Constructing Medical Social Authority on Dress in Victorian Canada

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Abstract. During the late-Victorian period, campaigns to “reform” middle-class women’s dress were grounded in discourses on health, eugenics, declining birth rates, comfort, and aesthetics. In Britain, the United States and Germany, organized “dress reform” movements emerged in the latter half of the 19th century, while in Canada the campaign was led primarily by physicians through public health education. This article explores the discussion on women’s dress in public health literature in Canadian circulation between 1860-1900 and interprets findings within a feminist poststructuralist framework that posits the understanding of women’s bodies and gender regulation to be central to knowledge construction on women’s dress.

Keywords. dress reform, Victorian medicine, discourses, gender

Résumé. Dans la dernière partie de l’ère victorienne, on a tenté de réformer la tenue vestimentaire des femmes de la classe moyenne par un discours sur la santé, l’eugénisme, la dénatalité, le confort et l’esthétisme. L’Angleterre, les États-Unis et l’Allemagne virent également surgir semblables mouvements de réforme au cours de la même période alors qu’au Canada, ce sont principalement des médecins qui ont mené une campagne d’éducation publique. Cet article explore le traitement de la tenue vestimentaire des femmes dans les textes de la santé publique entre 1860 et 1900, interprété dans une perspective féministe poststructuraliste et postulant que la connaissance du corps de la femme et la régulation sociale régissent la construction des savoirs sur la tenue vestimentaire féminine.

Mots-clés. réforme vestimentaire, médecine victorienne, discours, genre

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During the late-Victorian period, acceptable dress for most middle-class women included long-fitted dresses, crinolines, petticoats, corsets, and heeled shoes. This dress code, however, was by no means fixed, and attempts were made to "reform" women's dress from the Victorian period onwards. In Britain, the United States, and Germany, a cohesive and organized "dress reform" movement emerged in the latter half of the 19th century, sustained by various associations who campaigned to reform middle-class women's dress for reasons of comfort, aesthetics or health. There existed no Canadian dress reform association, but a survey of scholarship on medicine, first wave feminism, and social reform reveals the importance of the subject to Canadians in the 19th century. Wendy Mitchinson discussed how members of the medical profession urged men and women to adopt healthier forms of dress within the context of expanding medical authority on women's bodies. Mariana Valverde linked dress reform discourses to eugenics and social purity campaigns while Angus McLaren and Carol Lee Bacchi also situated dress reform within a eugenics discourse and the anxiety resulting from changing demographics, notably the birth rate decline from 7.02 children per woman in 1851 to 3.54 in 1921. Sharon Anne Cook contextualized dress reform within the work agenda of the Canadian Woman's Christian Temperance Union (WCTU) and its campaign for modest and loose-fitting women's dress. Although the WCTU promoted dress reform in Canada, it was the medical community who initiated discussion on dress and health and who led the way in educating the Canadian public on "healthy" dress.

Paul Starr argued that North American physicians attained at least two different kinds of authority in the 19th century: a "cultural authority" which implied the power to define health, illness and healing, and a "social authority," which led the public to accept their advice. This study explores how physicians communicated their social authority on women's dress to the Canadian public. The methodological approach will consist of a content analysis on dress from public health literature in Canadian circulation between 1860-1900 and interpreted within a feminist poststructuralist framework that posits the understanding of women's bodies and gender regulation to be central to the knowledge construction on women's dress.

E. T. Renbourn and W. H. Rees traced interest in the link between clothing and health back to the 5th century BC when Empedocles, the Greek philosopher, drew an analogy between the circulation of blood in vessels and the circulation of air. Air vapours were thought to be squeezed in and out of invisible pores throughout the body. This circulation, or skin breathing, involved the continuous liberation of invisible perspiration insensibilis. Renbourn explains: "Great importance was attached to the cutaneous respiration, for not only did it allow the smoky
or fuliginous vapours of the heart to get out partly through the skin pores, but also water vapour and the insensible excretory matters of the body poured out through this channel." It was believed that if perspiration were obstructed by damp air, clothes, bedding or by wet feet, it was forced inward to the internal organs through a process of metastasis. This was believed to cause a cold or catarrh of the head, inflammation of the brain, lungs or kidneys, an excessive flow of urine or a looseness of the bowels. Thus, keeping skin pores open was necessary for a healthy body.

Classical beliefs regarding skin breathing resurfaced centuries later, when in 1614 Paduan physician Sanctorius concluded the perspiratio insensibilis of the skin was far more important than all other excretions combined based on his experiments weighing himself, his food and his excreta under almost every conceivable condition. Followers of Sanctorius believed that health depended upon all measures which kept the skin thoroughly warm and its pores open, which in turn encouraged a continual free flow of the insensible perspiration. As a result, many physicians argued it was essential to wear an abundance of warm clothing in the form of flannel next to the skin in both summer and winter. Yet conflicting ideas on humoural theory, skin breathing, open pores, and the regulation of hot/cold body temperatures continued to be discussed and debated well into the 19th century, as alternate theories and medical findings emerged in light of new laboratory experiments and teachings.

The first evidence of prescriptive literature on the subject of dress and health dates back to the 18th and early 19th centuries when Enlightenment philosophers John Locke and Jean Jacques Rousseau discussed the need to "liberate" babies from swaddling and children from corsets. Prior to the French Revolution, the corset had been viewed as an extension of swaddling clothes, meant for use as a protective, corrective mould for soft bodies, and especially so in the case of children. By the 18th century however, Rousseau, Dr. Samuel Auguste David Tissot, and later Dr. Henri Joseph Hardy all wrote on the "dangers" of the corset. Stiffened corsets and swaddling clothes were blamed for degeneration, weakness, and organ deformities. Concern over corsets endured and was subject to enhanced medical scrutiny during the Victorian period, a time of changing demographics and a time in which industrialization and urbanization greatly influenced urban and social life.

As physicians in Canada began to receive specialized education and training in gynaecology and obstetrics in the late 19th century, there was greater opportunity to read and discuss research findings published in medical journals and textbooks. The reason tight-lacing became a medical issue in the late 19th century was not because women were lacing tighter; corsets or stiff-bodied gowns had been around since the Renaissance. It was due to the development of the medical specialists who were carving
out a medical/moral space for themselves and to do so, they “problema-
tized” women and their bodies. Their publications provided physicians
and medical students with greater specialized knowledge in which to
ground their theories on dress and women’s bodies. The cultural author-
ity gained from academic training and practice allowed medical special-
ists to define dress as a problem in the healthy development and func-
tioning of women’s bodies. The social authority by which a larger number
of general practitioners and specialists constructed and disseminated this
knowledge took on many forms. Health information in these books and
magazines was based on findings and discussions published in peer-
reviewed medical journals, textbooks and theses. Family medical
almanacs were particularly popular for people who would otherwise not
be able to afford to consult a physician.16

Medical discussions on clothing found in almanacs, advice books,
and articles covered many topics during the Victorian period. Nonethe-
less, three main issues emerged: the need to regulate body tempera-
tures through dress; the effects of tight clothing on the organs; and the
“unnaturalness” of fashionable dress. Knowledge about heat regulation
was largely found in literature destined for the medical community, was
considered scientifically based (and often developed for military pur-
poses), and targeted to both men and women. Medical knowledge on
“restrictive” and/or “unnatural” dress, however, was more widely dis-
seminated to the general public and grounded in a maternalist discourse
emphasizing women’s reproductive capacities and perceived primary
responsibility as potential mothers.17

The most widely read health almanac for the treatment and preven-
tion of disease during the early- to mid-19th century was British physi-
cian William Buchan’s Domestic Medicine.18 Published in Canada in 1782,
the popular, multi-edition of Buchan’s almanac became “the family
physician” not only in England, but in English North America as well. Dr.
Buchan promoted the idea that every individual needed to maintain a
mean temperature of 97 degrees Fahrenheit and hence protect their
body from the cold. To ensure warm body temperatures, Buchan sub-
scribed to the prevailing ideology that a heat-generating process needed
to occur within. It was believed that if the body maintained a warm
temperature, a free and equal circulation of blood would occur. The pub-
lic was instructed that if the skin’s surface was subjected to cold tem-
peratures, capillaries and vessels would contract, causing blood to accu-
mulate in the internal organs and result in serious congestion.

In the popular medical manual Anatomy, Physiology, and Hygiene, pub-
lished in Toronto in 1874, New Hampshire physician Dr. Calvin Cutter
expanded on the prevailing theories of heat regulation by introducing
the role of clothing in protecting the body and by making a distinction
about the protective properties of clothing.19 Cutter believed that cloth-
ing in and of itself did not bestow heat, but was necessary in the pre-
vention of heat loss as it helped to protect the individual from fluctuations in atmospheric temperature. When selecting clothing, he offered the following suggestion:

The material for clothing should be a bad conductor of heat; that is, it should have little tendency to conduct, or remove heat from the body. This depends on the property possessed from the material in retaining atmospheric air in its meshes. Moisture renders clothing a good conductor of heat. Thus all articles of apparel should not only be non-conductors of heat, but should not possess the property of absorbing and retaining moisture. 20

In 1880, Severin Lachapelle, Montreal physician and professor of hygiene, wrote several advice manuals for the public and also translated Chicago professor Henry Lyman’s popular Practical Home Physician into French under the title La santé pour tous. Dr. Lachapelle’s advice on clothing was directed to young mothers who were advised to wear flannel to keep healthy during the long winter months.21 Equally popular in Quebec was Dr. J. Israël Desroches’s 1889, Traité élémentaire d’hygiène privé, in which its eighth lesson addressed clothing. Men and women were urged not to wear cotton undershirts, but wool, “l’aïne du notre pays,” except for a month or two during the summer. To ensure adequate heat regulation, it was not to be changed more than two to three times per week.22

Ottawa physician Dr. Edward Playter, who devoted an entire chapter to clothing in his manual, Elementary Anatomy, Physiology, and Hygiene (1880),23 advocated wearing wool as he believed it “to form the most valuable material of clothing in use.”24 His views on wool were interesting in that he made a distinction between appropriate day and night dress, dependent on the internal temperature of the body: “For underwear, next to the skin, during the day, woollen flannel is decidedly the best. […] During the night…nothing makes a better bed-gown than thick soft cotton…”25 The 1894 Canadian publication The Household Guide also encouraged women to wear loose woollen clothing, a concern that was echoed in most popular medical advice manuals until the end of the 19th century.26 Wearing wool was considered necessary to protect the body from indecency and the fluctuations in atmosphere, particularly heat, cold, and moisture. Wool was also considered waterproof, wind-proof, and always warm on the skin.27

Medical authority was broadened as more areas of everyday life and popular culture came under the scrutiny of medical purview, and urban social problems like poverty and crime were now linked to defective genes.28 One factor believed to have caused defective genes and consequently feeble infants was the perceived restrictive clothing worn by women during pregnancy. As a result of the high rate of infant and
maternal mortality at this time, the concern over women’s fertility shaped medical discourses on women’s bodies. The prescriptive literature on restrictive clothing was thus targeted toward middle-class women of childbearing age, specifically adolescent girls and young married women. Public medical social authority on corsets concerned not only the body, but women’s lifestyle behaviour as well.

Research findings on corsets and their impact on women’s bodies were published in medical textbooks such as Queen’s University’s Manual of Obstetrics and Gynaecology published by Professor Kenneth Fenwick in 1889. He blamed women’s displaced uterus on the dress adopted by “the girl of the period.” The corset, Fenwick argued compressed the abdominal organs causing muscles to become atrophied and the viscera to be displaced, leading to congestion of blood in the pelvic organs and the distortion and displacement of the uterus.29 These findings were congruent with the majority of specialized literature published at the time.

The Family Physician or Every Man His Own Doctor (1889), a Canadian health almanac compiled by “the leading Canadian men,” warned that the likelihood of having a prolapsed uterus was increased by tight-lacing and the pressure of clothing. The authors of the almanac believed the abdomen sustained the pressure of heavy clothing, adding pressure on the uterus and causing the “uterus (to press) down the vagina until it sometimes comes out externally. Even young girls, eighteen or twenty years old have falling of the womb. Very few entirely escape it, for very few women are entirely well.”30 Dr. Edward Playter also wrote: “The effects of tight clothing are sometimes of a serious character. Compression of the chest and abdomen by corsets or stays is a fruitful cause of disease.”31

Particular attention was paid to pregnant women, since women’s maternity dress was considered an important factor in infant mortality or in complications during delivery. In 1876, an article published in the Canadian Public Health Magazine discussed acceptable clothing for a pregnant woman:

The clothing should be warm and comfortable. Tight lacing especially should be avoided, as deforming the mother and foetus. The origin of the word “Enceinte” may serve to show that the Roman ladies were wiser in their generation, for on the occurrence of pregnancy the tight girdle or “centure” was discontinued hence the pregnant woman was said to be incinta, or unbound.32

Not only was infant mortality believed to be linked to restrictive dress, but maternal death during delivery as well. For example, an excerpt from Canada’s New Dominion Monthly (1876) reads: “In this condition, no wonder so many (women) look upon childbearing with repugnance, and die in the attempt to become mothers.”33 In the popular prescriptive almanac Searchlights on Health: Light on Dark Corners (1894), Benjamin Grant Jefferis discusses the history, mystery, benefits and injuries of the
corset, concluding, like his contemporaries, that tight-lacing destroyed natural beauty and caused infant mortality. He estimated that half of all children died before reaching the age of five, due to organ deformities caused by their mothers wearing corsets while pregnant.

In his best-selling text *The Physical Life of Woman: Advice to the Maiden, Wife and Mother* (1870), Dr. George Napheys advocated loose and comfortable dress during pregnancy, when a woman occupies “an intermediate state between health and sickness.” Expectant mothers were advised that “garters should not be tightly drawn, but should still firmly support the ankles or else it would lead to swelling and ulcers of the legs, by which many women are crippled during their pregnancies.” A source of concern for physicians was the link between tight-lacing and miscarriage/abortion. There was debate on whether women should be publicly informed of potential ways to terminate a pregnancy. Physicians like Dr. Napheys faced this dilemma on how much information to reveal. In his book, he informed women and urged: “What ever a woman has the right to do to her own body, the mother has no right to blight for all time the prospects of another being possessed of individual right…although a prisoner in her body.”

Similarly, Dr. J. Hamilton Ayers in the Canadian edition of *Every Man Is His Own Doctor* (1881), cautiously informed the public of the potential harm caused by wearing corsets during pregnancy. By the late 1880s however, concerns regarding the connection between tight-lacing, pregnancy, and miscarriage were clearly expressed in the Canadian manual *The Family Physician* (1889): “The custom of wearing tightly laced corsets during gestation can not be too severely censured. It gives rise to functional disorder of the stomach and liver, as well as to uterine haemorrhage and abortion in the mother; it likewise impedes the regular nourishment of the foetus in the womb.” In *Searchlights on Health*, Jefferis stated that tight-lacing during pregnancy caused displacement of the womb, miscarriage, and sterility. Further, women who continued to wear corsets during the early period of gestation would “suffer severely during childbirth.”

Jefferis’s manual cited the work of American physician Alice Stockham, whose manual *Tokology: A Book for Every Woman* (1893) had been reprinted in Canada the year prior. Jefferis noted Stockham’s discussion on tight-lacing to be the chief cause of infantile mortality. She wrote: “The corset should not be worn for 200 years before pregnancy takes place. Ladies, it will take that time at least to overcome the ill effect of tight garments which you think so essential.” She believed that many young women gave birth to frail children due to their suspected compromised respiratory systems. Stockham also concluded that pregnant mothers who tight-laced provided insufficient levels of oxygen to sustain foetal development. In language adopted by moral crusaders at the time,
Stockham wrote that the death toll of corset-related deaths from the upper and middle classes to be in the millions:

This practice is murderous to both. It often destroys germinal life before or soon after birth by stopping the flow of life. The death total is in the millions.... If this murderous practice continues another generation, it will bury all the middle and upper classes of women and children and leave propagation to the coarse grained but healthy lower classes. 46

Her explicit reference to the working class was absent in Jefferis’s Canadian almanac. Further, while Jefferis reprinted Stockham’s plea to completely abandon corsets, citing her 50% mortality statistic, he simultaneously endorsed “new” corsets made with coralline, advising that they provided adequate flexibility and resistance. 47 Stockham, on the other hand, was committed to the belief that corsets in any form reduced pelvic room and thus caused abortions and miscarriages. 48

The social authority on dress and health also extended to women’s lifestyle. The fashionable mother was blamed with harming her child in two ways: the fetus was injured by way of tight-lacing; and after birth, the infant was harmed by the mother’s “irrationality” in her clothing choices and lifestyle outings. 49 Echoing the concerns of his colleagues, Dr. Richard William Garrett in a Canadian textbook on gynecology remarked: “Society often demands the exposure of the neck, arms and shoulder to the suddenly varying temperatures of heated ball-rooms, corridors and garden, while closely associated with these are: improper diet, irregular meals and late hours.” 50

Furthering the link between fashion and lifestyle was Dr. Pye Henry Chavasse, author of Advice to a Wife on the Management of Her Own Health (1897). Chavasse was one of North America’s most vocal opponents of women wearing corsets during pregnancy. In a moralist tone, Chavasse wrote: “It behoves a medical man to speak out plainly and call things by their right name. Fashion is often times but another name for suicide and for baby slaughter—the massacre of the innocents.” 51 His main concerns were the impact of maternal corsets and infant deformity, complications that arose during delivery, and severe uterine problems believed to be caused by corset use. 52 He also expressed concern for women who experienced fainting during pregnancy: “If the patient feels faint, she ought immediately to lie down flat on her back. The stays and any tight articles of dress—if she has been so foolish enough to wear either tight stays or clothes—ought to be loosened.” 53

Canadian medical prescriptive literature on women’s dress differed from its American counterparts in that it did not simply fault women as being irresponsible but attempted to understand why women even wore corsets. Canadian physicians like Dr. Benjamin F. Austin understood that corsets provided abdominal muscle and mammary support, and
warmth; and could be used as an aid to achieve weight loss. In their writing, some physicians demonstrated that they understood corsets were a product of an increasingly consumer-oriented society in the late 19th century. They realized that men controlled the flow of market goods available, were responsible for advertising and also largely defined norms of female beauty.

It is important to note that opinions expressed in medical prescriptive literature in Canada were not unanimously opposed to corsets. In 1890, Austin endorsed wearing corsets that snugly fit the body, while arguing that lacing too tightly was dangerous.54 This sentiment was also found in Canadian physiologist Professor Charles Roy’s treatise *The Physiological Bearing of Waist-Belts and Stays* (1888). He advocated wearing stays but cautiously introduced his text by stating: “To explain the use of any article is not to justify its abuse.” He believed that stiff belts or corsets supported weakened muscles and the front and sides of the abdomen that was “bounded by walls having no bony framework.”55 Roy also supported men wearing tight belts, and particularly those who were long distance runners, manual labourers, soldiers, sailors, and those who exercised in the gymnasium or frequently lifted heavy objects. While men were urged to wear tight belts in the above scenarios, women instead were encouraged to wear corsets. Roy reasoned that corsets must not hurt if horses could be saddled without harm and if peasant women in France wore them while working.56 Roy argued that only excessive or abusive corset use endangered the health of women. As such, he suggested a simple strategy to determine whether corsets were laced too tightly:

If the corset be so tight as to cause the wearer to become short of breath when walking fast, when playing tennis or running upstairs, or if any discomfort is experienced, then it may easily be assumed that the wearer is making an unwise sacrifice to fashion.”57

Roy’s depiction of women running, walking fast, or playing tennis was uncommon in medical discourses on women’s bodies in terms of their physical capabilities and acceptable limits. Equally intriguing was his endorsement of corsets as a means of weight control for women who feared growing larger, and tight-laced as a means to quell hunger pains. Roy discussed how North Germans wore the “hunger belt” or “schmachtriemen” to compress the organs of digestion, which he believed interfered with blood supply, thus dulling the sensation of hunger.58 He concluded that women who worried about not fitting into their clothes could control their weight through this method, which was not necessarily harmful or wrong if done in moderation.

For Quebec’s Dr. J. Israel Desroches, author of *Traité élémentaire d’hygiène privée* (1889), wearing a well-fitted corset gave women support,
and thus was not a problem: “Le corset bien porté est utile à la femme. Son usage ne doit pas être un objet de compression, mais un support pour la taille.”\(^5\) For Desroches, it was the abuse of excessive compression that caused harm to the heart and lungs. Men’s clothing however was singled out as potentially lethal, as is the case with his findings on men’s neck ties: “La cravate ne doit comprimer le cou et empêche la circulation du sang...on cite des cas de mort par congestions cérébrales.”\(^6\) In the Quebec manual, *Traité élémentaire de matière médicale et guide pratique* (1890), corsets also were favourably endorsed as a means of support: “Le meilleur appareil pour soutenir les mamelles est un corset bien fait, et peu serré.”\(^6\)

While some physicians endorsed wearing a loosely laced corset, others held a nuanced understanding of the complex process of dressing fashionably. Some physicians found that women were not solely to blame, since they were caught in a gendered beauty trap governed by men. Men had real economic, political and social power, and selected brides of their pleasing. If women desired marriage, then the cultivation of beauty was of utmost concern, whether it was overtly admitted or not. Several physicians understood the constraints of beauty and the unequal power relations that ensued. In a series of articles on the link between corsets and women’s diseases, Dr. A. Lapthorn Smith, a gynecologist and professor at Bishop’s University, considered women, men, “fashion” and “civilization” at fault:

I do not think that women are alone to blame for wearing tight corsets. They only try to meet a demand. If men admired women of natural shape more than thin waisted girls, the supply of the latter would soon cease to come on the market. So we should educate our male acquaintances to understand the probably sickness and costliness of corset-laced wives.\(^6\)

For Lapthorn Smith, part of the blame lay with “short-sighted men” who continued to admire and marry a thin-waisted woman, while she “only tries to fill the want which man desires.” He believed that if men could understand that a thin waist meant a sickly and consequently costly wife, they would understand beauty in terms of breathing capacity and large waist size. Lapthorn Smith believed that if men changed their perception of what was considered beautiful, women would voluntarily discard “the implement of torture which they have so long and so patiently been accustomed to bear.”\(^6\)

While the Canadian medical community published discourses on women’s dress and health, they did not assume the same moral and emotional language as in other countries. This did not escape the attention of some academics who called for a greater sustained effort by the medical community to discuss women’s dress and its impact on her health. In 1883, G. F. Watts of the Royal Academy demanded that “the
comparative silence of the medical profession on this subject” be addressed. Yet T. Arnold Haultain of Peterborough disagreed, defending the somewhat limited medical involvement in this area: “To his censures on the medical profession, we can legitimately and strongly object.” Haultain referred to the many institutions in England actively involved in the issue of dress and disease, and argued that Canadians benefited from the fruits of British Dress Reform Associations. He demonstrated that teachings advocated by the British National Health Society, the Ladies’ Dress Association, and the Rational Dress Society were reprinted in *The Canada Lancet*. Haultain argued that medical links were not only created through these associations, but also through a London exhibition of clothing organized by Miss Ray Lankester, daughter of “one of our greatest biologists.” Although the medical connection with the exhibition seems tenuous, Haultain proudly affirmed, “This last fact (the exhibition) shows us how we may more than plausibly trace the source of all these efforts to the medical profession.”

In essence, Haultain believed the medical community did not need to be further involved in dress reform in Canada because the problem of women’s dress was considered trivial. Perhaps his vantage is best understood in the context of the professional infighting between gynecologists and lay medical practitioners. He urged the medical community to leave discussions of high heels, small gloves, and tight-lacing to the “irresponsible literati,” and concentrate on clothing issues of greater importance, namely the irregularities in heat regulation due to clothing fabric. For Haultain, the physician’s duty was to show the violations of the rules of health and “to combat any arguments that may be raised in their defence. If we can thoroughly persuade mothers to see the evils with which the prevailing fashions are pregnant, we may trust the remedies to their own good sense and acute inventive genius.” Thus, for Haultain and others, once Canadian women were receptive to medical social authority and expertise on dress, they would be responsible and make appropriate clothing decisions on their own.

The significance of the development of medical social authority on women’s dress resides in the ways in which the profession constructed knowledge and leadership as public experts or “physicians of fashion” on matters of women’s dress. Through their education and training, physicians expanded their expertise on women’s bodies and broadened their authority to include discussion on the inherent characteristics they thought women should possess: a desire and capacity to reproduce, modesty, piety and strong moral character. In the context of eugenics and social purity movements, any deviation from these gendered character traits was deemed unhealthy and potential cause for disease. Medical to moral messages were constructed through the use of binary opposites of healthy/diseased bodies, natural/artificial and tight/loose dress. The
reforming logic, developed by doctors, was that clothes were a symbol of society’s health, and women’s dress was at the heart of this symbolic representation. With birth rates declining and changes occurring in the context of increased urbanization, physicians defined middle-class women’s experience of dressing as potentially problematic and treatable as a medical condition. By the end of the century, “understanding” women’s unhealthy bodies was partly linked to how they dressed. As women’s wombs were under surveillance for the well-being of the nation, much of the medical public discourses on dress reform were aimed at safeguarding women’s reproductive capacities to ensure healthy pregnancies. While the texts designed for the public discussed clothing and heat regulation in some detail, prescriptive literature on clothing and health largely focused on women’s perceived restrictive dress and irresponsible lifestyle.

The physicians leading the dress reform campaign in Canada invoked their scientific training to instil beliefs that reformulating clothing codes was necessary for the betterment of society. That physicians were gaining increased cultural and social authority, as Paul Starr asserted, was evident in Canada, as physicians suggested they were justified to determine the “problem” of what was “tight and restrictive,” and to define appropriate responses to perceived problems. Their cultural authority as physicians and gynaecologists allowed them to define illness and locate disease, while their moral social authority enabled them to disseminate this knowledge through prescriptive literature.

While women in the United States, Great Britain, and Germany were exposed to a plethora of literature condemning women’s fashionable dress, for the most part prescriptive literature published in Canada adopted a more cautious tone and distanced itself from the zealot tone of the non-Canadian literature. When citing American texts, the assertions were adapted for a Canadian readership. By and large, francophone physicians from Quebec assumed women dressed responsibly, their prescriptive literature undoubtedly a product of a different context in which the birth rate among French Canadian women was not a cause of concern. Other Canadian physicians attempted to understand the impact of societal values and norms of beauty that discreetly encouraged women to tight lace in order to succeed in attracting a husband. This research argues that concern over women’s fashionable dress related was grounded in the context of maternalism, professionalization of ob/gyn, the changing demographics and low birth rate of the Canadian-born middle class and the social purity campaigns during the Victorian period. When acceptable clothing norms were transgressed, particularly in the case of pregnant women, medical scrutiny on women’s dress intensified and was communicated to the public. Attitudes about women’s bodies and reproductive functions were important in shap-
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ing the maternalist tone of discourses on dress reform in 19th-century prescriptive literature in Canada.

NOTES

1 While physicians universalized the term “woman,” the medical discourses examined here concern mainly middle-class women.


6 The average number of children a woman would have borne in 1851 was 7.02 which dropped to 3.54 by 1921. See Roderic Beaujot and Kevin McQuillan, “Social Effects of Demographic Change: Canada 1851-1981,” *Journal of Canadian Studies*, 21, 1 (Spring 1986), p. 57-59. While the birth rate declined, the number of single women rose; in 1851, the number of single women between the ages of 45 and 49 was 8.2, by 1921, it climbed to 11.1. See Ellen Thomas Gee, “Marriage in Nineteenth-Century Canada,” *Canadian Review of Sociology and Anthropology*, 19, 3 (August 1982): 315.


11 Liquid sweat (Latin, sudor) was regarded as distinct to the invisible, insensible, perspiratio or perspiratio insensibilis. For discussion on this theory, see E. T. Renbourn and W. H. Rees, Materials and Clothing in Health and Disease: History, Physiology and Hygiene: Medical and Psychological Aspects with the Biophysics of Clothing (London: H. K. Lewis, 1972). See also Dr. J. J. Jenny, “Unhygienic Fashions,” Ciba Symposia, 6 (April 1944): 1967-77.

12 Renbourn, Materials and Clothing, p. 3.

13 For further discussion, see Wendy Mitchinson, The Nature of Their Bodies, p. 22.


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21 Séverin Lachapelle, *La santé pour tous* (Montréal: Compagnie d’imprimerie canadienne, 1880). Another widely read manual was Dr. Auguste De Bey, *Hygiène et physiologie du mariage, histoire naturelle et medicale de l’homme et de la femme maries dans ses plus curieux details* (ca. 1850, 90 édition, 1876).


38 The word abortion was not generally used, and instead, was cautiously referred to as an obstruction problem that women needed to clear.


41 *The Family Physician or Every Man His Own Doctor* (Toronto: Rose Publishing Company, 1889), p. 183.
44 The first American edition of this manual was published in 1883.
51 Dr. Pye Henry Chavasse, *Advice to a Wife on the Management of Her Own Health* (Toronto: Hunter Rose, 1897), p. 28.
52 Chavasse, *Advice to a Wife*, p. 148.
53 Chavasse, *Advice to a Wife*, p. 164.
54 Benjamin Fish Austin, *Woman: Her Character, Culture and Calling* (Brantford: Book and Bible House, 1890), p. 228.
63 Lapthorn Smith, “Gynaecology and Obstetrics,” p. 70.
68 See discussion in O’Connor, “Regulating Healthy Bodies,” p. 37-66, in which I construct Canadian women’s clothing practices based on photographs, school records, and diary accounts.