of Support program has the goal of increasing representation of Black students within medicine and is designed to provide prospective Black applicants with a network of support that seeks to break some of the salient institutional, cultural, and financial barriers to medical training.<sup>10</sup> Similarly, the Diversity Mentorship Program at University of Toronto has the aim of connecting undergraduate medical students or first year residents from minoritized groups to faculty mentors.<sup>11</sup> The Indigenous Physicians Association of Canada Mentorship Circle also connects Indigenous medical students, residents & physicians across Canada and hosts various mentorship events throughout the year.<sup>12</sup> I went through some negative experiences related to my identity during medical school. Discussing with my friends who were going through similar experiences was helpful, but I would have appreciated the support of a senior resource person who understood what I went through. Overall, students from underrepresented communities have unique experiences during medical school and would benefit from the mentorship and support of physicians who are from similar backgrounds and have comparable life experiences.

Although there are still many issues to address, the increasing awareness and effort being placed into providing equitable opportunities for students from underrepresented communities to be accepted into and be well-supported during medical school makes me hopeful for what the future has to hold for our next generation of physicians.

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## Reflective piece

### Beyonce Once Said: Say My Name

By Tharaniya Vallipuram, MDCM 2023

I remember standing on stage in my blue ball gown, my sixth-grade valedictorian speech blaring through the speakers in the school gymnasium. I chuckled and concluded, “Remember, Mr. Gold, it’s pronounced Tha-ra-nee-ya.” More than one decade later, I have become too accustomed to the long pause and confused stares signifying that my name is next on the list. Following the silence, an effortless go at pronouncing my name accompanied by a shrug implying “I tried” transitions the moment onto the next name on the list. Entirely fueled by the desire to avoid this awkward feeling, I went by “Thara” – an anglicized and shortened version of Tharaniya – thinking that would improve things. However, this would not help when they told me I did not look like a physician, during the moments I got a look of despair when I answered my parents were not physicians but blue-collar workers, or during the times I was advised to stop pursuing critical care because of the negative impact it may have on the prospect of starting a family. It did not shield me from male chief surgeons saying, “Students without physician parents enter medical school thinking this will be easy,” or physicians from making me feel alienated for “going to public schools and making it into medical school.” The stark truth is that no matter how much I tried to assimilate myself into the systems founded on colonial and patriarchal principles, no matter how much I attempted to ease the discomfort of those while compromising my own, I would always find myself in situations where I was the other. It is both heartbreaking and surprising to think that the intersectionality of my race, gender, my socioeconomic status, and other characteristics impact my position within this medical system. However, I recognize that my experiences do not nearly catch the breadth of structural injustices permeating healthcare, amongst other societal infrastructures.

This essay will explore the historical context of representation in medicine and draw a parallel to current structural barriers and disparities, specifically within the Canadian medical system. Furthermore, it will explore the impact of these barriers and

disparities on patient care and patient outcomes. Lastly, this paper will discuss the importance of acknowledging medical injustices as a fundamental step in decolonizing healthcare and medical science.

In Canada, using our American counterparts for reference, we pat ourselves on the back for being part of a diverse and accepting country, reassuring ourselves, *“That doesn’t happen here.”* However, it is imperative to recognize Canada’s distressing legacy of discrimination and inequality committed for centuries. Many medical institutions, including the medical faculty at McGill University, have been implicated in perpetuating systemic racism, classism, ableism, and sexism through its adoption of Eugenics.<sup>1,2,8,10,11</sup> Eugenics was a theory that sought to achieve “race betterment” through selective genetic breeding. Disguised as a legitimate science, it was a powerful tool to promote white supremacy.<sup>1,11</sup> Many prominent historical medical figures regarded as heroes are guilty of making McGill and Montreal the intellectual center of Eugenics in Canada.<sup>1,2,8,10,11</sup> Physicians such as Dr. Alexander Peter Reid and Dr. John George Adami and professors such as Carrie Derrick were implicated in constructing and promoting various discriminatory policies, such as the forced sterilization and euthanasia of those deemed “unfit” and “inferior,” including members of BIPOC communities, immigrants, lower class citizens, incarcerated population and those with physically or mentally disabled.<sup>1,2,8,10,11</sup> Dr. Alexander Peter Reid, a McGill University formed physician, is believed to have first introduced eugenic ideas to the Canadian public, calling for *“improved ‘sanitary’ education to reduce the risk of producing the sorts of ‘diseased ulcerous growths on society.’”*<sup>1,3</sup> Another prominent McGill physician was Dr. John George Adami, recognized as *“a leading pathologist, a genial companion, a man of great culture outside his profession, and of tireless energy.”*<sup>4</sup> He taught and led Pathology and Bacteriology at McGill for several years and was elected president of the Association of American Physicians and the Royal Society of Canada.<sup>5</sup> Like the other medical figures applauded and honoured for their work, his direct involvement in devastating transgressions against oppressed community members is a suppressed truth. Adami was a leading advocate for horrific racist, ableist and classist eugenic notions, which are even featured in his valedictory address delivered at the convocation for the McGill Medicine graduating class of 1895, as he eludes to caring for those considered ‘inferior’ does not align with his mission as a physician: *“The only doubts that can come to us in labouring faithfully are as to whether we fulfill our mission and do alright when we save sundry who, continuing to exist, will have feeble and diseased progeny, and will lower the quality of the race.”*<sup>6</sup> His obsessive preoccupation with ensuring the propagation of the best in the race justified implementing classist methods such as the ‘Intelligence Test’ to guide the selection of members for his ideal aristocratic society and justify the segregation of those with intellectual disabilities: *“Think of the start in the world it would give to a man or woman to be able to refer to his or her record as belonging to the A1 class; think of the status it would give him or her for the years to come, of the preferential treatment that would*

*be afforded when applying for posts.”*<sup>7</sup> Lastly, Carrie Derick is recognized as the first female Canadian professor at a university level and the founder of the Montreal Suffrage Association. She continues receiving praise on McGill’s website as being *“crucial in the early development of Genetics studies at McGill.”*<sup>1,8,9,10</sup> This honourable description conceals her wicked commitment to Eugenics and her beliefs that those deemed defective were wards of the state and required to be segregated or her advocacy for involuntary sterilization, restrictive immigration or eliminating all contributing to “hereditary degeneration.”<sup>1,8,9,10</sup> It may be challenging to understand the breadth to which Eugenics influenced political and social discourse. The following excerpt from *The Oxford Handbook of the History* reveals how sinister people used and moulded the concepts underlying Eugenics to inflict rampant harm worldwide:

*The most notorious national context for eugenics was that of Nazi Germany under the banner of “racial hygiene”— policies that resulted in the forced sterilization and killings of many disabled and Jewish people as part of state-sponsored policies directed at “inferior peoples”.*<sup>1</sup>

Many claim that they were men and women of their time, the victim of the circumstances of their era. It begs the question, why does this history matter now? It is vital to admit that many of these colonial sentiments are the seedlings of the persistent ideologies that underpin racism, classism, misogyny, homophobia, transphobia, and stigma permeating societal infrastructures, including healthcare today.<sup>12</sup> These impacts manifest as significant societal and health inequalities deeply affecting Indigenous and Black communities, sexual and racial minorities, immigrants, people with functional limitations and women.<sup>13</sup> Unfortunately, these disparities are enduring, even in Canada, as portrayed in the following examples. Infant mortality is twice as high for First Nations as for the Canadian population.<sup>13</sup> Diabetes is nearly twice as prevalent among South Asian and Black adults compared to white adults and 2.9 times more prevalent amongst women with the lowest level of education compared to those with the highest level of education.<sup>13</sup> Disability is 2.2 times more prevalent amongst adults with less than a high school education than university graduates.<sup>13</sup> Furthermore, this history portrays the origin of many implicit biases- attitudes or associations to race, age, ability, gender, or other characteristics that unconsciously influence our perceptions, behaviour and clinical decisions- that remain ingrained within the medical system.<sup>14,15</sup> Even medical curriculums are complacent in propagating biases. We have normalized associating clinical vignettes with an Indigenous woman reported to have a heavy smoking history with tuberculosis, the immigrant Chinese male with Hepatitis B or the Black child with bone pain to sickle cell anemia.<sup>15</sup> As stated by Marcelin et al.,<sup>15</sup> *“these learning associations may be based on true prevalence rates but may not apply to individual patients,”* and I believe healthcare professionals may find themselves dangerously using these assumptions to guide clinical care. These biases are not limited to patient care.

They are present in practices and policies influencing medical training environments by limiting the “diversity of the health care workforce, leading to inequitable distribution research funding [and] hindering career advancement.”<sup>14</sup> Lastly, institutions and societal structures continue to create environments that operate and propagate inequities and instill mistrust between health care and marginalized communities. As explained initially by Benkert and colleagues and analyzed by Jaiswal et al.,<sup>12</sup> mistrust is a “protective response against the pervasive, interlocking structural inequalities that result in restricted access to resources, including housing, educational opportunities, employment, and healthcare.”

These longstanding biases and stereotypes entrenched invisibly within our societal structures continue to influence the care provided by healthcare professionals leading to devastating consequences such as poorly treated health conditions, misdiagnoses, poor and culturally insensitive patient care and patient abuse.<sup>16</sup>

Through my last few years trudging through medical school, I seldom heard about McGill’s involvement in significant medical injustices. After learning about Eugenics and the power it had in underpinning mass genocides across the world, I question its contribution to the many current inequalities within my medical cohort. Is the prominent underrepresentation of Black or Indigenous students or students from neighbourhoods considered to have lower socioeconomic status a consequence of this? I believe we can only truly embark on the journey toward decolonizing healthcare by acknowledging the truth about the injustices that have harmed and continue to harm marginalized communities. Talking openly about medical injustices and recognizing them holds those with privilege accountable to pursue knowledge on how the burden of the past shapes present-day injustices. Engaging in this discourse encourages individual and institutional participation in forming allyship with oppressed communities, and it can help restore the feeling of safety and trust in the medical system. All this can translate into informed policy changes to address disparities, the implementation of strategies to empower marginalized communities, and improved patient care and outcomes.<sup>17</sup> Learning about this history can ensure we reflect and cognize our roles in dismantling harmful rhetoric. It can provide a more meaningful perspective on why microaggressions, such as dismissing one’s name as a core feature of their identity, matter and how they influence relationships.

While I reflect on the ideas and themes this paper illustrates, a whirlwind of thoughts is triggered. What am I doing to participate in this process of dismantling our Eurocentric healthcare system? What am I doing to ensure I continue to learn and grow as a physician? Who am I, and what defines my identity? When will I garner the confidence to be proud of what makes me “different”?

*I will actively continue to acknowledge my gaps in knowledge, participate in learning how to be an ally and dismantle the deeply seeded colonial ways within our society.*

*I will continue to remind myself to proudly carry my vast array of experiences and my unique characteristics and traits.*

*I am proud to call myself a BIPOC woman.*

*I am proud to call myself the daughter of immigrant parents who fled war, weren’t granted the privilege of education, and are blue-collar workers from the lower middle class.*

*My name is Tharaniya (Tha-ra-nee-ya) Vallipuram; say my name (correctly).*

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By **Stefan Wladysiuk** (MLS),  
Librarian of the Polish Institute Library

**2023** marks the 550th anniversary of the birth of the father of modern astronomy, Nicolaus Copernicus. The Osler Library and the Polish Institute of Arts and Sciences in Canada jointly organized an exhibition entitled, *(He) Stopped the Sun and moved the Earth - Copernicus* in the collections of McGill University Libraries Celebrating the 550th Birthday of Copernicus. The exhibition ran at the Osler Library from April 17th - May 5th, 2023.

The exhibit opened with a conference on Thursday, April 20 in the beautiful and historic Osler Library. It was attended by various representatives of both institutes, students and members of the general public. Other invited guests were Prof. Rolando del Maestro, Chairperson of the Standing Committee of the Osler Library Board of Curators, Mr. Dariusz Wisniewski, Consul General of Poland in Montreal and Mrs. Bozena Pyrkosz, Vice-President of Polish Canadian Congress (Quebec).

In the welcome speech Christopher Lyons, Interim Associate Dean of ROAAr (Rare Books and Special Collections, Osler, Visual Arts Collection, Archives), McGill Libraries, spoke about William Osler, his life, reputation and the importance of his library in the medical world. The President of the Polish Institute, Stan Latek, highlighted various events jointly organized by the Polish Institute with departments and libraries of McGill (the latest being a conference dedicated to the life and times of distinguished diplomat and humanitarian, McGill Prof. Tadeusz Romer).

The stars of the exhibition were the original edition of Copernicus' monumental work *De revolutionibus orbium coelestium*, published in 1543 (from the collections of the Osler Library) and the second edition (1563) (from the collections of Rare Books). *De revolutionibus orbium coelestium* (1543) is an exclusive artifact and the Osler Library preserves the only first edition found in Canada. Of the original five hundred copies printed in 1543, eighty-two have survived to our times.

Another rare book exhibited was splendid Andreas Vesalius's *De Humani Corporis Fabrica Libri Septem* (*On the fabric of the human body in seven books*), one of the most influential books on human anatomy, published the same year as Copernicus' original work (1543). It is worth noting that Copernicus, in addition to astronomy, was also a physician.

The Polish Library presented books by and about Copernicus in three languages, as well as a portrait of Copernicus (1943) by

renowned Polish artist Arthur Szyk. The Rare Books collection holds a large number of his works. These works were presented at the joint exhibition *Ink and Blood Works of Arthur Szyk* in 2012.



Mary K. K. Hague-Yearl (PhD, MLIS), Head Librarian at the Osler Library, gave a presentation entitled "Copernicus in the collections of McGill University Libraries."

Stefan Wladysiuk (MLS), Librarian of the Polish Institute Library, gave the second presentation, "Celebrating Copernicus in Montreal 1967-2023." He focused on the history of the Montreal monument to Nicolaus Copernicus which is now found at the Rio Tinto Alcan Planetarium. He spoke equally about the celebration of the 500th anniversary of Copernicus in 1973 (declared by UNESCO as the Year of Copernicus). Many Canadian organizations and universities held specific events that year. This included McGill University, which held an exhibition dedicated to Copernicus in the hall of the McLennan Library. The Polish Institute published "Copernicus and His World: A Biographical Sketch" by Wanda Stachiewicz, in both French and English. It sold over ten thousand copies.

Lastly, Mr. Wladysiuk spoke about the commissioning of the Copernicus Monument in Montreal, which was the contribution of the Canadian Polonia to the Montreal Expo (in 1967), including the many efforts to fundraise for the monument, the popularity of the monument at the expo and the symbolism of the monument (communist Poland did not participate in Expo 67 and Nicolaus Copernicus was therefore the main representative of the Polish nation at the world exhibition). On the last day of the exhibition the monument of Copernicus was officially handed over to the mayor of the City of Montreal, Jean Drapeau. The city of Montreal is the owner of the monument and is obligated to place it in a worthy place and take care of its appearance and maintenance.

The exhibition at the Osler Library was noted with respect in the Polish community of Canada. The Polish Institute of Arts and Sciences in Canada thanks the Osler Library for making it possible to honor the memory of our great compatriot who *stopped the sun and moved the earth*.

# Celebrating Michèle Larose-Osler Library Artist-In-Residence Ana María Gómez López

On 3 April 2023, we hosted our first in-person non-hybrid event in over three years. We were delighted to welcome Ana María Gómez López, whose original residency in March–April 2020 had been put on indefinite hold at the start of the pandemic. The evening featured introductory remarks by Trenholme Dean of Libraries, Guylaine Beaudry and by Professor of Art History, Mary Hunter, who introduced the inspiration and benefactor behind the residency, artist and paediatric neuropsychiatrist Michèle Larose. Dre Larose shared thoughts about her vision for the residency and reflections upon the first few years of its presence at the Osler Library. The evening concluded with a presentation by Ana María Gómez López about her work, followed by comments within the Osler Room explaining the exhibit she had set up in the space.

Ms. Gómez López’s original proposal was for her to use the residency to further develop *Punctum*, which she described as “a durational artwork based on the creation of an extracorporeal circulatory structure for self-transfusion” (Figure 1). In her talk in April, Ms. Gómez López provided an overview of a number of projects she has developed. She updated the audience as to the status of *Punctum*, including challenges wrought by the pandemic. Other artworks that drew upon self-experimentation include *Inoculate*. In her talk, she shared a number of images from *inoculate* and described the process by which she germinated a begonia seed in her lower right tear duct using a silicone punctal plug.

Although the pandemic delayed Ms. Gómez López’s residency by three years, contact between her and Osler Library staff has been consistent during this pause. During her talk, the development that occurred over those years was evident. Among the resources that she has consulted – from afar and then in the library in March and April – include the Frank Campbell MacIntosh Fonds (re: George Mines), the Harold Griffith Fonds (re: curare), and numerous works on anatomy and medicine that support the artworks Ms. Gómez López is developing.

## About the artist

Ana María Gómez López is an interdisciplinary artist, writer, and educator from Cali, Colombia based in Amsterdam. Her practice centers on self-experimentation, definitions of biological life, legacies of utopian thought, and archival research in the history of science, medicine, and technology. Ana María was selected for a 2023 CIFO-Ars Electronica Award, to be exhibited at the Lentos Kunstmuseum. Her work has been shown at the de Cordova Sculpture Park and Museum, Fonds d’art contemporain Genève, Rijksmuseum Boerhaave, V2\_Lab for Unstable Media, Rencontres Internationales, and DOK Leipzig. Ana María was a resident artist at the Rijksakademie van Beeldende Kunsten and has held fellowships at the Beinecke Rare Books and Manuscripts Library, International Institute for Social History, and Max Planck Institute for History of Science. She currently teaches at the Sandberg Institute in Amsterdam and the Royal Academy of Art in The Hague.

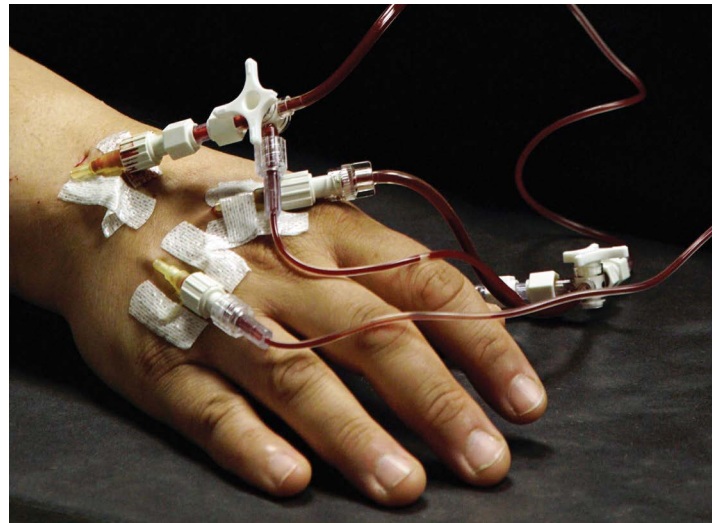


Fig. 1. Ana María Gómez López, *Punctum* v.5 (detail) 2018. – Photo credit: Shen Xin.



Figures 2 and 3. Details from the exhibit Ms. Gómez curated to go with her talk. Items shown here come from the Maude Abbott Medical Museum and from the Osler Library.



# CONFERENCE ROUNDUP

May was an important month for the Osler Library on the conference circuit. Four meetings convened that were directly relevant to our work: LAMPHHS (Librarians, Archivists, and Museum Professionals in the History of the Health Sciences) and AAHM (American Association for the History of Medicine) in Ann Arbor, Michigan, followed by the AOS (American Osler Society) in London, UK, and finally the CSHM-SCHM (Canadian Society for the History of Medicine) in York, Ontario. Osler Library staff cannot always make it to all of these meetings due to scheduling, but it is certain that each of those conferences will be attended by multiple scholars who have used our resources.



LAMPHHS President Polina Ilieva presents the Recognition of Merit Award to Dr. J. Mario Molina. Photo credit: Stephen Greenberg.

Of the meetings this year, LAMPHHS provided an exciting start. In the opening session, close colleague and Osler Library curator Dr. Richard Fraser gave a virtual talk about his successful work in rejuvenating past collections to create the Maude Abbott Medical Museum, the success of which owed much to the support of ex officio Chair of the Osler Library Board of Curators, outgoing Vice-Principal (Health Affairs) and Dean of the Faculty of Medicine and Health Sciences, Dr. David Eidelman.

The highlight of the conference came at the awards luncheon, which saw two curators independently selected for the Recognition of Merit Award: Dr. Rolando Del Maestro and Dr. J. Mario Molina. The award is typically given to one individual each year and acknowledges significant contributions made by someone who is not a member of LAMPHHS to support institutions who work to preserve heritage collections in the history of the health sciences.

The nomination for the award must come from a LAMPHHS member, but it can be supported by two other individuals, who need not be members. The two categories of recognition are: a) for a member or non-member of LAMPHHS “who make gifts of an extraordinary nature

to health sciences libraries” and b) for “non-members of LAMPHHS who have provided long-time excellent service to health sciences libraries.” It is clear that Dr. Del Maestro and Dr. Molina each qualify for the award many times over, and to have two curators recognized in one year is a reflection of the collective strength and dedication of the Board.

Following the meetings in Ann Arbor, the American Osler Society met in London for a weekend of tours organized around the history of medicine, followed by two and one half days of presentations.

Representing McGill were Dr. Rolando Del Maestro, who spoke in the opening session about “Freud and Leonardo: Confabulation and Creativity,” and medical students Ali Fazlollahi (“History of Apprenticeship in

Neurosurgery at the Montreal Neurological Institute, 1934-1960”) and Yoel Yakobi, whose presentation “Concessions, Coercions, and Coveted Conversions: Exploring Pope Gregory XIII’s Injunction of the 1584 Against Jewish Physicians,” was awarded first prize among the Best Student Presentations of 2023. Another highlight of the conference was the enthusiastic professionalism with which Ali Fazlollahi executed his role as the first ever medical student moderator of a session at an AOS meeting.

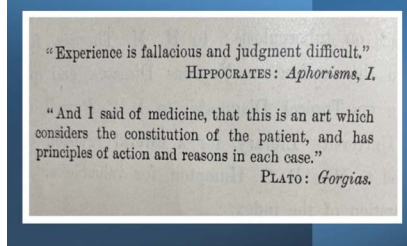
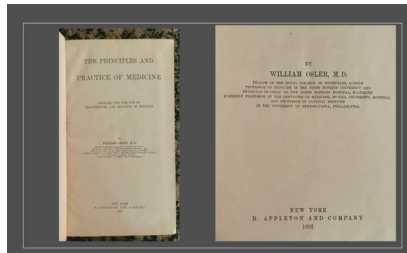


# Osler's *Principles and Practice of Medicine* (1st edition, 2nd impression) Auctioned Off to Support the Osler Library

In fall 2022, Dr. Frederic Braun (MCDM, 1972) offered the Osler Library a unique gift: his personal copy of William Osler's *The Principles and Practice of Medicine*. Dr. Braun is a pediatric neurologist based in Bellingham Washington and the book had been a gift from his friend and mentor at the University of Washington, Dr. Ronald Lemire.

Knowing that the library possesses a number of first editions of Osler's textbook, Dr. Braun proposed that we sell the book to benefit the library; specifically, we agreed that the most fitting application of the funds raised would be to support the work we do to engage medical students.

This particular copy was a first edition, second impression; after all, the spelling of Gorgias in the quote on p. vi had been corrected from the first impression's erroneous Georgias. The book came in a beautiful custom-crafted protective box and was in excellent condition, except that both covers were detached. After some discussions at the library, Dr. Rolando Del Maestro proposed that we have the book



repaired by Timothy Dyck of The Colour Jar, whose services he uses for his personal collection.

A special silent auction took place during the first three days of the annual meeting of the American Osler Society in London (21-24 May 2023). There was considerable interest around the table at the meeting, as attendees kept their eye on bids coming in from Oslerians present at the auction and some who were keeping tabs from afar. Bidding closed at the end of the second day of talks, prior to the banquet.

We are pleased to announce that the winner of the auction was Dr. C. Ronald MacKenzie, C Ronald MacKenzie Chair in Ethics and Medicine, Hospital for Special Surgery, New York. In keeping with his interest in humanities and medicine, Dr. MacKenzie gave a talk at the AOS meeting on "Lord Strathcona, William Osler, and a Pinch of Shakespeare."

Thank you, Drs. Braun and MacKenzie, for your generous support of the library; Dr. MacKenzie, we hope that the volume brings you much joy.

By **Ali M. Fazlollahi**, MSC, MDCM, Class of 2025

As a medical student at McGill University, the institution Sir William Osler once called home, I embarked on a brief yet transformative journey to participate in the American Osler Society Meeting held in London, UK. Upon arrival, I was welcomed by the city's rich history, cultural heritage, and academic prominence, which evoked a profound connection with the great physician himself.

Participating in the conference was a gratifying experience. I enjoyed listening to presentations on diverse topics related to art and history and engaging with the audience, consisting of scholars and enthusiasts of medical humanities. I presented on the history of apprenticeship at the Montreal Neurological Institute and the role of Dr. Wilder Penfield, one of Osler's students, in setting the institution up for success.



Yoel Yakobi and Ali Fazlollahi outside of the Royal College of Physicians, London

Furthermore, I had the opportunity to moderate a session on the "Search for Beauty in Art & Prose" within medicine, which added a new dimension to my experience. I especially enjoyed meeting scholars from around the world and connecting with medical students who shared the same passion for the art of medicine. It was an honour to represent McGill with my friend and fellow Molina Foundation Scholar, Yoel Yakobi, and we had fun exploring London together.

Throughout my time in London, I was captivated by the city's vibrant energy. The rich tapestry of history, art, and culture that permeates its streets served as a constant reminder of the enduring impact of human creativity and innovation. The conference, in its entirety, embodied the essence of Sir William Osler's pursuit of intellectual curiosity and holistic understanding. I am immensely thankful to the Osler Library and McGill University for supporting my travel and enabling this unique opportunity.

# The MDCM Medical Degree: A History

By Joseph Hanaway, MDCM, FAAN

## I. The first CM degree

Surgeons for more than a century were trained as apprentices by Barber Surgeon guilds and did not have MDs but traditionally were quite influential. By the 19th century, surgery was being taught in the universities in Scotland. This story begins in the early 19th century when a private surgical corporation, the Faculty of Physicians and Surgeons of Glasgow,<sup>1</sup> (eventually a Royal College) began to question the quality of surgical training in the School of Medicine of Glasgow University. Convinced that the surgical education at the University was inadequate, the Faculty used its influence to eliminate competition and successfully petitioned a local court to issue an order preventing anyone from practicing surgery in Glasgow who had not passed its examinations.<sup>2</sup> The University, not wanting a private organization to dispute its degrees, in 1816 countered the Faculty's challenge by offering the degree of Master of Surgery (Magistratus Chirurgia or CM) to certify that there was surgical as well as medical training in the school.<sup>3</sup>

The Faculty's prestige and income in surgery, heretofore unchallenged, was threatened by this action. To save face, it requested and received an Order of Interdict in the courts in session in 1826 that would prevent Glasgow University from awarding its CM degree. The prolonged trial eventually reached the House of Lords, sympathetic with the Faculty, and the order was finally passed in 1840 and Glasgow University was forced to cease awarding the degree. According to Glasgow University archival records, no CMs were granted in the 1840s and early 1850s but the degree was restored in 1858<sup>4</sup> when the parliamentary Medical Act legislated the CM for the entire United Kingdom.

“ The registries were the government's first major step to control the quackery problem.

The CM was awarded by Glasgow until 1973, when it was finally discontinued as surgical education was firmly ensconced within the standard medical curriculum. Edinburgh University adopted the MB<sup>5</sup> and CM degree in 1858 as did the other two universities (St Andrews and Aberdeen), which dropped the MD for the MB being used throughout the United Kingdom.

## II. The medical reform movement in the mid-19th century and the CM degree

The next appearance of the CM degree was in the British Parliamentary Medical Act of 1858, passed to control rampant quackery in the United Kingdom. A lack of adequate laws for credentialing and licensing the medical profession in the United Kingdom in the first half of the 19th century was widely acknowledged to be such a problem that Parliamentary reformers began to propose bills to rectify the situation in the 1840s.

The power of the Royal Colleges was so great that they made it almost impossible to practice unlicensed within the city limits under their control, which made quackery mostly a suburban and rural problem. With no oversight or accountability beyond the reach of the Royal Colleges, patients were the victims of unscrupulous practitioners and had no way to determine who was qualified and who was not, particularly with the surgeons.<sup>6</sup>

John Simon (1816-1904) a prominent figure in government public health issues<sup>7</sup> and a reform leader, recognized the serious problem of the public not knowing the qualifications of their doctors. As a coauthor of the Medical Act (1858), he proposed that the CM be required and believed adding it would certify surgical training in the medical schools and satisfy the many complaints members of Parliament were receiving about surgical qualification. On August 2, 1858, two educational reform acts were passed by Parliament that affected medicine: the Medical Act and the Universities Act (for Scotland).

## III. The Medical Act (Cap. XC, 2d, August 1858)

For the purposes of this article, the Medical Act of 1858 can be boiled down to the establishment of a General Council of Medical Education and Registration of the United Kingdom (GMC) to monitor medical practice. It would appoint a Registrar to establish what constituted legal qualifications for practitioners and draw up a national registry of qualified practitioners to be printed, published and sold annually to the public.<sup>8</sup> The registries were the government's first major step to control the quackery problem.<sup>9</sup>

Regarding the CM degree, Schedule A at the end of the Medical Act lists eleven professional credentials (e.g., Fellows, Licentiates, Members of the Royal Colleges in the U.K.) that conferred legal qualification to practice as physicians and surgeons. Included in this list were recipients of University CM, MB and MD degrees.

#### IV. The Universities Act (Cap. LXXXIII, 2 August 1858) and the MD and CM degrees mandated for Scottish Universities

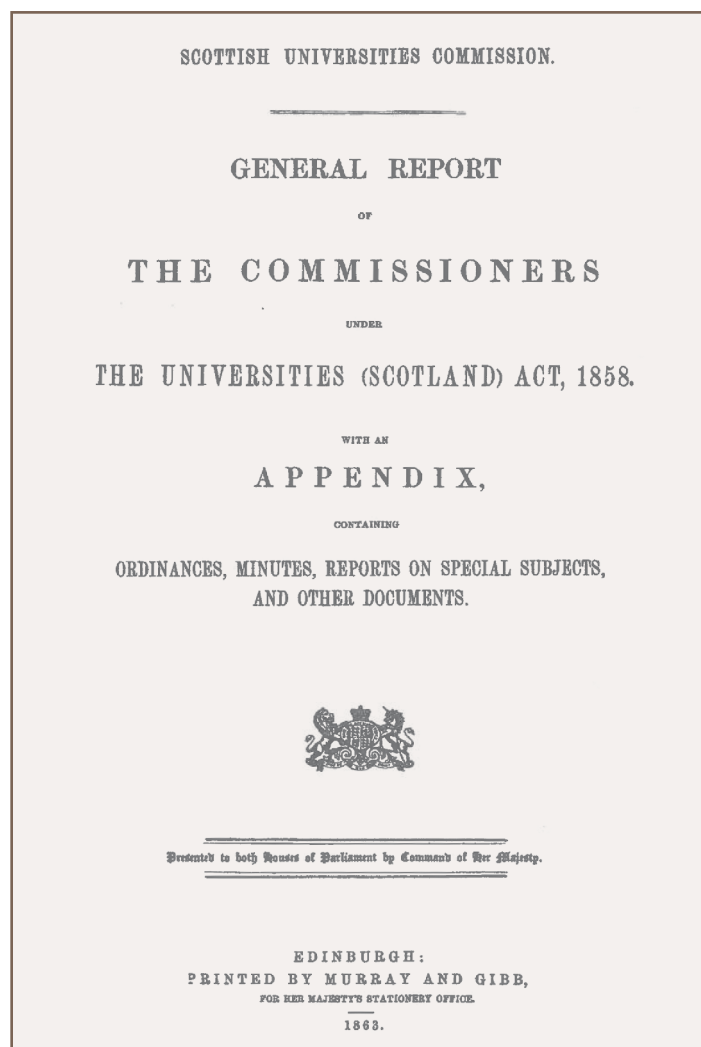


Fig. 1. The title page of the Scottish Universities Commission, General Report, 1863.

The Universities Act 1858 for Scottish universities was an attempt to standardize all aspects of university activity in the four universities. The Act's most important charge was to appoint a Scottish Universities Commission in an 1858 to investigate and recommend its comprehensive findings in a 1863 report that included medical education (Figure 1).<sup>10</sup> Out of ninety ordinances indexed in the Commission's Report in 1863, only five are rules for the four medical schools: one each for the universities in Glasgow, Aberdeen, and St. Andrews, and two for Edinburgh.<sup>11</sup>

The medical ordinances specifically outline the premed and medical courses required, the length of time spent in medical school, the examinations for graduation, and most important the types of degree to be awarded: the MB, CM, and the MD, the latter of which became a post graduate degree.

Standardizing medical education in Scotland was a major priority of the Act. The CM degree to be awarded by Edinburgh

starting in 1858, however, presented a problem. The Edinburgh University School of Medicine was regarded as the leading medical school in the western world and its CM was viewed by the private corporations (Royal Colleges) in the UK as a threat to their income and the traditional prestige they garnered from licensing surgeons, and they wanted it struck out.

In 1860, in a desperate and self-serving class action, the Royal Colleges of Physicians and the Royal College of Surgeons of Edinburgh, the Faculty of Physicians and of Surgeons of Glasgow, and the Royal College of Surgeons of England, had the audacity to petition the crown to prevent Edinburgh University from awarding the CM degree. Accordingly, a Royal Commission was convened to hear the petition.

#### V. The Report of the Petition against Ordinances #5 and #8 relative to graduation in medicine in the University of Edinburgh (1860)<sup>12</sup>

The Royal Commission heard the arguments of the petitioners (Royal Colleges) on three points, paraphrased for clarity:

1. Did the University have the right to grant the degree of Master of Surgery (CM) as proposed in the fifth ordinance in the Scottish Commission's report of 1863?
2. Was there a precedent for the University to grant the degree, supposing it had the power to do so (Schedule A of the Medical Act of 1858)?
3. Was the quality of the surgical education in the university reliable as required under the eighth ordinance in the 1858 Scottish Commission's report?

In an eight-page summary report of the hearings, the Commission, astonished by the obvious self-serving attempt to censor a university degree, rejected the petitions. It concluded that the University did have the right to grant the CM when surgery was a department and was taught in the medical school, that there was legal precedence to grant the CM based on the Medical Act, 1858 (schedule A) and that there was no question of the quality of the surgical training in the medical school based on the curriculum information and testimony provided.

#### VI. The CM degree at McGill University

One cannot overstate the influence of Edinburgh medicine on the founding and early years of McGill University and its medical school. McGill was a clone of Edinburgh, which was its strength in its first six to eight decades.<sup>13</sup> The four founders of the Montreal Medical Institution, which would be incorporated as the Medical Faculty of McGill College in 1829, were physicians educated at Edinburgh University who transferred its traditions to McGill. Andrew Fernando Holmes (1797-1860) and John Stephenson (1797-1842) were graduates, and William Caldwell (1782-1833)



and William Robertson (1784-1844) dropped out before graduation to be military surgeons. Based on their Edinburgh records and military experience, Caldwell purchased an MD from Marischal College (Aberdeen) in 1819 and Robertson was granted an honorary MD degree “Honoris Causa” by the University of Vermont in 1832, whose medical college had been founded by fellow Edinburgh graduates and where he was a part-time teacher.

The founders of the Montreal Medical Institution began teaching in 1823 and were invited to become the Medical Faculty of McGill College in 1829 (the first McGill Faculty). Opened as a medical school, the medical faculty carried on the Edinburgh tradition of didactic teaching, with a strong emphasis on anatomy and limited student access to the wards of the Montreal General Hospital. McGill’s reputation and strength grew with its steadfast adherence to the traditional methods of teaching transferred from Edinburgh.

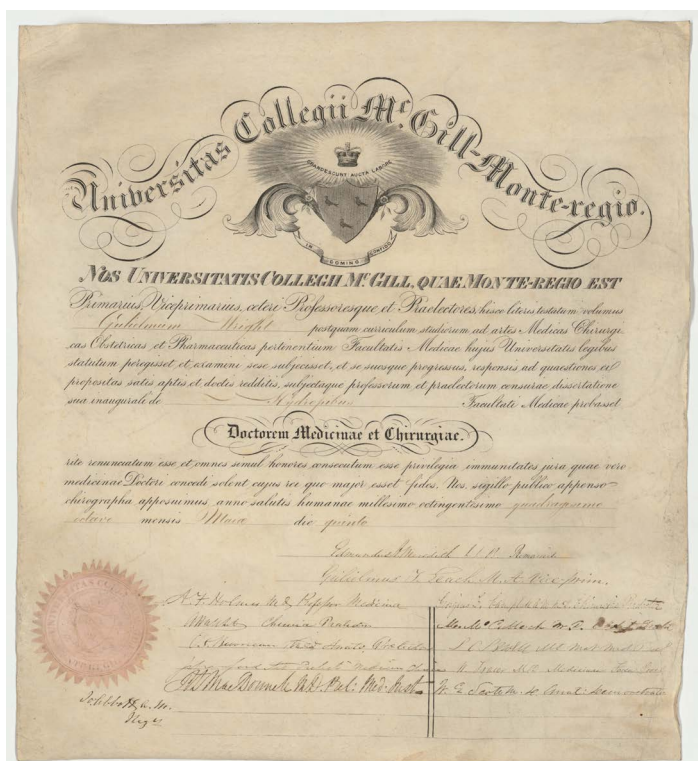


Fig. 2. In 1848 William Wright, the first Black medical graduate and professor in Canada, received the degree of DMC.

The first degree awarded was the MD (1833) and according to the McGill Statutes, etc. of 1832, “the degree was to be the MD or Doctor of Medicine and Surgery” (see figure 2).<sup>14</sup> Adding the CM to the MD was the suggestion of the second Dean of Medicine and Professor of Surgery (1860-1882), George Campbell (1810-1881), a Glasgow University graduate familiar with the history of the CM degree. He argued that the MD alone was misleading because it emphasized medical training in the medical school because the graduates were referred to as medical doctors. He recommended that adding the post- nominal CM to the MD would correct this misconception. Campbell’s 1861 plan to change the degree to MDCM, presented to the Corporation and Board of Governors

of McGill College was accepted and the graduating class of May 1862 was the first to receive the new degree (see figure 3).<sup>15</sup>

The change to the MDCM, though considered historically important now, was not so in 1862. For some reason there was hardly any official notice, except a note in the Annual Announcement of the Faculty of Medicine and the Dean’s Annual Report of 1862-63. The official record of the degree change to the MDCM is found in the *Statutes of McGill University*, 1864.<sup>16</sup>

During the 160 years since the first MDCM degree was awarded at McGill, there has never been serious thought to change it. McGill, steeped in the tradition of medical history from William Osler, considers that the historic importance of the MDCM far outweighs any thought of its literal meaning.

## VI. Brief history of the CM in other Canadian medical schools

McGill’s medical monopoly in Montreal and Quebec included controlling local and provincial medical organizations and staff privileges at the Montreal General Hospital. This caused bitterness and an anti- McGill sentiment, particularly among the other Edinburgh graduates who felt left out. Disgruntled by McGill’s control, a number of these Edinburgh graduates formed three competitive medical schools: École de Médecine et de Chirurgie de Montréal (1843), the Bishop’s School of Medicine (1871), and the St Lawrence School of Medicine (1850), which lasted less than a year and never graduated a student or granted a degree.

### a. École de Médecine et de Chirurgie de Montréal

In 1843 a rival medical school “École de Médecine et de Chirurgie de Montréal,” opened as a bilingual school, appealing to francophones<sup>17</sup> since at that time there was no French language medical school. It was subject to Quebec restrictions on degrees issued by free standing schools not attached to a university or college. The École could not grant a degree but its graduates could obtain Quebec licenses after four years if they passed the appropriate exams. In 1866 the École affiliated with Victoria University in Cobourg, Ontario as its Montreal medical branch and could then grant degrees starting in 1870.<sup>18</sup>

Based on records held in the Université de Montréal Library of Special Collections the first notice of the intent to award the MDCM degree is found in the *Circulaires, École de Médecine et de Chirurgie de Montréal* in 1882-1883. Between 1885 and 1889 École awarded twenty-three students and six staff MDCMs and 304 MDs.<sup>19</sup> The École became the Montreal Medical Branch of Laval University in 1890, at which time the MDCM ceased to be awarded. In 1920, the École became the Medical Faculty of the Université de Montréal.

### b. Bishop’s College Faculty of Medicine

Founded in 1871 by McGill graduates William Hingston, A. H. David, and E.H. Trenholme, together with Charles Smallwood

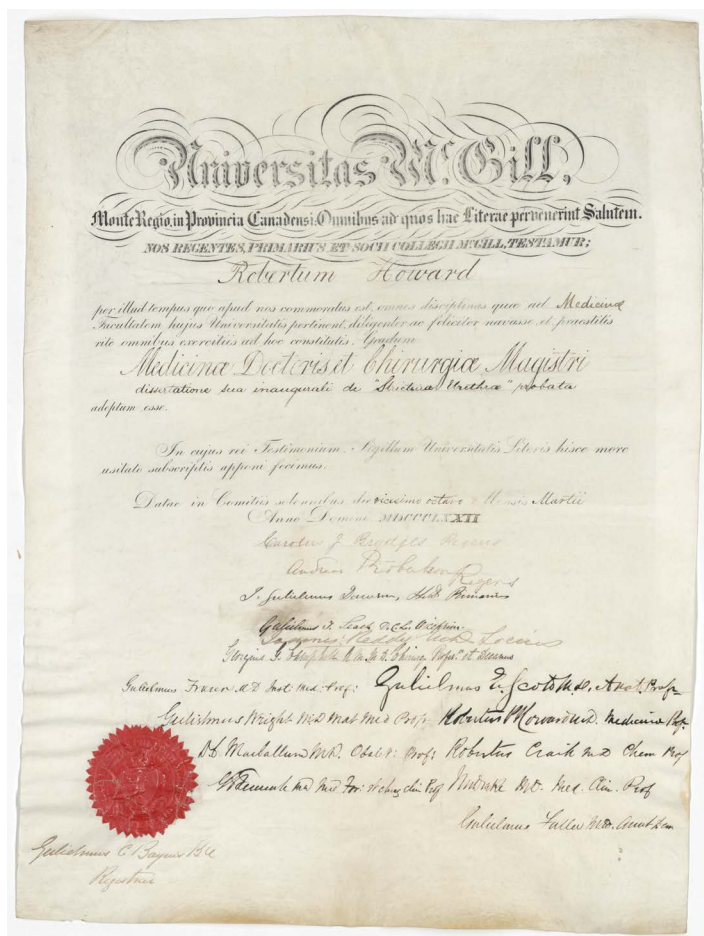


Fig. 3. The earliest copy of an MCDM diploma at the Osler Library is this one, awarded to Robert Howard in 1872. Wellcome Collection in London has one (not shown) awarded to Edward Lewis Lundy in 1862.

from the University of Birmingham, Bishop's was the only McGill rival already part of an Institution of higher learning, Bishop's College in Lennoxville, Quebec.<sup>20</sup> This meant that Bishop's Faculty of Medicine could award degrees.

Francis Wayland Campbell (1837-1905) a McGill graduate and a long-time Dean of Medicine at Bishop's (1875-1903), was a vocal anti-McGill activist who never lost an opportunity to criticize McGill's medical monopoly in Quebec and its unfair treatment of anyone not associated with the institution.<sup>21</sup> Regarding its medical degree, according to Bishop's Faculty minutes April 4, 1872,<sup>22</sup> it reversed the traditional order of the degrees to the CM MD and it continued awarding the CM MD until 1905, when it officially closed upon amalgamation with McGill.

Bishop's was notable for its inclusive policies. It also did everything to attract students and was the first medical school in Quebec to admit women in 1890 (McGill didn't until 1918) and granted the first degree to a Jewish woman in Quebec in 1895. In addition, it started the first dental school in Quebec in 1896. Among its graduates were Maude Seymour Abbott, renowned cardiac pathologist; William Henry Drummond, a famous habitant poet; Casey Wood, renowned ophthalmologist and bibliophile; and Grace Octavia Ritchie, the first female medical school graduate in Quebec.

By 1905, Bishop's had graduated 246 CM MDs, but the facilities needed extensive renovation. Not in debt but without the resources to pay for the renovations, the only option for the sake of the students was to amalgamate with McGill in 1905. Bishop's students could enter McGill and graduate with a Bishop's CM MD or, if they wanted a McGill degree, they had to start in first year. McGill also offered an "Ad Eundem" degree to Bishop's graduates for years on a case-by-case basis, but they had to apply; the last was granted in 1914.<sup>23</sup>

### c. Queen's University Faculty of Medicine

Outside Quebec, other medical schools founded by Scottish and English graduates adopted the MDCM. Queen's University in Kingston, Ontario was founded in 1841 by Scottish Presbyterians to counter the authority of the Anglican Trinity University in Toronto. Queen's was to be the Edinburgh of Ontario, open to all religions.<sup>24</sup> When the Kingston General Hospital was chartered in 1847, a group of physicians led by Edinburgh attendees organized a Faculty of Medicine for Queen's, in 1854. It opened ambitiously as a four-year school but struggled, closing in 1866. The staff regrouped and founded the independent Royal College of Physicians and Surgeons of Kingston (called the "Royal"). It moved to the Queen's campus in 1880, became the Faculty of Medicine of Queen's University in 1881, and the Royal was dissolved in 1882.

In 1881, Queen's medical students, influenced by McGill's decision to issue an MDCM,<sup>25</sup> petitioned the school to add the CM to the MD. Queen's students received the MDCM for seventy-four years, until 1955-56 when the need for surgical recognition in the degree was no longer relevant. In the section on the Faculty of Medicine in the 1955-56 *Principal's Report*, there is a note that the CM would cease to be awarded by 1960.<sup>26</sup>

### d. The Halifax Medical College and Dalhousie University

Officially founded in 1818, Dalhousie University in Halifax, Nova Scotia did not offer medical education until 1868. A group of Scottish and McGill trained physicians proposed the school, coinciding with the reopening of the Halifax Provincial & City Hospital and a provincial anatomy act legally supplying the school with cadavers.<sup>27</sup> The preclinical years were to be in Halifax and the clinical years in major medical centers such as Boston and Montreal. This plan did not work, however, so reluctantly Dalhousie became a four-year school in 1870. From the minutes of the Dalhousie University Faculty of Medicine 12 August 1870, it was decided to award the MDCM degree starting in 1872,<sup>28</sup> to certify that its graduates had training both in surgery and medicine. This school closed as a four-year endeavor in 1875 because of staff resignations and financial constraints.

A proprietary Halifax Medical College (the "Halifax") was formed in 1875 and took over medical education in the city. Dalhousie taught some of the first- and second-year courses, conducted the final exams and granted the degrees. Otherwise, it had no connection with the Halifax. In 1885 Dalhousie and the Halifax officially affiliated, but the school was still proprietary until 1911.



In his famous 1910 *Report on Medical Education in the United States and Canada*,<sup>29</sup> Abraham Flexner found that Dalhousie had little participation in the education of students at the Halifax, yet Dalhousie was awarding the MDCM degree. As a result of the report, the Halifax Medical College closed in 1911 and the Dalhousie administration was motivated to reorganize and form a Dalhousie University Faculty of Medicine, which has become one of Canada's major eastern medical centers. Dalhousie continued to offer the MDCM until the early 1950s, when the literal meaning of the CM part of the medical degree began to be challenged as being irrelevant. As per the minutes of the Senate of Dalhousie University, 25 February 1954,<sup>30</sup> the MD would be granted from 1959.

## e. The Women's Medical College of Kingston

The first three women enrolled in the "Royal" in 1880 were forced out in 1883 by chauvinistic male students who objected to their presence.<sup>31</sup> There had been plans to open a Women's College of Medicine in Kingston, where the women transferred from the "Royal". Opening in October 1883, it was to provide medical education for women in Eastern Canada. The curriculum was similar to the Royal's and graduates had an arrangement with Queen's to sit for the Queen's University MD or MDCM degree examinations to qualify for the Ontario Medical Board exams and a license.<sup>32</sup>

Because of competition from the Toronto Women's Medical College (1883) and Bishop's in Montreal, which had begun to accept women in 1890, the Kingston school had a decreasing enrollment and decided to close in 1894. It had enrolled fifty-six women, forty-two of whom graduated with the Queen's MD (thirty-five of these with the Queen's MDCM). Before the school closed, five went to Toronto for their MD and two went to Bishop's for the CMMD. The seven students that remained in the school in 1894 transferred to the Toronto school to finish their education.<sup>33</sup>

## References

<sup>1</sup> "Faculty," although it has other meanings, in this article refers to the private medical corporation of Glasgow, the Faculty of Physicians and Surgeons of Glasgow (eventually granted Royal College status).

<sup>2</sup> Comrie, John, *History of Scottish Medicine to 1860*, Bailliere, Tindall & Cox, London, 1927, 218-219.

<sup>3</sup> Comrie, 218.

<sup>4</sup> W. Innes Addison, "A Roll of the Graduates of the University of Glasgow from 31<sup>st</sup> December 1727 to 31<sup>st</sup> December 1897." It was discontinued by Resolution 104 of the Glasgow University Court, which came into force October 1973. There was a grace period and the last was awarded in July 1976. (The University of Glasgow Archival Inquiry Services, November 28, 2017).

<sup>5</sup> *The Scottish University Commission Report 1863*, section on Graduation in Medicine, General Report; Medical students in England are considered undergraduates. Since all undergraduates are awarded bachelor's degrees on graduation, medical undergraduates received the MB, which was accepted as a full qualification to practice medicine in the UK.

<sup>6</sup> Roberts, M.J.D., "The Politics of professionalism: MP's, medical men, and the 1858 Medical Act." *Medical History* 2009, Jan. 53(1), 40.

<sup>7</sup> Roberts, 37-46 about John Simon and the politics of the Medical Act of 1858; <https://www.encyclopedia.com/people/history/british-and-irish-history-biographies/john-simon>.

<sup>8</sup> *The Medical Act of 1858*, Cap. XC, 2 August 1858, articles X and XIV concerning registrars and registers.

<sup>9</sup> Lord Cohen of Birkenhead, Hastings and the General Medical Council, *Brit. Med.J.*, 1966, 2, 191-192; Roberts, 38-39. Although Roberts argues that the Medical Act of 1858 didn't accomplish what many people lobbied for, he conceded on the first page of his article that "the Act was the first major bill for medical reform passed by Parliament."

<sup>10</sup> *The Universities (Scotland) Act 1858*, Cap. LXXXIII, 2 August 1858, Graduation in Medicine, General Report, XXXII.

<sup>11</sup> *The General Report of The Commissioners under the Universities (Scotland) Act 1863*, Appendix 1, Ordinances: Edinburgh #5 & 8, Glasgow #11, Aberdeen #16 and St. Andrews #19.

<sup>12</sup> *The Commission's Report*, 1863, Appendix III, Reports, Etc. # 7.

<sup>13</sup> Cleveland, D.E.H., "The Edinburgh Tradition in Canadian Medical Education," *Vanc. Med. Ass. Bull.* V28, 1928, 219; Ewing, M., "Influence of the Edinburgh Medical School on the early Development of McGill University," *Can. J. Surg.*, v14, 1975, 287- 296; MacDermot, H.E. "The Scottish influence in Canadian Medicine," *The Practitioner*, v. 183, Jul.1959, 84-88; Hanaway, J and R. Cruess, *McGill Medicine* v.1, MQUP, 1996, 15.

<sup>14</sup> Statutes, Rules and Ordinances made and established by the Principal and Governors of McGill College for Government of the Medical Department of said college. 22nd of February, 1832, Chapter 11, article 1: "The medical degree granted by this university shall be that of Doctor of Medicine and Surgery." It was McGill's belief that graduates in medicine should be considered Doctors (MD) and not bachelors (MB).

<sup>15</sup> Minutes of the McGill Corporation 1/23/61, 4/24/61, & 9/23/61 and the Board of Governors, 5/7/61, 5/2/62 & 5/6/62, considering and agreeing to the MDCM degree. A few key dates are cited: April 24, 1861 the McGill Corporation having heard the reasons why the Faculty of Medicine wanted to change the medical degree from Doctor of Medicine and Surgery (MD) to Doctor of Medicine and Master of Surgery (MD et CM), moved to debate the proposal. More than one year later on May 2, 1862, the Board of Governors agreed to the degree change and the first class to be awarded the MDCM was in late May 1862.

<sup>16</sup> The Statutes of McGill University (1864). Chapter VIII, #5 on degrees: "Students who shall have completed the regular course of study in Medicine and shall have passed the prescribed examinations...shall be entitled to the Degree of Doctor of Medicine and Master of Surgery" (MD et CM).

<sup>17</sup> An Act to Incorporate the Montreal School of Medicine and Surgery, Cap. LXXXI, 29 March 1845.

<sup>18</sup> *Circulaire*, École de Médecine et de Chirurgie de Montréal, Session 1882-83, "Affiliée l'Université du Collège Victoria, Cobourg, L'École de Médecine (1866) est en demeure de conférer les titres de Docteur en Médecine et celui De Maître en Chirurgie..."

<sup>19</sup> From the Library of Special Collections of the Université de Montréal contacted 1/16/20. Based on the *Circulaires* for the École between 1885 and 1890, it conferred 23 student and 6 faculty MDCMs and 304 MDs.

<sup>20</sup> Campbell, F.W., History of the Foundation of the Faculty of medicine of Bishop's College, Osgood, Waterville, Qc., 1990, 1-10; Bensley, E.H., Bishop's Medical College, *CMAJ*, 1955, 72: 463-465.

<sup>21</sup> Campbell, F.W., article in *Canada Lancet*, Montreal, Sept. 15. 1863, 52-53. He rails about McGill's dominance and mistreatment of Bishop's students, etc.; Milner, E.H., Francis Weyland Campbell, *DCB*, v. 13, 1994: 1901-10.

<sup>22</sup> Milner, E.H. *Bishop's Medical faculty 1871-1905*, Rene Prince Imprimeur.



Sherbrooke, QC. 1995: Medical faculty minutes, April 4, 1872, 84 “In the afternoon of the ceremony, the Chancellor granted the degree of CM, MD (Master of Surgery and Doctor of Medicine) to the first graduates of the Medical faculty of Bishop’s College.”

<sup>23</sup> Hanaway, v11, 60-64. The 1905 amalgamation of Bishop’s and McGill and arrangements for the students and staff at Bishop’s.

<sup>24</sup> Travill, A.A. *Medicine at Queens, 1854-1920*, The faculty of Medicine of Queens University and the Hannah Institute for the History of Medicine, Kingston, Ont. 1988, 88-101, 122-148. A well-written and comprehensive history of Queens.

<sup>25</sup> Travill, 98, “Early in 1881, the students petitioned that the degree of CM (Chirurgiae Magistri- Master of Surgery) be conferred on those who passed The University examination for MD. The Faculty concurred and Dean Grant Indicated the terms on which the Senate would institute the degree.”

<sup>26</sup> *The Principal’s Report*, Queens University, Kingston, On., 1955-56: 39 in the section on The Faculty of Medicine, under changes in Curriculum: The CM degree: “The growing awareness that an undergraduate training does not fit one to be Master of Surgery has convinced the Faculty that Queens should no longer award the CM degree along with the MD. The faculty recommended to the Senate that after 1960 the graduates be given the MD alone; the Senate approved...”

<sup>27</sup> Personal communication from Dr. Allan Marble, MDCM, Chair of the Society of the History of Medicine of Nova Scotia, Oct. 28<sup>th</sup>, 2019 outlining a chronology of events in the History of the Dalhousie University Faculty of Medicine.

<sup>28</sup> From the minutes of the Dalhousie University Faculty of Medicine 12 August 1870: Resolved by the Board of Governors of Dalhousie to establish a full medical school. The degree to be MD, CM. The first graduates to be awarded the MD, CM on 19 April 1872.

<sup>29</sup> Flexner, A., *Medical Education in the United States and Canada*, Bulletin No. 4 of the Carnegie Foundation for the Advancement of Learning. The Merry Mount Press, New York, 1910, 320-321. He wrote a negative report

on the Halifax Medical College with poor student laboratory facilities, and weak clinical teaching by the part time staff who didn’t put money back into the school to keep it up to date. His between-the-lines opinion was that if Dalhousie had any future, the Halifax had to close and the University had to organize a Faculty of Medicine on University lines.

<sup>30</sup> Minutes of the Senate of Dalhousie University, Feb. 25, 1954: “Dean Grant asked for Senate approval of a decision of the Faculty of Medicine that beginning in 1959, graduates in medicine should receive the degree of MD and not the MD, CM.”

<sup>31</sup> Travill, 122-136; Godfrey, CM, *Medicine for Ontario, A history*, Mika Publishing Belleville, On. 1979, 186-190.

<sup>32</sup> Travill, 143.

<sup>33</sup> Travill, 147; Godfrey, 189. An error, 56 had enrolled in the Women’s Medical College not 26.

## Final thoughts

This article is dedicated to retired Director of the Osler Library and past president of The American Osler Society, Pam Miller, a good friend and Osler Library advocate.

We want to thank David Crawford, retired Director of the McGill Medical Library for his insightful suggestions and his remarkable record searches.

A profound gratitude is due to Mary Yearl, present Director of the Osler Library, Richard Cruess, Abe Fuks retired Deans of Medicine, and Rolando del Maestro Professor of Neurosurgery for defending the Osler Library’s independence and getting the books, moved after the 2018 library fire, back on the shelves in the Osler Library which reopened in September 2022.

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► Continued from page 4 “Exceptional Women”...

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Diplomats from the Embassy of the People's Republic of China in Canada visited the Osler Library of the History of Medicine on Saturday 3 June 2023 to see the library's Norman Bethune Collection.



## THE OSLER LIBRARY NEWSLETTER

NUMBER 138 · SUMMER 2023

Osler Library of the History of Medicine, McGill University, Montréal (Québec) Canada



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### Library Matters Osler-tagged material:

<http://news.library.mcgill.ca/tag/osler-library/>

Legal Deposit:

02/2023 ISSN 0085-4557 (Print)

02/2023 ISSN 1712-7955


### Contact:


Osler Library of the History of Medicine  
3655 Promenade Sir-William-Osler  
Montréal, Québec, Canada H3G 1Y6

Tel: (514) 398-4475

E-mail: [osler.library@mcgill.ca](mailto:osler.library@mcgill.ca)

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