

Possibilities for Intersectional Theorizing in Canadian Historiography: The Subaltern Narrative of Canadian Medical Schools

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Abstract: This paper contributes to current debates on the importance of incorporating critical race and intersectional feminist theorizing into canonical academic disciplines such as history. It is my intention to draw a connection between the historical and contemporary position of medical schools and the social, political, and economic context of Canada as a settler colonial, liberal, democratic nation. Drawing on an interdisciplinary body of literature, I argue that Canada, a growing capitalist state, can be examined from the perspective of a country built on gender- and race-based hierarchies. Salient to current scholars of social theory, critical pedagogy, medical history, and medical education, I use this lens to reflect on the establishment of and reforms to medical schools as institutions from the pre-Confederation era into the modern paradigm of neoliberalism. This analysis suggests that medical schools are important sites to examine the gendered and racialized divisions of bodies and ideologies. This introspection of medical school history is an important part of making changes in our health systems to move forward global and local projects of health equity.

Medical schools in Canada have changed drastically since the founding of the first institution more than 150 years ago. The vast majority of recent scholarship on this topic has focused on the application of clinical based interventions, evaluation of competencies and practice, and cross-comparative analysis between countries.² However, as an emerging scholar attempting

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² For example, see the following articles in recent medical education literature: Barry Issenberg et al., “Features and Uses of High-Fidelity Medical Simulations that Lead to Effective Learning: A BEME Systematic Review,” *Medical Teacher* 27, no. 1 (2005): 10-28; Karen Mann, Jill Gordon, and Anna MacLeod,

to blur the boundaries between the natural sciences, health policy, critical pedagogy, and intersectional theories of identity, I find that there is an exciting opportunity for interdisciplinary analysis that explores the historical, political, economic, and social contexts in which medical schools operate and grow. The main thesis of this paper is that the establishment and reforms to Canadian medical education are a compelling departure point for medical historians, social scientists, and the public health community. Adding to the call for framing medical education research using social theory, I make a case for further examining the intersections of patriarchy, colonialism, capitalism and the institutionalization of biomedical dominance in health.³ On the health care system as a whole, critical health researchers state that ideologies of “egalitarianism and individualism” have permeated all aspects of policy and practice in Canada—ostensibly legitimizing the erasure of the inequitable processes through which one of the pillars of the health care system has been built.⁴ As an upstream element of the health

“Reflection and Reflective Practice in Health Professions Education: A Systematic Review,” *Advances in Health Sciences Education* 14, no. 4 (2009): 595-621; Anne Wong, “Culture in Medical Education: Comparing a Thai and a Canadian Residency Programme,” *Medical Education* 45, no. 12 (2011): 1209-1219; Patrick Sullivan, “Canadian-Style Medical Education in China,” *Canadian Medical Association Journal* 188, no. 1 (2016): E13; Nicolette Caccia, Amy Nakajima, and Nancy Kent, “Competency-Based Medical Education: The Wave of the Future,” *Journal of Obstetrics and Gynaecology Canada* 37, no. 4 (2015): 349-353; Betty Onyura et al., “Affordances of Knowledge Translation in Medical Education: A Qualitative Exploration of Empirical Knowledge Use Among Medical Educators,” *Academic Medicine* 90, no. 4 (2015): 518-524; Tahara D. Bhate and Lawrence C. Loh, “Building a Generation of Physician Advocates: The Case for Including Mandatory Training in Advocacy in Canadian Medical School Curricula,” *Academic Medicine* 90, no. 12 (2015): 1602-1606; Gerald Choon-Huat Koh, Hoon Eng Khoo, Mee Lian Wong, and David Koh, “The Effects of Problem-Based Learning during Medical School on Physician Competency: A Systematic Review,” *Canadian Medical Association Journal* 178, no. 1 (2008): 34-41.

³ Brian Hodges, “The Many and Conflicting Histories of Medical Education in Canada and the USA: An Introduction to the Paradigm Wars,” *Medical Education*, 39 no. 6 (2005): 613.

⁴ Joan Anderson and Sheryl Reimer-Kirkham, “Constructing Nation: The Gendering and Racializing of the Canadian Health Care System,” in *Painting*

care system, I suggest that the area of medical education from a critical perspective is both under-researched and under-theorized. This paper has the aim of offering an exploratory feminist, anti-racist critique of the history of medical schools and the current medical paradigm in Canada.

In this paper, I construct an abridged though dynamic chronology of Canadian medical schools with special focus on the (c)overt exclusion of women and racialized groups from these institutions (which warrant further exploration by more skilled archivists). I attend to the ways in which the trajectories of medical schools align with political and economic changes starting with the establishment of the European medical system during pre-Confederation, reforms following the Victorian period and rise of liberalism, and how this has culminated in neoliberal higher education and contemporary Canadian racial exceptionalism. In this history, I suggest that race has at times been used as an exclusionary category to distinguish between settlers from the French and British founding nations and racialized groups (including other European immigrants, non-European immigrants, and Aboriginal peoples). Moreover, that ideologies of nation-building centering Whiteness used to justify the land on which medical schools have been built are the same ideologies that produced the violence of western medicine's humanitarian mission of colonization.⁵ At the same time, gender has been the basis for carving out the category of 'physician,' a masculine figure corresponding with the ideal liberal individual, with women often being relegated to the softer and more feminine work of nursing. By pivoting an analysis of medical education history on sex/gender and race, two axes of power, the retention and

the Maple: Essays on Race, Gender, and the Construction of Canada, eds. Veronica Strong-Boag, Sherrill E Grace, Avigail Eisenberg, and Joan Anderson (Vancouver: UBC Press, 1998), 242-261.

⁵ Upon reading the chapter titled "Acts of Humanity: Indian Health Services" in *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-50* by Mary-Ellen Kelm (Vancouver: UBC Press, 1999), the disjuncture in world-views between First Nations and Europeans is made abundantly clear. The civilizing-project virtually erased Indigenous healing practices in dominant settler society.

recruitment of individuals in student, faculty, and administrative positions within these institutions can be re-thought. In conversation with Canadian scholars that are doing the important work of looking at the current representation of women of colour within universities and colleges, I argue that gendered and racialized processes have shaped the deepening of educational and social stratification and new forms of health inequities.⁶ It should be noted that these are intersectional and emergent relations that work “in and through each other.”⁷

This paper is structured by three sections: (1) a brief history of the formation of the Canadian medical schools until the end of the 20th century; (2) an exploration of the intersections of race and sex/gender in medical school history; and finally, (3) a few notes on the dominant paradigm of medicine and its relation to the logics of neoliberalism. Neoliberalism can be described here as the shift in the global political economy that has taken place in the last few decades, characterized by increased ‘free’ trade, opposition to state regulation, state refusal of responsibility for social welfare, and increase in resource privatization.⁸ As a non-historian drawing on the work of historians, health researchers, and social justice scholars as evidence, I aim to offer a re-thinking of the history of Canadian medical schools that is critical in its analysis. Indeed, this paper does not aim to provide a comprehensive review of the history of the Canadian medical schools or the medical profession.⁹ Instead, through my training

⁶ See the work of Malinda Smith, President of the Academic Women’s Association at the University of Alberta.

⁷ Himani Bannerji, *Thinking Through: Essays on Feminism, Marxism and Anti-racism* (Toronto: The Women’s Press, 1995), 12.

⁸ Alison M. Jaggar, “Vulnerable Women and Neo-liberal Globalization: Debt Burdens Undermine Women’s Health in the Global South,” *Theoretical Medicine and Bioethics*, 23, no. 6 (2002): 432.

⁹ For this refer to: John Joseph Heagerty, *Four Centuries of Medical History in Canada and a Sketch of the Medical History of Newfoundland, Vol. 2*. (Toronto: Macmillian Co. of Canada, 1928); Juaane Nancarrow Clarke, *Health, Illness, and Medicine in Canada* (Don Mills: Oxford University Press, 2004); William Canniff, *The Medical Profession in Upper Canada 1783-1850: A Historical Narrative with Original Documents in Relation to the Profession, Including Some Brief Biographies* (1894); Pat Armstrong, Hugh Armstrong, Ivy

as a developmental biologist, a policy analyst, a once budding pre-medical student, daughter of Indian immigrant parents, and now a gender and ethnic studies doctoral student, I wish to bring attention to the ways in which medical schools have worked to legitimize gender-ed and race-ed “ruling relations” in Canada.¹⁰

Medical Schools Until the Late-Twentieth Century

Medical Schools and the Two Founding Nations

Medicine began in Canada centuries before French and British colonization. Indeed, there were intricate systems of medicine practiced by Indigenous communities that centered around healers drawing on herbalism, prayer, and the extraction of spirits—all given the name of ‘Shamans.’¹¹ Although seen as peripheral to allopathic medicine, Indigenous systems of healing having continued to evolve parallel to and in interaction with dominant European medicine, withstanding many extensions of this system including residential schools, the reservation system, and eugenic sterilization practices. Early settler writings describe the Algonkian speaking traditional healers of the Ojibwa tribe who had “the presumption and folly to fancy that [they were] immortal, and possessed of the power of curing all diseases, by speaking to the good and evil spirits.”¹² These shamans were described to be mediators of the Mide’wiwin or “Grand Medicine Society.”¹³ Mary-Ellen Kelm, drawing on early ethnographies describes with detail the road and selection process for becoming a healer in

Bourgeault, Jacqueline Choiniere, Eric Mykhalovskiy, and Jerry P. White. *Heal thyself: Managing Health Care Reform* (Aurora: Garamond Press, 2000); and, Hodges, *Paradigm Wars*.

¹⁰ Dorothy Smith, *Conceptual Practices of Power: A Feminist Sociology of Knowledge* (Toronto: University of Toronto Press, 1990), 74.

¹¹ Descriptions taken from: Walter James Hoffman, *The Mide’wiwin: Grand Medicine Society of the Ojibway* (7th Annual Report of the Bureau of American Ethnology, Washington, 1891), 156; Kelm, *Colonizing Bodies*, 98.

¹² Louis Armand Baron de La Hontan, *New Voyages to North America Volume 2* (London: H. Bonwicke, 1703), 47.

¹³ Ruth Landes, *Ojibwa Religion and the Midewiwin* (Madison: University of Wisconsin Press, 1968), 48.

many west coast First Nations communities. In many cases, it required the prospective trainees to be isolated from the human world, perform “ritual purifications” culminating as a quest to hone healing powers, and ending with severe illness from which they would either recover, having passed their test, or perish.¹⁴ Upon successful transition novice doctors were re-integrated into the community through feast, dance, performance, and ceremony. Particularly relevant is her mention of the differences in paths for women and men. The prospective trainees were thought by some to have a particular connection and control over a spirit, passing through the liminal space between human and non-human worlds. For men this spirit would take the form of a wolf, killer whale, or bird and for women the spirit would exist in song. After marriage many women were seen as unclean and therefore not as desirable to the spirits, meaning fewer women healers. Historical accounts show that these healers did interact with and treat European settlers; in fact, as highly proficient herbalists Aboriginal Shamans remedied sailors accompanying Jacques Cartier of scurvy using the vitamin rich sources of spruce and hemlock buds and bark.¹⁵ It should be noted that these written accounts of Aboriginal beliefs and customs have been textualized by settlers, historians, and anthropologists using the romantic languages and their alphabets; traditionally, Aboriginal healing practices are passed down through oral histories and stories. Indigenous medicine began to break down after prolonged contact with the Europeans and their imported (often epidemic) diseases such as measles, typhoid, typhus, sexually transmitted infections, and smallpox.

Due to the unfamiliar territory, the non-industrialized conditions of the land, and slow pace of ‘scientific’ development, European medicine in pre-Confederation Canada at the time of colonization was largely stagnant and there were sparse numbers of health professionals in the major settlements. In fact, “barber-surgeons” (all of whom were men) tended to most early French settlers’ illnesses, as at the time the universal treatment for

¹⁴ Kelm, *Colonizing Bodies*, 88-89.

¹⁵ Elizabeth MacDonald, “Indian Medicine in New Brunswick,” *Canadian Medical Association Journal*, 80, no. 3 (1959): 220.

virtually every physical illness was “bleeding.”¹⁶ Most of these men had little formal training in anatomy and biomedicine. Others, such as Michel Sarrazin and Jean François Gaultier who were educated in French Schools of Medicine acted as accomplished physicians, scientists, and surgeons for the first colonists.¹⁷ Both men were part of the first groups of physicians at the Hôtel-Dieu, the first hospital in Canada, originally founded by a religious order from France in 1639.¹⁸

Moving into the eighteenth century, the colony of New France was ceded to the British. By this time there had been more than a century’s worth of environmental uncertainty and acclimatization, disease, hunger, and continued disenfranchisement of Aboriginal peoples by French settlers. Furthermore, much of the settler activity was concentrated in Upper Canada (Southern Ontario), Lower Canada (the cities of Montréal and Québec, the surrounding area), the Maritimes (Nova Scotia and New Brunswick), and the West (Prairie Provinces and British Columbia). The imposition of the British medical system took largely the same form as the French; barber-surgeons and military surgeons continued to dominate the practice and organization of the profession, with the near total exclusion of Indigenous medicines and the imposition of the colonial framework of residential schools and reservations. French physicians were relegated to the role of serving poorer, rural areas as English physicians took control of the larger, urbanized cities. Some settlers, who could not access the services of European physicians, treated themselves with home remedies and cures based on Aboriginal peoples’ prescriptions.¹⁹

¹⁶ Charles Roland, “Medicine and the Dictionary of Canadian Biography,” *Canadian Medical Association Journal*, 95, 26 (1966): 1377.

¹⁷ Hugh Ernest MacDermot, *History of the Canadian Medical Association, 1867-1921* (Toronto: Murray Printing Company, 1967), 16.

¹⁸ *Ibid.*, 16.

¹⁹ *Ibid.*, 35.

19th Century Medical Education, Moral Reform, and Liberalism

During the 19th century, the population of physicians increased dramatically. If contextualized using the “third paradigm” of historiography anchored in centralizing ideology and state-formation, it can be proposed that this increase was due in part to the rise of liberalism in moral reform in Canada.²⁰ For Canada as a progressing liberal state, ensuring the health and viability of individuals was (and is) paramount. However abstract the discursive formation of the ideal liberal individual, morbidity and mortality (materiality) is still part of the equation. The concentration of wealth, western knowledge, and White hegemony contributed to the growth of medical schools an essential “material precondition” of a liberal society and as sites of social, cultural, and financial capital and power.²¹ Indeed, the 1820s saw the establishment of the first medical schools. Dr. N Tait McPhedran has done the important work of writing an extensive volume on the history of medical school establishment in Canada—the only compilation of these histories to date.²² In the writing of his book he interviewed ten to twenty faculty members, deans, and other key informants at each of the sixteen medical schools in Canada, and supplemented this qualitative work with a review of primary historical documents. Missing from his analysis is the Northern Ontario School of Medicine, established in 2005.²³ He writes that the founding of medical

²⁰ Ian McKay, “The Liberal Order Framework: A Prospectus for a Reconnaissance of Canadian History” *Can. Historical Rev.* 81 (2000): 620.

²¹ *Ibid.*, 628.

²² Norman Tait McPhedran, *Canadian Medical Schools: Two Centuries of Medical History 1822 to 1992*. (Montreal: Harvest House Ltd., 1993).

²³ Marie Matte, Joel Lanphear, Roger Strasser, “Northern Ontario School of Medicine,” *Academic Medicine*, 85, no. 9 (2010): S628-S632. The Northern Ontario School of Medicine (NOSM) functions as collaboration between Lakehead University in Thunder Bay and Laurentian University in Sudbury and is registered as a not-for-profit corporation. As a not-for-profit corporation, NOSM is not in itself an academic body. It has a strong emphasis on learning medicine in the context of Northern Ontario communities and a social accountability model. In many ways it is an exception to the urban medical focus of the other sixteen medical schools in Canada.

schools was driven by settler physicians wanting to establish a Canadian pedagogical foundation for practicing medicine, standardize medical knowledge across the country, and to increase the numbers of health professionals able to serve the rapidly growing population. The majority of these men were educated in Edinburgh (English) or Paris (French) and were supported by politicians, members of the public, and other doctors who wanted to create distance between themselves and their US neighbours. It was generally felt that medical education in the United States was inadequate; that US medical schools kept low standards in order to profit from a high volume of students; and that Canadians studying in the United States would be “exposed to dangerous democratic principles” during their tenure.²⁴ This coincides with the ideals of the Canadian social gospel and social purity movements of the late nineteenth and early twentieth century.²⁵ Driven by a growing national social sentiment of temperance and prohibition, one can interpret that medical schools and the medical profession played an important part in calls for increased public health during this national shift conceptualizing charity and philanthropy.²⁶ This movement in Canadian morality and its ideological underpinnings can help explain the normative role that medicine took into the twentieth century.

The first medical school to open in Canada, the Montreal Medical Institute in 1822 (later absorbed as the Faculty of Medicine at McGill University in 1828), was headed by practicing physicians from Montreal General Hospital who had been trained at Edinburgh Medical School in Britain.²⁷ In fact, most medical schools in Canada were established by small groups of medical men (educated in Britain or France) working together to provide

²⁴ Charles Roland, “History of Medicine to 1950,” *Canadian Encyclopedia*, 2006, Accessed 10 November 2015, <http://www.thecanadianencyclopedia.ca/en>.

²⁵ Mariane Valverde, *The Age of Light, Soap, and Water* (Toronto: McClelland and Stewart, 1991): 18.

²⁶ Valverde, *Light, Soap, and Water*, 20.

²⁷ Francis J. Shepherd, “The First Medical School in Canada: Its History and Founders, with Some Personal Reminiscences,” *Canadian Medical Association Journal* 15, no. 4 (1925): 418.

lectures on the basic sciences and pathologies of disease to supplement clinical training. Prior to this, “the only medical education available in the colony was by apprenticeship to an established practitioner for five to seven years, followed, if there was money, by further study in Europe.”²⁸ Early medical schools were proprietary, owned by one or a few physicians, operated on a for-profit basis, ran on the small amount of revenue generated from student fees, and relied heavily on the support of the Church and private funders. However, as a wealthy class emerged in Canada, as the different sectors of Canada became less isolated, and as industrialization swept across the country, optimism about the future of science and biomedicine quickly grew, leading to government interest in the support of medical education. By the end of the nineteenth century, there were eight established medical schools (all of which were in Eastern Canada). The curriculum and teaching of these schools began to take the form of research-based medicine, whereby laboratory learning, the scientific method, and specialization (a product of advances in technology) were set up as educational pillars.

Largely missing from the few accounts of early medical education in Canada is any description of (the lack of) gender-ed or race-ed diversity in the administration, faculty, and students in these schools. The sparse statistics available also show that White men of French or British descent dominated medical schools until the mid to late twentieth century; initially women and racialized groups did not have access to studying medicine.²⁹ Marked by the very aliberal characteristics of community and kinship, racialized men, racialized women, and non-racialized women largely did not participate in the ultra-liberal transformation of medical education. The image of ‘sickness’ and the image of all women and racialized individuals were constructed as one and the same, and therefore in opposition to the role of medical expert. Indeed, the virtually un-erasable line between physical, felt, and real

²⁸ McPhedran, *Canadian Medical Schools*, 2.

²⁹ Veronica Strong-Boag, “Canada’s Women Doctors: Feminism Constrained,” in *Medicine in Canadian Society: Historical Perspectives*, ed. S.E.D. Shortt (Toronto: McGill-Queen’s, 1981), 209-22.

gendered constructions of modern medicine (female and male, XX and XY, vagina and penis) governed access to medical education. For example, the expectations of women in Victorian society and the “idealization of women as wives, mothers, and homemakers” largely rooted in biologically determinist views of femininity meant that women were seen as too frail and sickly to engage in medical practice.³⁰ The same can be said about theoretically biological racial or cultural markers such as melatonin levels, religion, and rationales for illness whereby racialized groups were seen as primitive, diseased, and all around anti-modern. Described as a “hallmark of racial pride” the imposition of European medical science and practice in part justified colonialism, while simultaneously precluding racialized groups from gaining more knowledge about advances in western science.³¹ Moreover, scholars show that students were drawn almost exclusively from middle and upper classes, positioning doctors simultaneous in the bourgeoisie and as highly valuable.³² Despite structures put in place for exclusion of aspiring ‘non-preferred’ physicians (read: the Other), there are narratives from members of these marginalized groups who had the agency to overcome these barriers. For example, challenging the colourline in medical education, in 1856, Alexander Thomas Augusta graduated from Trinity College (which joined the University of Toronto), becoming the first Black physician in Canada. He later became the first physician of African descent to work in the United States Army.³³ Studying under Augusta at the University of Toronto,

³⁰ Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto Press, 1991), 6. In this book Mitchinson provides a history of women as patients and physicians during the Victorian period and analyzes the ways in which interpretations of sex and gender influenced all aspects of women’s health at the time. In the introduction, she cites the work of other feminist thinkers on the topic including Gail Parsons, Regina Morantz-Sanchez, and Barbara Ehrenreich.

³¹ Kelm, *Colonizing Bodies*, 101.

³² Howard Becker, ed., *Boys in White: Student Culture in Medical School* (Piscataway: Transaction publishers, 2002), 54.

³³ William Montague, “Alexander Thomas Augusta, 1835-1890,” *Journal of the National Medical Association* 44 (1952): 327-329.

Anderson Ruffin Abbott graduated with a license to practice in 1861 and became the second Black physician in Canada.³⁴ In 1865, challenging the gender and sexual logic of the time, Emily Stowe, a White woman, attempted to join the Toronto School of Medicine after her husband was diagnosed with tuberculosis.³⁵ Upon application, she was told by the Vice President that, “the doors of the University are not open to women and I trust they never will be.”³⁶ After being denied by Canadian institutions, Stowe went to the United States to earn her medical degree. On her return to Canada and after several years of practice, in 1870, the president of the Toronto School of Medicine granted special permission to Stowe and another American trained physician Jenny Kidd Trout to attend their classes with the goal of eventually obtaining a Canadian medical license. Stowe and Kidd Trout became the first two Canadian women physicians. The first woman to begin her medical studies at a Canadian medical school was Augusta Stowe-Gullen, daughter of Emily Stowe, who was admitted in 1879 (her admission was largely attributed to the influence of a family friend who was president of the school at the time).³⁷ In 1883, a public meeting of the Canadian Women’s Suffrage Association headed by Emily Stowe led to the creation of the Women’s Medical College, which became affiliated with University of Toronto in 1890.³⁸ The establishment of a separate school for women, rather than co-education, is simultaneous illustrative of activism of women and the general sentiment of men

³⁴ Heather M. Butts, “Alexander Thomas Augusta: Physician, Teacher and Human Rights Activist,” *Journal of the National Medical Association*, 97, no. 1 (2005): 106.

³⁵ Jacalyn Duffin, “The Death of Sarah Lovell and the Constrained Feminism of Emily Stowe,” *Canadian Medical Association Journal* 146, no. 6 (1992): 881.

³⁶ Collections Canada, “Dr. Emily Howard Stowe,” 2008, Accessed 5 November 2015, <https://www.collectionscanada.gc.ca/physicians/030002-2500-e.html>.

³⁷ Kathleen Smith, “Dr. Augusta Stowe-Gullen: A Pioneer of Social Conscience,” *Canadian Medical Association Journal* 126, no. 12 (1982): 1465.

³⁸ This is now Women’s College Hospital in downtown Toronto and is recognized as the only Collaborating Centre in Women’s Health in the Western Hemisphere designated by the World Health Organization.

(that medical education for women was perhaps a necessity, though should not be conflated with the more rigorous training of medical men). After twenty-two years of operation, the college closed in 1906 when women were accepted into University of Toronto Faculty of Medicine.³⁹ However, it was only in the 1920s, because of their contributions to the war effort that women were “admitted to [all] medical schools more freely.”⁴⁰ In a final and perhaps most striking example, Aboriginal peoples were prohibited from pursuing European higher education until the 1960s.⁴¹ The first Aboriginal woman physician, Dr. Elizabeth Steinhauer of the Cree Nation, did not gain a license to practice until 1980.⁴²

20th Century Medical Education

By the early 20th century most schools had been absorbed into the Faculties of Medicine of Universities. Until this time, the establishment of medical schools in Canada occurred largely without any federal state regulation or intervention. The passing of the Canada Medical Act in 1912 by the federal government, however, created the Medical Council of Canada, which would set up “uniform standards for medical education, examination and licensing [which would be transportable between] all Canadian provinces” and aim to move beyond the period of provincialism.⁴³ Through this legislature and the creation of other professional bodies (e.g. Canadian Medical Association and Royal College of Physicians and Surgeons of Canada), medical schools and their administrators began to tightly control the Canadian medical field through strict accreditation. Three important events catalyzed this

³⁹ Augusta Stowe Gullen, “A Brief History of the Ontario Medical College for Women,” 1906, Accessed 7 November 2015, <http://images.ourontario.ca/Laurier/2738529/data>.

⁴⁰ McPhedran, *Canadian Medical Schools*, 16.

⁴¹ Michael Mendelson, *Aboriginal Peoples and Postsecondary Education in Canada* (Ottawa: Caledon Institute of Social Policy, 2006), 81.

⁴² The Record, “Laurier Student Uncovers Canadian Female Aboriginal Leaders,” 2013, Accessed 7 November 2015, <http://www.therecord.com/news-story/2623994-laurier-student-uncovers-canadian-female-aboriginal-leaders/>.

⁴³ McPhedran, *Canadian Medical Schools*, 12.

institutionalization of medicine: the publishing of the Abraham Flexner report in 1910; the fallout of World War II and the Massey Commission; and the rise of Canadian welfare state.

The Flexner Report

There has been no single document that has had a greater impact on medical education in North America than *The Flexner Report on Medical Education in the United States and Canada*.⁴⁴ The report was commissioned by The Carnegie Foundation for the Advancement of Teaching through a recommendation of the American Medical Association to survey the state of education at American and Canadian medical schools.⁴⁵ Using Johns Hopkins University as the standard, Flexner visited 155 medical schools across Canada and the United States.⁴⁶ Canadian medical schools included all the extant schools at the time: McGill, Toronto, Queen's, Manitoba, Laval, Western Ontario, and Dalhousie University. Published in 1910, the document provided the first external review of Canadian medical education. Unlike some American schools, "every Canadian school survived and achieved Grade A status within twenty years" of the report.⁴⁷ One of the main proposals was to have "fewer and better" students, which would eventually reduce the number of physicians and raise the

⁴⁴ See for instance: Howard S. Berliner, "A Larger Perspective on the Flexner Report," *International Journal of Health Services* 5, no. 4 (1975): 573-592; Charles Boelen, "A New Paradigm for Medical Schools a Century after Flexner's Report," *Bulletin of the World Health Organization* 80, no. 7 (2002): 592-593; Carleton Chapman, "The Flexner Report" by Abraham Flexner," *Daedalus* 52, (1974), 105-117; Molly Cooke, David M Irby, William Sullivan, Kenneth Ludmerer, "American Medical Education 100 years after the Flexner Report," *New England Journal of Medicine* 355, no. 13 (2006): 1339-1344; Mark D. Hiatt, and Christopher G. Stockton, "The Impact of the Flexner Report on the Fate of Medical Schools in North America after 1909," *Journal of American Physicians and Surgeons* 8, no. 2 (2003): 37-40; Kenneth M. Ludmerer, "Commentary: Understanding the Flexner Report," *Academic Medicine* 85, no. 2 (2010): 193-196.

⁴⁵ Thomas P. Duffy, "The Flexner Report: 100 years later," *The Yale Journal of Biology and Medicine* 84, no. 3 (2011): 269.

⁴⁶ *Ibid.*, 269.

⁴⁷ McPhedran, *Canadian Medical Schools*, 13.

social class standing of the profession.⁴⁸ The Flexner Report described a strong commitment to scientific principles, laboratory research, and evidence-based medicine. The ideal curriculum in the eyes of Flexner would consist of a pre-medical degree followed by two years of basic sciences study with a medical focus and finally two years of clinical training—this is the model that has continued to dominate medical schools in Canada.⁴⁹

Interestingly, in his report, Flexner includes two short sections of two pages each titled “The Medical Education of Women” and “The Medical Education of the Negro.”⁵⁰ An extensive search of databases suggests that the impact of Flexner’s reporting on women and Black students has seemingly not been taken up in the Canadian medical education literature. Despite the dearth of literature, it can be argued that this format explicitly designated the training of women and racialized persons as separate from and inferior to mainstream, masculinized medical education. In the first page on women, Flexner states, “now that women are freely admitted to the medical profession, it is clear that they show a decreasing inclination to enter it.”⁵¹ Though historical statistics on the admission of women into medical schools are available for the United States, there is no Canadian data available to substantiate this claim. Flexner was generally in opposition to segregated schools for men and women, and further states “if separate medical schools and hospitals are not to be developed for women, internal privileges must be granted to women graduates on the same terms as men.”⁵² This recommendation led to the further incorporation of women into

⁴⁸ Ann Steinecke and Charles Terrell, “Progress for Whose Future? The Impact of the Flexner Report on Medical Education for Racial and Ethnic Minority Physicians in the United States.” *Academic Medicine* 85, no. 2 (2010): 236-245.

⁴⁹ Abraham Flexner, *Medical Education in the United States and Canada* (Washington, DC: Science and Health Publications, Inc. 1910).

⁵⁰ It should be noted that the excerpts taken from these text are presented out of context of the full report—as such, the reader is encouraged to read the entire four pages of the report. Moreover, it should be noted that I, the author, do not endorse the racist language used in the Flexner Report.

⁵¹ *Ibid.*, 178.

⁵² *Ibid.*, 179.

medical schools from 1910 onwards with significant consequences. Within these institutions ‘female quotas’ were enacted in admissions and faculty positions and pioneering women advocated for their equal inclusion. Some evidence shows that male students were reluctant to consult with female colleagues, and women medical students were subject to forms of sexualized violence and harassment.⁵³

In reference to medical education for Black students, Flexner was much less inclusionary. He states in his very first line “the medical care of the negro race will never be wholly left to negro physicians.”⁵⁴ He further writes, “the negro must be educated not only for his sake, but for ours [...] the negro needs good schools rather than many schools—schools to which the more promising of the race can be sent to receive a substantial education in which hygiene rather than surgery, for example, is strongly accentuated.”⁵⁵ In reading these statements, I interpret that Flexner believed in the importance of high quality education, but maintained the status quo when it came to race and racialization. His report suggests that Black students should practice with a primary focus on the remedy of the poor ‘hygiene’ of the Black population and the treatment of ‘Black diseases.’ This invokes notions of “Black inferiority” and the divergence between self/Other, liberal/non-liberal, civilized/primitive.⁵⁶ Hunt finds in the US context that “because of inadequate clinical and surgical experiences, Black practitioners [are] aware of their deficits and [suffer] from low professional self-esteem. In turn, Black patients became skeptical of Black practitioners and often resisted their treatment.”⁵⁷ Flexner’s statements and the subsequent consequences are reflective of the current and historical neglect and systematic violence that is imposed on Black communities through mediated relations of power, based on concepts of

⁵³ Strong-Boag, *Canada’s Women Doctors*, 210.

⁵⁴ Flexner, *Medical Education*, 180.

⁵⁵ *Ibid.*, 180.

⁵⁶ Susan Hunt, “The Flexner Report and Black Academic Medicine: An Assignment of Place,” *Journal of the National Medical Association* 85, no. 2 (1993): 151-155.

⁵⁷ *Ibid.*, 154.

Whiteness and Blackness. Given the distinct history of slavery and arrival of African immigrants to Canada (e.g. the destruction of Africville and the construction of the African Nova Scotian subject), a further examination centering the experiences of medical students, faculty, and administrators from these communities would provide salient insight into the tensions between nation-formation and multiculturalism. Moreover, this could also be further studied from an Indigenous and settler-colonial perspective in the Canadian context.

World War II and the Massey Commission

World War II also had important implications for medical schools. Firstly, McPhedran states, “for the first time the federal government provided financial assistance to medical schools, on the grounds that production of physicians was part of the war effort.”⁵⁸ With this additional source of funding, medical schools began to accelerate their program in order to keep up with the need for physicians to be posted. Secondly, the majority of medical unit leadership within the military consisted of faculty members from various medical schools across the country, leading to the creation of “strong nationalist links in the previously fragmented Canadian medical profession.”⁵⁹ Thirdly, due to the impact made by advances in science and technology in warfare, the importance of scientific research contributed to large numbers of veteran men pursuing degrees in the medical sciences and engineering. Under pressure to increase class sizes and research capacities, universities lobbied the federal government for funding, “arguing that universities were national institutions and therefore a federal responsibility.”⁶⁰ In 1951, the Royal Commission on National Development in the Arts, Letters, and Sciences (also known as the Massey Commission) published a report that would lead to the allocation of \$150 - \$200 per student registered in professional schools, including medicine.⁶¹ In addition to the powerful rise of

⁵⁸ McPhedran, *Canadian Medical Schools*, 18.

⁵⁹ *Ibid.*, 19.

⁶⁰ *Ibid.*, 19.

⁶¹ Collections Canada, “Aid to Universities,” 1998, Accessed 15 November

the women's movement in Canada, this expansion in the capacity to intake students was one of the main reasons for the admission of more women into medical schools. The turn to new, more 'scientific' medicine was also heavily promoted by private interests (such as the Rockefeller foundation)—beginning the corporatization of the medical school.⁶²

Effects of the Canadian Public Health Care System on Medical Education

The post-war mindset, characterized by public dissatisfaction with high unemployment, huge debts, and general deprivation, led to an optimism about state intervention—contributing to the development and subsequent expansion of the Canadian public health care system.⁶³ Progressively, starting largely in 1947 through the work of Tommy Douglas in Saskatchewan, policies such as the Hospital Insurance and Diagnostic Services Act in 1957, the Medical Care Act in 1966, and the combination of this Act with funding for post-secondary education called the Fiscal Arrangements and Established Programs Financing Act in 1977 created an expansive public system.⁶⁴ Upon implementation of the 1984 Canada Health Act, “virtually all services provided within the hospitals and all necessary doctor care were paid for from the public purse, without user fees.”⁶⁵ This also meant that medical schools would need to further expand their capacity in order to meet the demands of the predicted shortage of physicians. During this time, four additional medical schools were established, bringing the total up to sixteen schools (which would

2015, <http://www.collectionscanada.gc.ca/2/5/h5-448-e.html>.

⁶² David Coburn, George M. Torrance, and Joseph M. Kaufert, “Medical Dominance in Canada in Historical Perspective: The Rise and Fall of Medicine?” *International Journal of Health Services* 13, no. 3 (1983): 407-432.

⁶³ Pat Armstrong, Hugh Armstrong, Ivy Bourgault, Jacqueline Choiniere, Eric Mykhalovskiy, and Jerry White, *Heal Thyself: Managing Health Care Reform* (Toronto: Garamond Press, 2001), 9.

⁶⁴ Pierre-Gerlier Forest, Gregory Marchildon, and Tom McIntosh, *The Governance of Health Care in Canada Volume 3: The Romanow Papers* (Toronto: University of Toronto Press, 2014), 51; Antonia Maioni, *Health Care in Canada*, (Don Mills: Oxford University Press, 2014), 43.

⁶⁵ Armstrong et al., *Heal Thyself*, 16.

remain until 2005). The Health Resources Fund, a collaborative action between provinces and the federal government, fueled this expansion that promoted the development of ‘academic health sciences centres’ consisting of a university hospital, related clinical institutions, a medical school, and other health professions schools.⁶⁶ In parallel to structural changes, amendments to medical curriculum included “early clinical exposure, emphasis on self-directed learning and integration of subject matter from the various disciplines” and a “revision of the public health component” to include a social sciences and humanities perspective (albeit a small one).⁶⁷ At this point, the state became highly involved in medical education because of its control over university and hospital funding and because of its direct funding of hospital residency placements.⁶⁸ Indeed, one could argue that medical education under the golden age of welfare was largely folded into the extensive fabric of state-run and regulated services, and following the increasingly neo-liberal turn in the late twentieth century has followed in the trajectory of financialization.

Thinking Race, Sex/Gender, and Their Intersections in Medical School History

I argue that the gendered division of power and access within medical schools is evident in the history presented above. As shown in the literature, the participation of women in medical schools has gone from almost total exclusion to women forming the majority of new admissions—termed the “feminization of medicine.”⁶⁹ The trend however is segregated by specialization,

⁶⁶ Robert B. Sullivan, Mamoru Watanabe, Michael E. Whitcomb, David A. Kindig. “The Evolution of Divergences in Physician Supply Policy in Canada and the United States,” *Journal of the American Medical Association* 276, no. 9 (1996): 704-709.

⁶⁷ Arnold Naimark, “Universities and Medical Schools: Reflections on a Half-Century of Canadian Medical Education,” *Canadian Medical Association Journal* 148, 9 (1993): 1538.

⁶⁸ David Coburn, Carl D'Arcy, George Murray Torrance, *Health and Canadian Society: Sociological Perspectives* (Toronto: University of Toronto Press, 1998), 336.

⁶⁹ Susan P. Phillips and Emily B. Austin, “The Feminization of Medicine and

whereby women are significantly underrepresented in residencies such as surgery, obstetrics/gynecology, and emergency medicine.⁷⁰ This can arguably be attributed, in part, to the extended length of these residences and the corresponding pressure put on women students who are foundationally expected to perform the lion's share of unpaid work in the household, such as childcare.⁷¹ In a recent study at a Canadian medical school, researchers found that at all career stages (medical school, residency, practice, and teaching) women were less likely than men to recommend parenting to their peers, were more dissatisfied than their male colleagues with the amount of time spent with their children, and were more likely to consider flexibility in their academic responsibilities.⁷² A rich but largely missing body of literature might also look into the heteronormativity of the institution and the erasure of queer, two-spirit, trans, and/or gender non-binary students throughout this history. Only in the last five years (of more than 100 years of medical education in Canada) has research on this topic begun to emerge. In the largest North American study on sexual and gender identity among medical students, Mansh et al. show that sexual and gender minority students are likely to experience discrimination based on their non-heteronormative identities, and therefore may choose to conceal these identities for fear of reprisal from peers, faculty members, and patients.⁷³ The authors present a quote from an

Population Health," *Journal of the American Medical Association* 301, no. 8 (2009): 863-864.

⁷⁰ Jeff G. Marschall, Ahmer A. Karimuddin, "Decline in Popularity of General Surgery as a Career Choice in North America: Review of Postgraduate Residency Training Selection in Canada, 1996–2001," *World Journal of Surgery* 27, no. 3 (2003): 249-252.

⁷¹ Kate Bezanson and Meg Luxton, "Introduction: Social Reproduction and Feminist Political Economy," in *Social Reproduction: Feminist Political Economy Challenges Neoliberalism*, eds. Kate Bezanson and Meg Luxton, (Montreal, QC: McGill University Press, 2006), 5.

⁷² Bibiana Cujec, Tammy Oancia, Clara Bohm, and David Johnson, "Career and Parenting Satisfaction Among Medical Students, Residents and Physician Teachers at a Canadian Medical School," *Canadian Medical Association Journal* 162, no. 5 (2000): 637-640.

⁷³ Matthew Mansh, William White, Lea Gee-Tong, Mitchell Lunn, Juno

Aboriginal medical student in Canada who states, “there are students in class who are conservative/religious/homophobic [...] Unfortunately, the idea of variation in sexual identities is not very well accepted in our society yet, even in medical schools and among the younger generation.”⁷⁴ Though a plurality of gender identities exists in medical education institutions, gender, as a social construct enforced by power relations, affects how the experiences of self-identified women and gender non-binary students are conceptualized, valued, and supported with differential impacts on their academic and personal lives. I believe that there is room to expand our understanding of how this distribution of power is historically linked to the disadvantages afforded to women and other marginalized genders in medicine, as a male/men-dominated profession.

Perhaps surprisingly (or not), issues related to race-based discrimination have been largely ignored by most medical schools, despite their inter-connections with issues of gender, the rise in feminist, anti-colonial, anti-racist student activism on campuses, and the proliferation of scholarship deploying intersectionality and postcolonial feminist theory.⁷⁵ On this topic, abstractions of

Obedin-Maliver, Leslie Stewart, Elizabeth Goldsmith, Stephanie Brenman, Eric Tran, Maggie Wells, David Fetterman, and Gabriel Garcia, “Sexual and Gender Minority Identity Disclosure During Undergraduate Medical Education: ‘In the closet’ in Medical School,” *Academic Medicine* 90, no. 5 (2015): 634-644.

⁷⁴ *Ibid.*, 641.

⁷⁵ For more on missing literature in medical education research see: Nancy Robb, “Racism Can Rear its Ugly Head at Medical School, Study Finds,” *Canadian Medical Association Journal* 159, 1 (1998): 66-67. Some important intersectionality and postcolonial feminist writings include: Gayatri Chakravorty Spivak. “Can the Subaltern Speak?.” In *Marxism and the Interpretation of Culture*, eds. Cary Nelson and Lawrence Grossberg (London: Macmillan Education UK, 1998), 271; Kimberlé Crenshaw, “Mapping the margins: Intersectionality, identity politics, and violence against women of color.” *Stanford Law Review*, 43 no. 6 (1991): 1241; Patricia Hill Collins, “It’s all in the Family: Intersections of Gender, Race, and Nation.” *Hypatia* 13, no. 3 (1998): 62; Sunera Thobani, *Exalted Subjects: Studies in the Making of Race and Nation in Canada* (Toronto: University of Toronto Press, 2007); Rakhi Ruparelia, “Legal Feminism and the Post-racism Fantasy,” *Canadian Journal of Women and the Law* 26, no. 1 (2014): 81.

universality need to be avoided—when speaking about ‘women’ and their gradual acceptance into the medical profession, I am writing specifically about White, European women, as their racialized counterparts have been largely left out of admissions, literature, and statistics. To speak of gender in the context of the medical school history, one must consider how this intersects with the history of immigration, slavery, women’s movements, and colonialism. Moreover, we should also think about the tensions between gender and race in discussions of equity and inclusion in institutions of higher education. Though overt racist practices have been eliminated from admissions criteria such as those described by Flexner, one could make the claim that they have now taken on more diffuse and less spectacular forms. It could be suggested that medical education institutions continue to leverage their equal acceptance of women into the institution to erase the exclusion of Black and Aboriginal students from their ranks. As of 2002, approximately one-third of Canadian medical students are from racialized groups, the majority of whom are classified as South Asian and Chinese. Black and Aboriginal students were under-represented in the classroom, comprising only 1.2 and 0.7 percent of students.⁷⁶ In my own review of the current ‘deans of medicine’ of the seventeen schools across Canada, fifteen are White men, one is a White women, and one a racialized man, who is a ‘chair’ rather than a dean.⁷⁷ A similar quantification of ‘diversity’ could be studied in the numbers of racialized vice-deans, department heads, and faculty. As one of the only Canadian scholars to have taken up the issue of racism in medical schools, Brenda Beagan finds that micro level interactions that constitute “everyday

⁷⁶ Brenda L. Beagan, “Is This Worth Getting into a Big Fuss Over? Everyday Racism in Medical School,” *Medical Education* 37, no. 10 (2003): 852-860; Irfan A. Dhalla, Jeff C. Kwong, David L. Streiner, Ralph E. Baddour, Andrea E. Waddell, and Ian L. Johnson, “Characteristics of First-Year Students in Canadian Medical Schools,” *Canadian Medical Association Journal* 166, no. 8 (2002): 1029-1035. Note: in the second study 1223 medical students across twelve medical schools were surveyed, which included schools in the major urban centers.

⁷⁷ These numbers are based on an online search of the respective administrators on Faculty and departmental websites.

racism” are still prevalent in medical schools and in the experiences of racialized medical students.⁷⁸ Bannerji describes this situational experience of racialized groups in Canada. She states:

Here we are marked by a difference which has less to say about us—our histories and cultures—than about a mode of socio-political interpretation within a pre-established symbolic and practical schema of a racialized or ethnicized colonial and slave-owning discourse.⁷⁹

The “mode of socio-political interpretation” Bannerji refers to above is neoliberalism and the process she describes can be framed using an anti-racist, anti-colonial critique as ‘recolonization.’ In other words, I would argue that the spatial dispersion in a largely non-racialized population subjugates racialized persons to colonizing structures and rhetoric that are still present in the thoughts and imaginations, constructions of knowledge, and public policies of settler-colonial countries. Racialized groups in medical schools have, in general, very different histories with the Canadian state as described by McGibbon and Etowa.⁸⁰ However, in their interactions with the institution, they share the common relation of being non-White and their experiences of racialization can be theorized by tracing the dualism between center and margin in Canadian history. Historical narratives presented above describe perceptions of the differences between women and men, and racialized and non-racialized medical students, indicating that structural disadvantages for the former groups can be further understood. Indeed, Razack et al. in their review of discourses of academic excellence, diversity, and equity on the websites of the medical schools in Canada find that these institutions “appeal to the

⁷⁸ Beagan, “Is This Worth Getting into a Big Fuss Over?” 2003.

⁷⁹ Himani Bannerji, *The Dark Side of the Nation: Essays on Multiculturalism, Nationalism, and Gender* (Toronto: Canadian Scholar’s Press, 2000), 157.

⁸⁰ Elizabeth McGibbon and Josephine Etowa, *Anti-Racist Health Care Practice* (Toronto: Canadian Scholar’s Press, 2009), 33.

trappings of superficial diversity (race, ethnicity, gender, and the like) as a commodity of cosmopolitan sophistication.”⁸¹ Through a critical perspective, the visual, textual, and corporeal representation of historically marginalized persons within the medical school can be situated in as objects derived from the White gaze discontinuous with the history of colonialism on which these institutions have been built. Linking this to the intersections presented above, the positioning of gender as separate from race, both currently and historically, echoes a cultural politics in which there is a pre-occupation with establishing boundaries in identity. It is ultimately a system based on categorization, and a filling of these categories with certain significance which influences who is and who is not rationalized to fit the expectations of medical schools as they have been constructed.

Modern Paradigm of Medicine, the Body, and Neoliberalism

Stemming from the increased relevance of medical research within the medical school after the release of the Flexner Report described above, medical education has been primarily organized into disease or organ blocks that emphasize microbiological, biochemical, and pathophysiological causes of illness, often termed “biomedicine.”⁸² The very existence of medical specialization rests upon a reductionist analysis of the body and disease, and as such curriculum and institutional departments began their division into specialized technical topics founded upon scientific medicine. As illustrated above, starting with colonization, the rise of liberalism, and catalyzed by visions of

⁸¹ Saleem Razack, Brian Hodges, Yvonne Steinert, and Mary Maguire, “Seeking Inclusion in an Exclusive Process: Discourses of Medical School Student Selection,” *Medical Education* 49, no.1 (2015): 39.

⁸² George L. Engel, “The Need for a New Medical Model: A Challenge for Biomedicine,” *Science* 196, no. 4286 (1977), 129-136; Shiloh Krupar and Nadine Ehlers, “Target: Biomedicine and Racialized Geo-body-politics,” *Occasion* 8 (2015); Richard C. Keller, “Writing History in the Age of Biomedicine,” *Journal of the History of Medicine and Allied Sciences*, (2015), 668.

technology after WWII, Canadian medicine quickly adopted European ideologies of the body as a bounded entity with a focus on the diseased body—drawing a distinct line between Indigenous knowledge and the western scientific knowledge. It can be argued that this modality reproduces the conservative orientation towards individualization, marginalization of patient voice, and clinical invisibility of the social construction of illness.

I would link this crystallization of the dominance of biomedicine with the new economy of the body in the West, whereby the bodies of individuals become the sites of institutional intervention—the major object on which the institution can exert its power. Indeed, I argue that this rise in the dominance of biomedicine is elemental to the rolling out of a neoliberal agenda in the late twentieth century influencing the spheres of education, social security, and health care. As stated above, neoliberalism can be broadly defined as a political and economic philosophy that articulates the transfer of responsibility for employment and wellbeing from the state onto households in the form of labour participation.⁸³ The ideological convergence of modern medicine and a neo-capitalist mode of governing renders a ‘victim-blaming approach’ to health that justifies state retrenchment from providing citizenship rights to health care and other social services, and also strongly reformulates health as an individual responsibility. This is an approach that “limits its attention to the materiality of the body and fails to pay sufficient attention to the politics of health.”⁸⁴ Both diverge from a materialist analysis of disease and disease prevention towards a model that places the onus almost squarely on communities for their aggregate health outcomes, while neglecting to critically engage with the production of systemic inequality and poverty by international and domestic institutions and decision-makers. Moreover, it actually provides a shield against uncovering Western complicity in the creation, spread, and maintenance of poor public health trends.

⁸³ David Harvey, *A Brief History of Neoliberalism* (New York, NY: Oxford University Press, 2005), 56.

⁸⁴ Susan Sherwin, *The Politics of Women's Health: Exploring Agency and Autonomy* (Philadelphia: Temple University Press, 1998), 50.

This contradictory context has had a role in the transformation of the medical school and medicine in general, involving corporatization, marketization, and privatization of knowledge. This is demonstrated in the increased presence of the pharmaceutical industry in the Canadian medical school classroom.⁸⁵ In this model, universities are increasingly seen as sources of industrial innovation, whereby national science policies in Canada encourage private investment in science and a strengthening of the academic-industrial complex.

Conclusion

In this paper I have argued that the processes of colonialism, patriarchy, and capitalism have played a role in the shaping of medical school history and its contemporary position in Canada. The building of these institutions began with British and French settlement in the seventeenth and eighteenth centuries. With an escalation of the colonial population in the nineteenth and twentieth centuries, Canadian medical schools began to take shape. Through the actions of the Flexner report, the advances of WWII, and the rise of the public health care system, the medical school situated itself at the dominant power in the medical division of labour and care in Canada. Analysis of the intersection of race and gender in the bodies occupying these institutions illustrates the fundamental reality of the privilege granted to certain groups, and the exclusion of others. Moreover, the rise of biomedical dominance in medical schools in conjunction with neoliberal ideologies help explicate the commodification of health (and all forms of social life), that continue to widen gaps in health equity in Canada. Overall, the history and critical analysis presented in this paper begins to show that the institutions of medical schools are constitutive of the processes of racialization, feminization, and historical subjugation that shape life opportunities and health in the present. I write this paper not as an affront to the medical profession, but rather a vantage point from which to re-

⁸⁵ Kelly Holloway, "Uneasy Subjects: Medical Students' Conflicts Over the Pharmaceutical Industry," *Social Science & Medicine*, 114 (2014): 113-120.

conceptualize what the next paradigm of medical education could be. Through this paper, I hope to encourage the proliferation and uptake of this critical stance within the literature of Canadian history, medical sociology, and health professions education.

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