Surgery being performed in the late nineteenth or early twentieth century at the Kansas Medical College. Note the presence of several females.
Women, Medicine, and Science

Kansas Female Physicians, 1880–1910

by Gail L. McDaniel

Oh who is this who casts her rose of youth
Beneath the feet of praise, nor fancheth,
The life of her ladyhood in sooth
Too white to bloom beside the couch of death.

It is the woman healer, here who stands
With tender touch upon the cruel knife;
With thought engraven brow and skillful hands
And yearning heart, to save the house of life.

Bless her O woman, for it was your call—
The agonizing cry of your distress
That urged her outward from the cloister
To make the burden of your misery less.1

Mary L. Angwin, M.D., 1897

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Women in Kansas and the nation who chose to be physicians in the mid-nineteenth century faced stalwart opposition from members of the medical profession, whose arguments echoed societal norms concerning the appropriate role of women in Victorian society. Despite claims that women were too frail, too delicate, and too intellectually inferior to be doctors, female physicians viewed the study and practice of medicine as part of a larger effort to apply traditional concepts of womanhood in the interest of health reform and the relief of female suffering. They were not uncomfortable with the concept of domesticity, and that domestic role supported their argument for entrance into medicine.

This article is based on a study of six female Kansas physicians between 1880 and 1910, who expressed their positions as traditionalists in their practices, publications, and public presentations. They believed as women they possessed unique “natural gifts” as healers and preservers of morality as an extension of their Victorian domestic role. The six focused on women’s health care, preventive medicine, female education, and erroneous medical practices. At the same time they struggled with the new science of bacteriology that challenged holistic theories and threatened their sense of the moral order and thus their unique position in the profession. In their profession they gradually and subtly began to adopt scientific precepts into their practices.

While emphasizing a “natural” nurturing capacity, middle-class white women who sought access to medical practice argued that their contributions would improve the health of women patients who were reluctant, and who sometimes even refused, to seek medical care from male practitioners. “No woman of sensibility could allow herself to be examined by her physician,” observed Dr. Elizabeth Blackwell; “to many death would be preferable to the treatment they would be subjected.” Female physicians justified their places in the profession on the basis of propriety and morality. According to Ann Preston, physician and dean of the Woman’s Medical College of Pennsylvania in Philadelphia, “Teaching women is a step not from but towards decency and decorum.”

Many female physicians hoped that medical training for women would serve to elevate the entire gender.

At the same time bacteriological discoveries threatened the domestic justification of women who sought to be physicians. Women practitioners as well


as men experienced this conflict created in the 1880s by Louis Pasteur and Robert Koch, who showed that specific germs caused disease. Their theory contradicted the traditional, holistic, moralistic, and fundamentally religious causation of disease as the inevitable result of one's violation of the laws of nature made manifest by God. Medicine revealed and taught the laws by which people could ensure the proper balance between the environment and individual behavior. Teaching health laws provided women a practical means of moving into the public world without wandering far from domestic concerns.5

When female practitioners in Kansas and the nation established their places within the profession, they emphasized their special understanding about women that many believed male physicians who practiced Pasteur's germ theory did not possess. The new bacteriology, according to Blackwell, appeared to develop at the expense of sanitation, hygiene, preventive medicine, and most importantly, morality itself. Blackwell and other feminists saw medical women as monitors of the moral truth. Female practitioners thus supported changes in the socialization and education of girls to build stronger, informed women, both physically and psychologically.6 They advocated preventive medicine by teaching laws of physiology and hygiene in connection with the middle-class antebellum health reform movement that emphasized massive sanitary measures to remove the filth and pollution believed to cause disease. Female practitioners concluded that knowledgeable women would be better mothers who reared healthier children and would enjoy improved physical health themselves because they understood their own bodily functions and basic health rules.7

The six Kansas physicians selected for study are Deborah K. Longshore, Maggie L. McCrea, Ida C. Barnes, Frances Storrs, Sara E. Greenfield, and Frances A. Harper. The availability of sources primarily dictated their selection. Yet they seem to be representative of female physicians in Kansas and the nation in educational background, professional membership, and contributions to professional literature. Two of the six attended the Kansas Medical College in Topeka and four attended medical colleges out of state in Illinois and Pennsylvania, two of the seven states where female medical education was clustered.8 Of the eighty-six Kansas female physicians identified whose educational background is known, approximately half attended medical school in Kansas or nearby Kansas City, Missouri.9 Many female physicians obtained their medical education in women's medical colleges or sectarian schools because women were denied access to regular medical schools in most states prior to 1890. Kansas had the Kansas Medical College in Topeka, which admitted women from its inception in 1872, four years prior to the admission of women to the American Medical Association. Many Kansas female physicians contributed to medical literature in Kansas in the Journal of the Kansas Medical Society and nationwide in the Woman's Medical Journal, the Journal of the American Medical Association, and the Medical Herald, among others.

As medical educators, three of the six Kansas female physicians became members of the faculty of


9. The names of eighty-six female physicians practicing in Kansas between 1880 and 1910 were found in documents such as Medicine Clippings, Library and Archives Division, Kansas State Historical Society; Zula Bennington Greene, “Kansas Women of Medicine” (paper presented at the Medical Assistants' Seminar, Lawrence, Kans., August 6, 1961); Journal of the Kansas Medical Society, Woman's Medical Journal, Kansas Medical College catalog; histories of Kansas counties; “Registration of Physicians in Kansas,” in Kansas State Board of Health, Annual Reports, 1897–1900; Howard D. Berrett, Who's Who in Topeka (Topeka, Kansas: Adams Brothers Publishing Co., 1905); “A Century of Healing Arts,” Shawnee County Historical Society Bulletin 57 (November 1980); Joanna L. Stratton, Pioneer Women: Voices From the Kansas Frontier (New York: Simon and Schuster, 1978); and American Women: 1500 Biographies (New York: 1987). This listing likely is not conclusive because often physicians were listed with only an initial, making it impossible to determine their gender.
the Kansas Medical College, a much higher percentage than the larger group of eighty-six. It is significant to note that by 1910 the women’s medical colleges were closed and medical training became co-educational. Ironically the closing of women’s schools had a negative effect on women in medical practice after 1900. Middle-class women for a variety of reasons found it less desirable to study medicine.  

The careers of these physicians spanned the period 1880–1910. The oldest, Deborah Longshore, graduated from the Woman’s Medical College of Pennsylvania in 1872. The youngest, Frances Harper, graduated from the Kansas Medical College in 1904. All attended schools of regular therapeutics, as did seventy-seven (90 percent) of all female practitioners identified in Kansas.

Female physicians who entered medicine prior to co-education often crusaded for specific changes in women’s health care, emphasizing educational reforms, preventive gynecology, and alternate approaches to health problems. An editorial in the 1909 Woman’s Medical Journal acknowledged that female physicians had been identified with teaching hygiene and public sanitation from the time they began the practice of medicine in this country in the 1840s and 1850s. Usually these same women were the most outspoken critics of the gender specific upbringing of girls. “She fails to teach her daughters aught the responsibility of life,” wrote Dr. Mary A. Spink in 1909. “Any independence of thought or action is hampered by foolish restriction. . . . Thus the daughter in nine cases out of ten grows up without any disposition to the free development of original thought, strong body and brain, which means steady nerves and good health.”

Three of the six female physicians in Kansas explicitly adopted these sentiments on the issue of educational reform. Dr. Deborah Longshore spoke in favor of changing educational custom by advocating the teaching of science in the public schools for both sexes. Longshore (1842–1919), born Deborah K. Smith to a Quaker family from McConnell, Penn-

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sylivania, settled in Topeka, Kansas, in 1879 with her husband, Edward, where she established a practice almost immediately. According to the Topeka Daily Capital, Longshore overcame prejudice against female physicians “by her skill and efficiency . . . willingly [giving] her services to those in need, regardless of remuneration.” She often went day and night to care for some of the most prominent families of Topeka and occasionally was scolded by her husband for taking so much time with her patients. Her nephew described her as possessing a curious and inquiring mind. She was an independent spirit, not only in her choice of vocation but in her nonconformity in clothing. Physically small and plump, she preferred two-piece dresses with pockets twenty inches square in her skirts, where she carried medical supplies.

As a prominent Topeka citizen and a member of several civic organizations such as the Good Government Club, Longshore gained respect within her community and her profession. She joined the Kansas State Medical Society and in 1883 accepted the office of second vice president. In 1885 she was a member of the committee on the practice of obstetrics, and she also served on the board of censors and membership. In 1887 Longshore was elected as a delegate to the American Medical Association. Locally she belonged to the Topeka Academy of Medicine and Surgery where she presented professional papers.

Longshore’s papers placed responsibility upon women for preventive measures, and she believed physiological instruction should be a vital element in women’s education. She represented feminine medical opinion that rejected the claim that education was derogatory for women. Longshore argued that education in female physiology in particular was beneficial to female health, for it would elevate all women to be better mothers and household managers.

As a respected member of the Topeka community and the medical profession, Longshore often spoke both to the laity and to the profession in support of women’s responsibility in general health care. “I do wish they [women] would use their brains more and their fascinations less,” she declared.” Implementation of scientific education for children (including girls), she suggested, should begin in the lower grades of the public schools. “Woman’s advancement is a part of civilization,” she argued, “and she will show and understand her interest in the State Board of Health as she is made to know her responsibility in the matters of general health and creature comforts.” As long as women do not understand the principles of hygiene, she explained, the laws of health will not be practiced. When women understand the necessity of health rules, Longshore declared, then they will willingly support them. She made these statements before the second state sanitary convention in December 1887, reportedly as the first woman to read a paper to that organization. Challenged by the responsibility to teach “helpless and ignorant” Kansas women, Longshore fulfilled the ideal of the special role of female physicians in preventive medicine.

Frances Storrs also spoke in support of education for women. Storrs (ca. 1868–1925) was a native Kansan, possibly born in Atchison. Her father was a prominent antislavery advocate who had come to Kansas prior to the Civil War. The Storrs family moved to Topeka in 1877, where Frances grew up and graduated from Washburn College. In 1893 she had the distinction of being one of the first two women to graduate from Topeka’s Kansas Medical College. She finished second in her class according to her test scores. As a member of the third graduating

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class, the first one to complete a full three-year course, she participated in professional organizations such as the Eastern Kansas Medical Society and the Topeka Academy of Medicine and Surgery. By 1895 she had a partnership in private practice with Dr. John C. McClintock. An advertisement for their joint practice ran regularly in the Kansas Medical Journal from 1895 to 1897. McClintock was a distinguished surgeon at Christ’s Hospital and one of the founders of the Kansas Medical College. McClintock and Storrs practiced surgery and gynecology exclusively. By 1898, according to an advertisement, Storrs had established herself in a single private “practice limited to surgery and gynecology [with] private hospital in the suburbs of the city under [her] personal supervision.” Her office and residence were at 1318 Firmore Street in Topeka. 20

In addition to conducting her private practice, Storrs found time to write numerous professional articles. She was the first woman to teach at the Kansas Medical College, initially as an instructor in Latin, and by the session of 1895–1896 as assistant professor of surgery. The catalog of the college for the years 1896–1897 described her course in surgery:

taught by dedicated lectures... upon the principles and practice of surgery for the second and third

year classes. Regular clinics will be held at which students of these classes are to attend. Practice of Surgery.—A course of didactic lectures upon the practice of surgery will be given in addition to the regular course upon the principles and practice. 21

When commenting on education for women, Storrs claimed that female ignorance in regard to women’s own vital processes was largely responsible for the prevalence of uterine disease. During the term of her faculty appointment, Storrs campaigned for female education. Women, she proposed, needed thorough training in anatomy and physiology beginning at an early age to prepare for the advent of menstruation. The aim of education for young women from fourteen to twenty should be toward physical perfection. This would be accomplished by systematic exercise in the gymnasium and outdoors. Girls and women should study gestation, parturition, and development of infants and children. 22

21. Kansas Medical College Minutes of Faculty Meetings, July 7, 1896, 114, Washburn College Records, 1881–1926, mss. 307, Library and Archives Division, Kansas State Historical Society. The Kansas Medical College minutes of July 7, 1894, report Dr. Storrs’s resignation as instructor of Latin. They do not subsequently indicate when she began the surgery position, but the Sixth Annual Announcement of the Kansas Medical College, Topeka, Kansas, Session of 1885–86, 4, 12, and the Eighth Annual Announcement of the Kansas Medical College, Topeka, Kansas, Session of 1897–98, 2, listed her as a member of the faculty in the department of surgery. Quote from Seventh Annual Announcement of the Kansas Medical College, Topeka, Kansas, 1886–1897, 12.

Storrs literally called for sex education in combination with increased physical exercise and fresh outdoor air. Reading her paper before the Eastern Kansas Medical Society at Kansas City in October 1894, Storrs strongly protested the failure of the medical community to endorse physiological education for women in their developing years. In a subsequent presentation, she claimed that it was not just the study and application of medicine to suffering humanity but rather consideration of the individual. Her philosophy proposed improvement of lives by preventing problems rather than just curing them after illness occurred.\(^{23}\) Her comments illustrate the fear and challenges that the new scientific understanding brought to female physicians who justified their places in medicine as an extension of their domestic roles.

Is there not a danger lurking in the perfection of technical training? in this flattering ability to classify men's ailing and give them names and the right proportion of approved and properly prescribed drugs? Is it not true that the tendency of much of this so-called education in medicine is to make of its practice a trade, rather than a service to man? Is it not true that this very training which extracts the minute and magnifies [sic] the little things is narrowing our conception of the office of him who would stand as a healer of the people, and is making him lose sight of the larger factors and influences of life?

The practice of medicine has a deeper meaning.\(^{24}\)

Here Storrs eloquently expressed the danger she sensed in the new scientific outlook, which she believed could lead to ignoring the whole person. She feared medicine was evolving into a trade rather than remaining a holistic art. It threatened the “office” of the physician whose moral responsibility to the patient, she believed, involved the “larger factors of life.” This moral responsibility required education of the “ignorant” so that they might be assisted into a better life and adopt that which is “natural” to a person’s existence.

Dr. Ida C. Barnes (1867–1910) also campaigned for improved health education for women. Born to pioneer parents in Jefferson County, Kansas, Barnes received an A.B. from the University of Kansas in 1885 and a medical degree from the Woman’s Medical College of Pennsylvania in 1890. After a year as resident physician at the Woman’s Hospital of Philadelphia, Barnes completed postgraduate work in electro-therapeutics, x-ray, and radium. Returning to Kansas the following year, she settled in Topeka. The only woman listed in James L. King’s History of Shawnee County, Barnes was in King’s words “the leading woman physician and surgeon of Topeka . . . who combines professional skill with attributes which made her an esteemed and beloved member of her sex.” Beginning practice in Topeka in 1891 in “finely appointed offices at No. 726 Kansas Avenue,” Barnes utilized “every pain-alleviating medium of modern days, which has received the sanction of the profession . . . She is a lady of most enlightened views and of great force of character.”\(^{25}\) She became a charter member of the Western Association of Obstetrics and Gynecology in 1895. The same year she accepted the office of treasurer of the Kansas Medical Society and the following as president of the Topeka Academy of Medicine and Surgery. On women’s health education Barnes emphasized that preventive medicine began in the physicians’ office, and she viewed this as one of the physician’s primary responsibilities. Abundant material was available to “the painstaking physician who will diligently search for knowledge and carefully weigh the evidence found; thus preparing the way for preventive medicine and thereby lengthening the average life.”\(^{26}\) Barnes claimed that unplanned pregnancies, venereal diseases, or some lesion of the pelvic organs in a large portion of women were not to be explained etiologically. These problems were due largely to ignorance, and to remedy existing conditions she proposed education in the community and the doctor’s office. “Much can be accomplished through the education of


\(^{24}\) Ibid., 527.

\(^{25}\) James L. King, ed., History of Shawnee County and Representative Citizens (Chicago: Richmond and Arnold, 1905), 423–24.

the community in the laws of health, including the
general principles of ventilation, out-of-door exercise,
proper food, pure water, good sanitation, physical
culture, etc., but after all, the greatest impression
is made by the physician in his office as he applies his
instruction to the exact needs of the case.”

While healthy parentage certainly was advanta-
geous, Barnes emphasized adherence to the laws of
health to ensure female health. “If we are to have
strong women it is important that the baby girl grows
well, and that as she develops, only such burdens
shall be imposed as shall secure an even progress of
both mind and body.” She advocated “the establish-
ment of courses of physical culture in all schools and
grades of school as a part of the regular work of each
day.” Barnes believed “that not only the health of the
individual, and of young women in particular, but
also the welfare of the nation” was at stake.

In a presentation on the subject of abortion before
the Western Association of Obstetrics and Gynecol-
ogy meeting in Omaha in March 1896, Barnes reiter-
ated the importance of education in the tradition of the
health reform movement, emphasizing the primary
role of the physician:

Women may be more strongly impressed by a
greater knowledge of the diseases entailed [with
abortion] . . . . The only successful method of incul-
cating proper knowledge, is to instruct mothers so
that they will utilize more distinctly their duties to
themselves, and to their children, . . . concerning
the functions of the generative system and of the
disastrous results of abuse and crime in this direc-
tion . . . I am persuaded that such knowledge
would make better women, who would make bet-
ter mothers, who would endure the discomforts of
pregnancy with greater fortitude and more joy of
the anticipation for the possibilities of the coming
generation, while no stain of mediative crime
[abortion] would blight their souls.

According to Barnes, no one could provide this edu-
cation better than the physician. She argued in favor
of giving women a greater knowledge of “functional
activity.” “So many young women . . . proudly de-
clare that they know nothing about the organs of gen-
eration,” she lamented. “Women,” she argued,
“should understand something of the function [of
sexuality] before contracting for functional activity.”
Women who were educated about sexual functions
and reproduction would not need to resort to abor-

27. Ibid.
28. Ibid., 117–18.
30. Ibid.
tion, and they would be better equipped to endure pregnancy and to fulfill the obligations of motherhood. According to Barnes, it was the medical community’s responsibility to provide appropriate education to women, to improve their health, to lengthen their lives, and to prevent criminal abortion.

According to Storrs, medicine had been revolutionized in the last half of the nineteenth century, since the publication of Dr. Oliver Wendell Holmes’s paper concerning the contagiousness of puerperal fever. But significantly, on the topic of gynecology, she continued, the prophylaxis of so-called diseases of women had been nearly ignored. In the Cyclopaedia of Gynecology, published in 1888, for example, one would look in vain for any article relating directly to the etiology of disease among women. Storrs emphasized that this was no isolated example.

Dr. Storrs divided preventive gynecology into two distinct categories. The first consisted of factors that women could control once they were made aware of the potential dangers. These included physical development of the body and nervous system, appropriate dress, prudence after parturition, prevention of criminal abortion, and medical examination before marriage. These were issues that could be addressed by appropriate educational changes. The second etiological category listed child-bearing and infection by the gonococcus. The potential of the former might be prevented by a doctor who practiced good prenatal and postnatal care. The latter, in ordinary cases, the husband might prevent. These two major categories, according to Storrs, accounted for 85 percent of women’s diseases.

Storrs described gonococcal infections as not immediately life-threatening but rather a disease that caused such misery that death was a longed-for release. Storrs faulted physicians with the failure to educate women. She blamed doctors for protecting the offender rather than the innocent offended woman. In other words, the physician who failed to educate women about the dangers of venereal disease, including the method of transfer, were shielding the transmitters of the disease rather than serving the female who innocently acquired the disease from a “faithless spouse.”

When addressing the issue of postpartum gynecological problems, Storrs asserted: “something must be radically wrong somewhere, that so many neglected cases of lacerated cervix and perineum, with the accompanying subinvoluted uteri and long train of nervous symptoms, come into the attention of specialist’s hands.” She criticized the physician’s tendency to accept the Victorian belief that the unhealthy condition of women was inevitable, or that women preferred to be ill; that women “choose a life of pernicious dressing and reckless immodesty, especially to exaggerate nervous phenomena and induce uterine affections.” Disease was not “fashionable,” according to Storrs, but rather a potentially preventable entity.

Men often blamed women’s ill health on inappropriate dress. Storrs countered this argument through her own investigation, which she claimed demonstrated that nine-tenths of the women in the ordinary walks of life dressed comfortably. The other excuse offered by the medical community was ignorance, which she rejected as no excuse at all. Continuing to speak about how ill-prepared women were for childbirth and confinement, she asked the ironic question, “If it takes three years of constant study and clinical observation to fit a man to wait upon a woman in confinement, . . . how much longer ought it take to fit that woman for her part in the preceding nine months, and for the responsibility which becomes hers at that time?”

In an article on menopause, Dr. Barnes argued that incidental small symptoms, which together might indicate more serious problems, often were ignored or viewed as insignificant by physicians:

I have felt that there is a lack of attention on the part of the medical profession, to the minor ail-

31. Storrs, “Education a Factor in the Prophylaxis of Diseases of Women,” 28. The Dr. Oliver Wendell Holmes of whom Dr. Storrs speaks is not the twentieth-century Supreme Court Justice but rather a medical doctor who wrote an article in 1844.
32. Ibid.
33. Ibid.
34. Ibid., 26.
35. Ibid.
36. Ibid. Dr. Storrs claimed she was “at no small pains to investigate” this conclusion.
37. Ibid., 26–27.
Frances A. Harper graduated from the Kansas Medical College in 1904, where she later became a faculty member. Harper's focus, like that of the other female physicians, was preventive medicine, ensured by proper attention from the physician.

Irregular or increased flow, according to Barnes, may indicate "malignant degeneration." Cases of "women with marked neurotic temperaments frequently culminate in insanity associated with the menopause," she observed. The prognosis in these types of insanity cases is relatively favorable—40 to 55 percent may recover. "Is it not reasonable to believe," asked Barnes, "that preventive treatment might have relieved many from such disastrous results?" In other words, why should women suffer unnecessarily? In her presidential address to the Topeka Academy of Medicine and Surgery in November 1897, Dr. Barnes once more emphasized the necessity "of preventive medicine, which, if successfully promoted, must yield great results in the prolongation of life and in the possibilities of an active life."

Like Longshore, Barnes, and Storrs, Dr. Sara E. Greenfield emphasized preventive medicine. Sara Greenfield (1874–1932), a native Kansan, was born in Sabetha in 1874. After gaining an education at the University of Kansas, she matriculated at the College of Physicians and Surgeons at the University of Illinois and earned her M.D. in 1900. After practicing for two years in Hiawatha, Kansas, she moved to Topeka. Greenfield became the bacteriologist for the State Board of Health and had a laboratory in her home. In 1903 she was elected assistant in the pathology laboratory class for one year at the Kansas Medical College. Following this she was appointed temporarily to the chair of bacteriology at a monthly compensation of twenty-five dollars. She subsequently held positions as instructor in histology (1907), instructor of bacteriology (1908), and professor of bacteriology and histology (1909).
Greenfield's interest in bacteriology and prevention of disease initiated public campaigns. On March 3, 1903, she presented a paper on the care of the consumptive to the State Board of Health, which had "a great influence in sparking the fight [against] tuberculosis." Bertha Campbell, a member of the state board for twenty-three years, reported that "Dr. Greenfield's letters to Dr. Samuel J. Crumbine over a number of years helped start his campaign against the disease." The board asked that Kansas physicians be given copies of the paper that she read in 1903. As a result of her paper, the board agreed that specimens of sputum would be tested for two dollars each as an initial step in prevention.

Because of her position with the State Board of Health, Greenfield had the opportunity to be the most outspoken among the six women on public health. Before the Shawnee County Medical Society she promoted prophylactic and curative measures for tuberculosis. She encouraged public education, to be followed by legislation against "crowding in tenements of great cities and the introduction of better sanitary measures among all classes,... the building of sanitoria, the establishing of fresh air camps, and improved therapeutic treatment."

Greenfield regarded menopause as the most important period of a woman's life and one where preventive measures could make a considerable difference in one's health. She placed the responsibility for detecting simple and subtle symptoms indicative of more serious problems in the hands of the general practitioner.

Dr. Frances A. Harper (1861–1925) was a native of Galveston, Texas. She graduated from the Kansas Medical College in Topeka in 1904, where she later became a faculty member. By the time she attended the Kansas Medical College, the course of study had been increased from three to four years, and prior to her graduation the school had merged with Washburn College. Requirements for graduation included attendance at four full courses of instruction of six months each, dissection during three classes, clinic and hospital instruction during the last two terms, and satisfactory completion of all exams. At her graduation Harper won two prizes: a phonendoscope, and the ten-dollar alumni award for her student paper entitled "The Diagnostic Value of Urine Analysis." Of the five graduate prizes awarded, three were won by females. Harper established a private practice in Pittsburg, Kansas. Unfortunately, few records exist concerning her practical career.

Harper also addressed the issue of those afflictions preventable by the physician. In her presentation before the Crawford County Medical Society in 1906, she spoke about the avoidance of subinvolution of the uterus as one component of preventive medicine. Subinvolution is the failure of the uterus to involute, to return to its normal size and weight. This could occur with the puerpera (after delivery) or after menstruation, and, according to Harper, failure to involute "constitutes the chief cause of all chronic uterine disorders, and for this reason alone its care and treatment cannot be overestimated.... It is important that the obstetrician should recognize its presence, and correct abnormal conditions in its early stages."

42. Greene, "Kansas Women of Medicine," 12; Samuel J. Crumbine, Frontier Doctor: The Autobiography of a Pioneer on the Frontier of Public Health (Philadelphia: Dorrara Co., 1946). Dr. Samuel J. Crumbine practiced in Dodge City, Kansas, during the late 1880s. He was appointed to the Kansas State Board of Health in 1904 and served until the 1920s.


She outlined a prophylaxis consisting of the complete evacuation of all secundines (placental tissue) after labor, the avoidance of lacerations and infections, and rest in bed until the cervix and uterus were firmly contracted. In fact, she added, prevention should begin at conception, by the woman maintaining as perfect a physical condition as possible. Harper’s underlying theme, like that of the other female physicians, was preventive medicine, ensured by proper attention from the physician.

Several Kansas physicians espoused gynecological therapy as a preventive measure to avoid unnecessary surgery. Longshore reported on a case in which her moderate intervention made pregnancy possible. The patient had constricting bands in the posterior wall of the vagina that decreased it to a size “no larger than a straw.” Through her repeated dilatations over a period of time, plus continued home treatment by the patient, pregnancy became possible. Longshore compared her less invasive procedure to a case of surgical intervention described in the New York Medical Journal, November 17, 1894. Here the physician advocated dissection or cutting of the bands. Longshore emphasized the effectiveness of her less radical method.

Dr. Maggie L. McCrea (1864–1938) was born near Crawfordsville, Iowa, and moved with her family at age ten to Winchester, Kansas. McCrea graduated from the Northwestern University Woman’s Medical School in 1891. She practiced medicine in Topeka for several years and in Winchester and Kansas City, before moving in 1914 to Sterling, where she worked as a physician the remainder of her life.

McCrea presented an alternative treatment to either manual external or internal versions (manually turning the fetus either outside or within the uterine cavity) for transverse presentations at birth. (Transverse presentation refers to the horizontal position of the fetus rather than the usual head first presentation). Such a position prohibits progress of labor and delivery and usually requires some type of interven-
tion to return the fetus to the desirable vertex (head) position for a vaginal delivery. McCrea noted that all authorities on midwifery divide the treatment of such abnormal presentations into external version and internal version or a combination of the two. She suggested an alternate method that she learned in medical college from Dr. Sarah Hackett Stevenson. The method applied only before any rupture of the membranes (bag of water) occurred. The laboring patient assumed a position on her knees and shoulders in the bed with her shoulders at the bed level, thus inverting the pelvis and the gravid (pregnant) uterus. The procedure, McCrea stressed, was an ancient one used by midwives. McCrea successfully utilized the method in two cases in her practice. She also noted that this was an especially useful procedure, since the amount of muscular strength a woman physician could apply to manually reposition the fetus was generally less than the degree required. It was also preferable because it avoided the extreme pain often perpetrated upon the patient by various version procedures. In her experience with one case, after about a half hour in the knee-chest position, “the head had descended sufficiently to be detected,” and after several hours had engaged in the lower pelvis. The second case was so successful in encouraging delivery that McCrea recommended employing it in “all cases where there is not an urgent demand for immediate interference.”

Dr. Storrs likewise spoke enthusiastically before the Eastern Kansas Medical Society at Kansas City in 1894 about alternatives to vivisection (removal of the gynecological organs). Regarding “the so-called diseases of women,” Storrs declared, “prophylaxis has been so nearly lost sight of, while surgery has usurped the field.” In the published works on this subject, she noted:

There seems to be a tendency . . . to accept the present condition of women as an inevitable one, and even imply that they prefer to be ill, and chose a life of pernicious dressing and reckless imprudence, especially to exaggerate nervous phenome-

na and induce uterine affections. What wonder that the art of extirpation has supplanted the science of prevention in treating such irrational beings, and that the very latest and most approved method of dealing with diseased pelvic organs is to preserve them entire in alcohol, as being too complicated a mechanism for the ordinary woman to be entrusted with!"

She continued, acknowledging that in many cases surgery was medically necessary. For example to treat a fallopian tube distended with pus by means other than surgical removal was “utter folly.” Storrs placed the responsibility in the lap of the profession to distinguish between cases where surgery was necessary and where it was not:

If the diseases of women are many of them preventable, then should the medical profession have a care that they are prevented. If women are reasonable beings, and who would deny that they are, then they can be taught, and it is the medical profession who must decide what they are to be taught."

Storrs emphatically admonished the profession to cease surgical removal of uteri and ovaries as treatment for all but diseased conditions of these organs. She criticized the belief that women were so irrational that they were incapable of understanding their own physiology or of maintaining the health of their own pelvic organs.

Barnes also proposed an alternate therapy, in this case for incomplete abortion that “if successful, [was] much easier both for physician and patient than the dilation of the cervical canal and manual extraction of secundines with finger, curette, or placental forceps. Moreover, it [could] be performed without family assistants, or anesthesia.” She described the therapy as an “intra-uterine douche, with a hot creolin solution,” allowed to flow freely inside the uterus. Afterwards all clots and debris were removed by dull curette. The

55. Ibid., 27.
hot solution acted as a hemostatic (blood clotting) agent and was allowed to flow until it returned white. Then the uterus was packed with iodoform (antiseptic) gauze causing the uterus to contract. The blood was unable to escape until the cavity distended when the flow dislodged the pack of gauze and all other uterine contents. The procedure, she explained, also prevented subinvolution because as the uterus contracted to rid itself of the pack and products of conception, it also involuted rapidly. This therapy contrasted with the more usual dilatation and curettage accomplished with a sharp curette, dilators, and excessive pain for the patient. The treatment, according to Dr. Barnes, “is endure[d] without a groan.”

Kansas female physicians at the turn of the century—as represented by the six women investigated in this study—proposed specific changes in women’s health care. They focused on preventive gynecology and antivivisection, since vivisection equaled mutilation, which violated the moral good—woman’s role to nurture and bear children. They also identified with teaching hygiene and sanitation, education for women in physiology and science, dress reform, and physical exercise. They placed responsibility for the implementation of these measures directly on the shoulders of all physicians, both male and female. They challenged certain traditional therapeutic measures as they attempted to protect the moral and natural order and at the same time taught health and hygiene to improve women’s lives.  

These females took a radical step, violating nineteenth-century norms for accepted female activity.


57. Ibid.
when they entered the public world of the male physician. Many of these women believed that females should enter public life because they had a unique contribution that men could not make. Much of their work attests to the connection of women’s traditional domestic sphere—the family—to the larger public sphere. They joined the profession by virtue of their “natural gifts” as healers and nurturers. They strove to be dedicated practitioners, oblivious to selfish motives and sensitive to the wives, mothers, and children who would be their primary constituency. Sara Greenfield expressed these ideas stating:

I feel that there is a place for women in the practice of medicine—or I should not have taken it up. . . . There are lines of work in medicine for which women are specially adapted, and I think that they can occupy their positions and do their work without at all interfering with or usurping the place of the men practitioners. . . . There is much in which they can help each other, and thus be a boon to suffering humanity in general.  

In the context of reform efforts, women physicians were highly visible. They were particularly adept at developing programs for women and children during the period between 1880 and 1910 and championed other progressive era reforms. Greenfield was the most outspoken on public health while Longshore, as president of the Good Government Club of Topeka, actively participated in the suffrage movement.

Each of these female physicians emphasized the destructiveness of traditional female socialization. Women, they claimed, were educated in an inappropriate manner. Properly educated women would be better mothers with healthier children. They would enjoy improved physical health themselves if they understood their own bodily functions and basic health rules.

The ideology that supported women’s role in medicine perpetuated these professionals’ social roles and tended to keep them separate. It was as if women were in the profession but not really an equal part of it. They used their special feminine skills to achieve a higher social purpose in medicine—the regeneration and maintenance of family life and social morality. Thus, the separation by gender implied that women had a place in medicine only in so far as their traditional roles applied to medical practice.

The six Kansas female physicians unanimously addressed the conflict created by the new germ theory. Storrs explicitly questioned the impact of the new scientific medical practice. It threatened women’s place as physicians, whose duties involved the whole person including the moral, the spiritual, and the physical—which made medicine a holistic art rather than a science with specific etiology. Greenfield supported the new germ theory as professor and state bacteriologist. Yet she too wrote on prevention as a reflection of the extended domestic role to which most female physicians ascribed. Barnes, described as a woman who believed in woman’s place in a man’s world, also sought postgraduate work in diagnostic techniques, x-ray, and radium, and frequently published her ideas stressing the domestic preservation of the moral order. Her paper on abortion, in particular, illustrates adherence to the idea that women’s role preserved morality that abortion violated. Most of Longshore’s articles supported femininity, domesticity, and morality, yet she encouraged women to become aware of the differences between diseases.

These Kansas women represent a widely held perspective among women who entered public life during their time because of the contributions they believed they could make as women to women and to society. They saw themselves as conservators of the past. At the same time, they struggled with the new science whose specific etiology undermined their sense of moral order. Gradually and subtly, however, they began to adopt its precepts into their practices.