

Quantity and Quality: The Problem of Admissions in Medicine at the University of Toronto, 1910–51

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University admissions policies do not, as a rule, rivet the attention of historians. Indeed, aside from the question of discriminatory practices,¹ they raise little interest at all. Perhaps they should. Controlling the number and the quality of entrants has extensive pedagogical implications, it is often an indicator of institutional prestige, it raises some knotty problems about the relationship between the university and the school system, and it poses interesting questions about just how to identify talent and who should do it. During the first half of the twentieth century, as the potential pool of qualified candidates grew substantially larger compared with that of previous decades, universities and their professional schools across Canada and the United States became increasingly exercised about such matters.

This article represents our initial attempt to untangle the issues as they presented themselves to Ontario's university professional schools—in this case in the medical school at the University of Toronto between 1910 and 1951.² Given a rapidly rising number of qualified applicants graduating from

¹On this aspect of admissions policies in the United States, see Marcia Graham Synnott, *The Half-Opened Door: Discrimination and Admissions at Harvard, Yale, and Princeton, 1900–1970* (Westport, Conn.: Greenwood Press, 1979); Harold S. Wechsler, *The Qualified Student: A History of Selective College Admission in America* (New York: John Wiley & Sons, 1977); Michael Greenberg and Seymour Zenchelsky, "Private Bias and Public Responsibility: Anti-Semitism at Rutgers in the 1920s and 1930s," *History of Education Quarterly* 33, no. 3 (Fall 1993): 295–319. For Canada in the 1930s, see Paul Axelrod, *Making a Middle Class: Student Life in English Canada during the Thirties* (Montreal and Kingston: McGill-Queen's University Press, 1990), chapter 2. On the admission of women to medicine at Toronto, see W. P. J. Millar and R. D. Gidney, "'Medettes': Thriving or Just Surviving? Women Students in the Faculty of Medicine, University of Toronto, 1910–1951," in *Women and Professional Education in Canada*, ed. A. Prentice et al. (Toronto: University of Toronto Press), forthcoming.

²Two of the most important sources for this study, located at the University of Toronto Archives (hereafter, UTA), are the complete set of applications to enter the Faculty of Medicine from 1910 to 1951 (UTA, Office of Admissions, A69-0008/178–195, Applications to the Faculty of Medicine, 1910–1951), and the academic records of all graduates 1910–29, numbering about 2,600 (UTA, Faculty of Medicine, A86-0026/001–004, 1890–1929, Student Record Cards; these are not complete for the period before 1910, and the last set belongs to the graduates of 1929). To follow students through their course of studies, we have also consulted the name lists of students enrolled in the faculty each year, which were printed annually in the university calendars.

high school, does one allow the uncontrolled growth of enrolments and its consequences by admitting all those who meet the minimum matriculation standards? If not, how are numbers to be limited? One way is simply to raise the minimum requirement for entry, thus making it more difficult to gain access. Another is to move to "selective admissions"—that is, to choose a limited number of "the best" candidates from a larger pool of qualified students. A third is to multiply the hurdles to be jumped, requiring for example not just high school matriculation but some additional certification such as a partial or even a complete undergraduate degree. Pursuing any or all of these options, however, can raise complex political, economic, and ethical issues within the university and beyond its walls.

Admissions policies are rarely an issue if there are fewer candidates applying than can be accommodated, or if there is a rough balance between entrants and the capacities and purposes of the institution. Although that had been the case for nineteenth-century Ontario universities and their medical schools, it ceased to be so by the early twentieth century. Enrolments at the provincial university at Toronto and its medical faculty more than doubled over the first three decades. In 1900, the number of medical students stood at some 400; by 1910, the figure was nearer 500; by the mid-twenties, over 700; and for much of the following decade, it rose to over 800.³ Sheer growth would create stresses within the Faculty of Medicine despite the fact that both physical plant and professoriate were expanded substantially throughout the period. A massive building campaign, for example, resulted in among other things a new medical school building in 1903, additions to Toronto General Hospital in 1913 and again by 1930, a new anatomy building and psychiatric hospital in 1925, the School of Hygiene in 1926, enlarged pathology facilities and other laboratory facilities during the twenties, and capping it all, the Banting Institute at the end of that decade. Concomitantly, the faculty itself increased in size, recruited

³See R. D. Gidney and W. P. J. Millar, "Medical Students at the University of Toronto, 1910–40: A Profile," *Canadian Bulletin of Medical History* 13 (1996): 30–31. Enrolments at Toronto accounted for by far the majority of medical students in Ontario; in Canada, only McGill was comparable in size. For comparative figures, see Robin S. Harris, *A History of Higher Education in Canada, 1663–1960* (Toronto: University of Toronto Press, 1976), 619, 626, 628; see also UTA, Faculty of Medicine Council Minutes, A86-0027/020, 5 Feb. 1932, 306; UTA, Faculty of Medicine, Office of the Dean, Faculty Secretary's files, A86-0028/014, Folder: "Statistics," "Summary of Estimate of Professional Opportunities in Ontario," Feb. 1943. For female enrolments, see Millar and Gidney, "Medettes."

more physician associates for hospital teaching, developed a system of full-time professors and of specialized research laboratories staffed by full-time clinicians, and engaged in fundamental restructuring intended to modernize and improve its organization.⁴ Yet with burgeoning enrolment unchecked, the perception remained that facilities and teachers were inundated by students, a phenomenon identified by the faculty as “overcrowding,” and one they associated with dire consequences for good, or even adequate, medical education.

Each surge of enrolment elicited complaints that excessive numbers were compromising the quality of instruction that the faculty could provide. As early as 1912, for example, the *Toronto News* revealed serious overcrowding in the anatomy classes fundamental to a medical education: “There are 8 students to a table, and only 2 subjects of anatomy [cadavers] are supplied each year, one for the Christmas and one for the springtime. Four men remain at the foot of the table and four at the head. At Christmas both parties change ends. . . .”⁵ Hospital clinics were equally congested.⁶ At the end of the First World War, the prospect of both rising enrolments and inadequate supplies aroused further concern. The professor of anatomy, J. Playfair McMurrich, pointed out that

the supply [of cadavers] should be a minimum of fifty subjects for every hundred students, and our supply has in my experience never been more than a little better than half that. . . . we cannot supply more than say two hundred students with opportunity for acquiring a satisfactory practical knowledge of Anatomy. . . . Just now we have over 350 students in the laboratory and for the next year a prospect of (including Dental students) seven hundred . . .⁷

The clinical departments were also alarmed. One faculty member noted that “facilities are taxed to the limit. . . . There is no immediate prospect of increasing the number of [hospital] beds available, and with increased classes

⁴See A. B. McKillop, *Matters of Mind: The University in Ontario, 1791–1951* (Toronto: University of Toronto Press, 1994), 310, 350–52; these developments can also be followed through the *Annual Reports* of the President of the University of Toronto for the year ending June . . . (hereafter, *President’s Reports*).

⁵*News*, 14 Dec. 1912, in UTA, Office of the Registrar, A73-0051/228, Medicine #1, Sheet 11 (clippings).

⁶*Varsity*, 4 Oct. 1912, 1.

⁷UTA, Office of the President (Falconer Papers), A67-0007/62, “Medicine, Faculty of, Resolution re Limitation of Students,” Appendix to Resolution on Limiting Registration, appendix 11, Anatomy—Professor McMurrich, enclosed in E. Stanley Ryerson to Falconer, 13 April 1920. For lack of space, the dental students were forced to take their anatomy instruction in the dental college for the next few years (a less than satisfactory solution for the students and their future patients); some 500 medical students remained.

the number of patients will not be sufficient to provide the necessary number for each student. . . . the Wards will be crowded with students. Experience shows that under such circumstances good work is not accomplished and teaching is seriously hampered.”⁸ In 1922, the excessive number of clinical students attending two to five hours a day at Toronto General Hospital overburdened its facilities, as they required

attention from nearly all Departments—the Nursing Staff, the Interns, orderlies, porters, the entire Housekeeping Staff, the Laundry, for they use many gowns, the power house, through the additional water and steam which is consumed by their presence, and even from the artisan help, for the necessity of replacements and repairs about an institution of this kind may often be attributed to the presence of students.⁹

Congestion of this sort remained a feature of medical education at Toronto well into the twenties, until the post-war bulge of students began to graduate. And relief was temporary: from 1930 on, a renewed chorus of complaints was heard. “Clinical instruction in internal medicine is given to the three final years of the undergraduate course,” explained one professor in 1932, but

the major and most essential part of the instruction is the bedside clinics and the practical work in the wards of the hospitals. If this part of the instruction is to be effective . . . student groups in bedside clinics must be small—not more than ten, the ideal number being six to eight (the present number is 12–17).¹⁰

The report of the Department of Surgery described a similar predicament:

With the present large number of students in the clinical years, the provision of adequate training is almost impossible on account of over-taxing the endurance of the patients by repeated examinations by individual students, as well as by repeated clinics in groups on the same patient. . . . it is impossible to provide the students with sufficient variety of clinical material, and the result is failure to give them a broad experience. The wards of the hospitals are at times so congested with students that the routine nursing is interfered with and the quietness of the patients disturbed. The size of the student groups in the operating room sometimes interferes with or threatens strict asepsis. The present size of the classes prevents any close personal contact between student and teacher which is so valuable as a method of instruction.¹¹

And Professor W. E. Gallie reported to the Dean in 1936 that

⁸Ibid., appendix I, Surgery—Professor Primrose.

⁹UTA, Falconer Papers, A67-0007/77, Flavelle to Falconer, 16 Dec. 1922.

¹⁰UTA, Faculty of Medicine Council Minutes, A86-0027/020, 5 Feb. 1932, 299.

¹¹Ibid., 300.

each year I bring to your attention the calamitous effect of the constantly increasing numbers of our students on the quality of our teaching. . . . it is becoming increasingly difficult, owing to the numbers, to teach them the bare essentials that are necessary for general practice. Beside interfering with the quality of our clinical teaching, the number of students is creating a nuisance in the hospitals. . . . We simply must find a way to limit the number of students coming into the clinical years.¹²

One must always exercise caution in evaluating the complaints of professors about overcrowded classrooms or inadequate laboratory or hospital facilities. But it is also important to try to understand why the complaints arise in the first place. And in the case of Toronto's medical faculty early in the twentieth century, the problem has to be understood not just in terms of the numbers themselves, but in the notions that professors of medicine held of an ideal pedagogy.

By 1910, and even more so by 1920 or 1925, Toronto was firmly committed to the new model of medical education emergent in North America from at least the 1890s onward. That model incorporated several innovations, prominent among which was a shift from "didactic" lectures to hands-on laboratory work in the pre-clinical years, accompanied by a substantial increase in the amount of instruction in the basic and medical sciences during the first years of the course; and a shift to small-group instruction, and to hands-on bedside experience, in the clinical years. It was a medical pedagogy that was incomparably more labour-intensive (and, one might add, more expensive) than any in the nineteenth century.¹³

Although a variety of measures were used to establish the ideal size of the student body, a critical one was the number of hospital patients available for observation and clinical instruction. Accordingly, this criterion was selected in 1920 when large post-war enrolments provided an incentive for the faculty to

¹²*President's Report*, 1936, Report of the Dean of Medicine, 29-30.

¹³See Falconer's comments in his brief of 1915 to the Hodgins Commission on Medical Education, 1915-17, typescript evidence, 23 Oct. 1915, 140-41, 143. On these developments generally, see Kenneth M. Ludmerer, *Learning to Heal: The Development of American Medical Education* (New York: Basic Books, 1985), 63-113, 140-51; Robert P. Hudson, "Abraham Flexner in Historical Perspective," in *Beyond Flexner: Medical Education in the Twentieth Century*, ed. Barbara Barzansky and Norman Gevitz (New York: Greenwood Press, 1992), 1-34; R. D. Gidney and W. P. J. Millar, "The Reorientation of Medical Education in Late Nineteenth-Century Ontario: The Proprietary Medical Schools and the Founding of the Faculty of Medicine at the University of Toronto," *Journal of the History of Medicine* 49, no. 1 (Jan. 1994): 63-68, 75-78.

present a plan for limiting registration. Since the number of public ward beds available for teaching purposes in the four teaching hospitals in Toronto was expected to be inadequate, and indeed to decrease as the ratio of public to semi-private patients shrank, the faculty recommended that, for the first time at Toronto, entry numbers should be limited:

[T]he number of available patients in the public wards and dispensaries of those hospitals which afford teaching facilities in the City of Toronto is inadequate to provide material for the instruction of more than 270 students, or thereabouts, viz. an average of 90 students in each year of clinical instruction . . .¹⁴

No more than 120 were to be allowed to enter first-year studies; through normal attrition, the ideal size would then be reached in three years.¹⁵

A decade later, first-year enrolments began to rise dramatically again, renewing fears of overcrowding and debased standards. Calculating that facilities and staff could now provide for 100 to 110 students in each of the three clinical years, the faculty postulated 80 as the ideal size for preliminary medical studies. Allowing for senior arts students transferring into fourth-year medicine, and for medical students coming to Toronto from other universities to complete their training, the result would be, they estimated, a total in years four to six of the programme of about 300 students, or perhaps, at the most, up to 330.¹⁶

But during the interwar period, entrants to first-year medicine almost always numbered more than the ideal of 80 to 100, and in some years the actual figure was much higher. During the early 1920s there were some 500 students in the clinical years alone. After the immediate post-war bulge had graduated, numbers declined, though they were always a little above the goal of the Toronto medical professors. From 1930 on, enrolments again rose well above it, thus creating, according to the faculty, unacceptable conditions for a medical education comparable to the best offered elsewhere.

What was the source of the problem? Why were there so many students entering first-year medicine? And why were total enrolments so much higher than the medical faculty might have wished? One reason lay in the entry requirements themselves. Throughout the entire period, as indeed before that,

¹⁴UTA, Faculty of Medicine Council Minutes, A86-0027/18, 9 Apr. 1920, 249.

¹⁵Ibid., 250.

¹⁶Ibid., A86-0027/020, 5 Feb. 1932, 298–308.

the sole criterion for entry to the University of Toronto, including its medical school, was the possession of an Ontario high school matriculation certificate.¹⁷ That is, passing the Ontario Department of Education examinations at the end of the high school course qualified students for university studies, and indeed for automatic access to the provincial university.¹⁸ Entrants to medical school, as to all other faculties, could come directly from high school after attaining matriculation, and the great majority of them did so. The sieve through which potential candidates had to pass was thus the high school, which had acted as chief gatekeeper to the university since the later nineteenth century.

In some respects the high school continued to act as an effective sieve throughout the first half of the twentieth century. It was a highly selective institution at every grade level. In 1900 only a minority of elementary school pupils passed its entrance examination (fewer still went on to enrol in Grade 9). Although that began to change in the first four decades of the century, most high school students left school before ever reaching the third or fourth year of the course. Only about a third of those entering in the 1920s, for example, survived to fourth year.¹⁹ During that decade, only about 8 percent of all high school students were in Grade 13.²⁰ And for those who made it that far and wrote matriculation examinations, the failure rates, by any modern standard, were high. In a compulsory subject for senior matriculation like algebra, failure rates in the 1920s and 1930s were typically 25 to 30 percent.²¹ Thus a dramatic thinning of the ranks took place even before applicants to the university presented themselves.

At the same time, however, an increasing number of students were attending high school and staying to complete junior or senior matriculation. The causes may be found both in the policies of the Education Department,

¹⁷Or its equivalent—but the majority of entrants had the Ontario matriculation certificate.

¹⁸For a more detailed explanation, see Gidney and Millar, "Medical Students," 31–33.

¹⁹Robert M. Stamp, *Ontario Secondary School Program Innovations and Student Retention Rates: 1920s–1970s; A Report to the Ontario Study of the Relevance of Education and the Issue of Dropouts* (Toronto: Queen's Printer, 1988), 30. For a discussion of enrolment patterns in Hamilton high schools in this period, see Craig Heron, "The High School and the Household Economy in Working-Class Hamilton, 1890–1940," *Historical Studies in Education* 7, no. 2 (Fall 1995): 217–59 and esp. table 4, 253.

²⁰Calculated from Ontario, Minister of Education, *Annual Report* (hereafter, *Annual Report*), 1925, table N, 196. Ontario is the only jurisdiction in North America with a five-year high school course; for most of this century, junior matriculation, or Grade 12, has taken four years, and senior matriculation, or Grade 13, five years.

²¹See for example table 5, 71, in Ontario, Sessional Papers 1926, 16th Legislature, 3rd Session, Vol. 58, Part 3; *ibid.*, 1932, 341; 1938, 220.

and in forces beyond the school system. In 1921, for example, the Department deliberately made senior matriculation more accessible by collapsing the last two years of high school into one, and by allowing students to write their examinations over more than one year.²² The purpose of these changes was to encourage high school students to remain beyond the junior matriculation level and in particular to acquire the credentials necessary for teacher training, as well as to reduce strain and cramming at the Upper School level.²³ They had the inadvertent effect, however, of immensely increasing the number of high school matriculants qualified to enter Ontario universities.²⁴

But there were also incentives to stay in school longer, such as the growth of various forms of work that required more schooling, and the raising of educational requirements for entry to many professions, as well as a host of other factors, right down to better roads, which made secondary schooling more accessible generally in the province. Thus while the high school remained highly selective academically, with stiff examinations and high failure rates, the absolute numbers surviving its rigours increased every decade after 1890. And the result was that more and more students were qualifying to enter Ontario's universities—including its medical schools.

Moreover, the rules governing the matriculation standard itself invited this result. The requirement for a certificate was straightforward: pass the necessary number of examinations, with the necessary marks, and a certificate was forthcoming. Nothing less—and nothing more. The matriculation *process*, however, was highly variable. Students who obtained a certificate might have high marks; on the other hand, they might have a bare pass that, with averaged marks, could incorporate failures in such subjects as science. They might have obtained it in one year, or over two, or even three or four. They might have failed a quarter or a half of their papers the first time they wrote, and only

²²For a decade or so, Ontario had a six-year high school programme, until the two years of Upper School, which led to senior matriculation, thus became Grade 13. For a brief explanation of the length of the Ontario high school course, see Robin S. Harris, *Quiet Evolution: A Study of the Educational System of Ontario* (Toronto: University of Toronto Press, 1967), 49–50.

²³See *Annual Report*, 1921, appendix D, Report of the Inspectors of High Schools, 40–42, in Ontario, Sessional Papers 1922, 15th Legislature, 3rd Session, Vol. 54, Part 4; and *ibid.*, 1922, appendix D, Report of the Inspectors of High Schools, 34–37, in Ontario, Sessional Papers 1923, 15th Legislature, 4th Session, Vol. 55, Part 4.

²⁴The faculty was well aware of this effect: see for example UTA, Faculty of Medicine Council Minutes, A86-0027/020, 5 Feb. 1932, 301. Burgeoning numbers of high school graduates in the United States in the first decades of the twentieth century produced a similar phenomenon for colleges (but not directly for medical schools, because they required two pre-medical years at college): see Wechsler, *Qualified Student*, 238.

succeeded on repeat attempts. They might have dropped difficult subjects and substituted ones they found easier.²⁵ In other words, the high school matriculation certificate was highly selective, but not selective enough. An effective means of discrimination in the last quarter of the nineteenth century, generating a rough balance between students and instructional capacity, it was ceasing to fill this role by 1910, and the problem grew progressively worse in the 1920s and 1930s.²⁶ In the Faculty of Medicine, the consequences were clear: overcrowding “might not be so serious if our students were of such quality that medical science and the community would likely suffer were some of them not afforded a medical education,” went one devastating comment, but “our best students are excellent; our poorest students are numerous and extremely poor.”²⁷

Yet the problem could not be blamed entirely on the high school. Part of the paradox of ever-increasing numbers lay in the university’s response to it. Why, for example, did the Faculty of Medicine not raise its entry standards much earlier, and more rigorously, than it did? “Partial” senior matriculation, consisting of three subjects only, was introduced as a requirement in 1922; not until 1928 was full senior matriculation required. Why did the faculty wait until 1933—several years after entry enrolments had taken a sharp jump upward—to demand, at last, that a candidate have taken basic science at senior high school level? And why did it not, like some American universities (and McGill) in the 1920s, not only select on the basis of marks, but require an aptitude test and/or a portfolio of personal characteristics that might help identify the potential “good” doctor—that is, why did it not move to *selection* from the pool of minimally qualified applicants?

²⁵The matriculation marks on the application forms provide a detailed record. For comments on the process and its results, see UTA, Office of the President (Cody Papers), A68-0006/038 (02), Undated file [1938–39], Department of Educational Research, Ontario College of Education, “Relation between Matriculation Marks and the Records of Students in the University of Toronto”; W. G. Fleming, *Ontario’s Educative Society*, Vol. 5, *Supporting Institutions and Services* (Toronto: University of Toronto Press, 1971), 294–95; Willson Woodside, *The University Question: Who Should Go? Who Should Pay?* (Toronto: Ryerson Press, 1958), 60–61, 73.

²⁶Unlike Toronto, many American colleges and universities chose at an early date to move to selective admissions; see Wechsler, *Qualified Student*, chapters 6–8. For figures demonstrating the rising number of high school matriculants in Ontario (from 1,446 writing senior matriculation in 1921, to 20,232 in 1939) see the relevant *Annual Reports* of the Department of Education, Ontario; and figures in UTA, Faculty of Medicine Council Minutes, A86-0027/020, 5 Feb. 1932, 306.

²⁷*President’s Report*, 1936, Report of the Dean of the Faculty of Medicine, 30.

In fact, throughout most of our period, from 1910 right through to the Second World War, each of these alternatives was canvassed, and some not just once but many times. There was clear support for some such action within the institution. The university leadership, above all President Falconer himself, was sympathetic. Before the First World War, and as one of his first presidential initiatives, Falconer had mounted a full-scale campaign to move the entire university to require senior matriculation. The argument he made for medicine was that Toronto was falling behind the standard set by the leading American medical schools in not requiring six years of training.²⁸ Indeed, despite Abraham Flexner's fulsome review of Toronto's medical faculty, that discrepancy was precisely why he categorized Toronto as a second-class medical school compared with the best in North America.²⁹ It was an indictment that stung the medical professors, and posed a threat to their ambitions to emulate the leading lights in medical education south of the border.

There were also direct outside pressures. The faculty's proposal of 1920 for limiting registration was sparked by the prospect of laying hands on a substantial part of the largest sum of money ever dangled before it up to that point: \$5 million for Canadian medical education from the Rockefeller Foundation. Immediately upon receipt of this offer, a committee was struck to prepare a report on the faculty's needs.³⁰ Its recommendations, made in March "in view of a possible grant" from the Foundation³¹ and adopted at Faculty Council in April,³² were intended to persuade the Rockefeller Foundation of Toronto's worthiness by setting out a long-term plan for excellence. In addition to providing for the appointment of full-time staff, adequate salaries for faculty members, and enlarged research laboratories, it stressed that student numbers must be limited. The issue of enrolment cut-off played a small but

²⁸See James G. Greenlee, *Sir Robert Falconer: A Biography* (Toronto: University of Toronto Press, 1988), 168–73. At that point, Toronto had a five-year medical course after junior matriculation. The leading American schools had a four-year course of medicine after four years of high school and two years of college studies.

²⁹See Gidney and Millar, "The Reorientation of Medical Education," 72. He made this assessment despite classifying Toronto among the best North American medical schools: compare McKillop, *Matters of Mind*, 351.

³⁰For a description of the Rockefeller Committee, including its personnel and work, see UTA, Faculty of Medicine, Office of the Dean, A79-0023, Series 2, 1922–23, Box 3, "Dean Primrose."

³¹*Ibid.*, Box 1 (4), 1 Mar. 1920; the report was submitted to the commissioners of the Rockefeller Foundation on their inspection visit: *University of Toronto Monthly* 20, no. 7 (Apr. 1920): 252–53.

³²UTA, Faculty of Medicine Council Minutes, A86-0027/018, 9 Apr. 1920, 249.

vital role in the long negotiations that followed,³³ and the official grant of \$1 million to Toronto medical school was conditional on, among other things, the “limitation of students to a number which can be adequately educated in the buildings and with the faculty and facilities available.”³⁴ It is clear that Toronto’s medical professors were convinced that manageable numbers of students were essential to a high quality of education; they were also in the happy position of being rewarded with a large sum of money for making that case.

In short, then, there was considerable reason for the medical faculty to want to limit registration, and it made repeated attempts to do so by one means or another. Before World War I, the pass mark on the junior matriculation examinations necessary for entry was raised successively until in 1912 it stood at 40 percent on each paper, with an overall average of 60 percent.³⁵ In the medical curriculum itself, examination marking schemes were periodically reviewed and upgraded.³⁶ There were fee hikes, and age restrictions eliminating those who were thirty or more, or under seventeen.³⁷ Out-of-province candidates to first year were excluded.³⁸ Regulations about the number of subject failures and supplementary examinations permitted in each year were stiffened up, and the medical course itself was lengthened from four to five and then to six years, with a seventh year of internship coming to be accepted, if not compulsory.³⁹ Most of these measures were instituted for purposes other

³³For detailed evidence on the terms, course of negotiations, and eventual outcome of the Rockefeller Foundation offer, see UTA, Falconer Papers, A67-0007/062, “Medicine, Faculty of. Resolution Regarding the Limitation of Students,” and “Rockefeller Foundation.” Falconer was pressed several times by the commissioners over the summer and fall of 1920 as to whether student numbers would be limited.

³⁴UTA, Falconer Papers, A67-0007/62, “Rockefeller Foundation,” Embree to Falconer, 19 Nov. 1920.

³⁵*Calendar*, University of Toronto, 1910/11, 46–47; *University of Toronto Monthly* 14 [sic: 13], no. 5 (Mar. 1913): 213.

³⁶See for example UTA, Faculty of Medicine Council Minutes, A86-0027/020, 6 Feb. 1931, 116–20; *ibid.*, Annual Report of the Faculty Council, 2 Oct. 1931, 221.

³⁷On fees, see *ibid.*, A86-0027/019, 4 Dec. 1925, 57–66; UTA, Cody Papers, A68-0006/019, “Fees,” Fitzgerald to Cody, 4 Apr. 1935; A83-0036/001, Papers of the University Historian, File: “MS. R. S. Harris, 1983, Ch. 5: The Depression,” unpaginated; on age restrictions, see *Calendar*, University of Toronto, 1922/23, 77.

³⁸On the grounds that the University of Toronto was a “State Institution” owing preferential status to provincial residents. *University of Toronto Monthly* 21, no. 2 (Nov. 1920): 56.

³⁹For regulations, see for example UTA, Faculty of Medicine Council Minutes, A86-0027/019, 5 Feb. 1926, 73–74; *ibid.*, A86-0027/020, 5 Oct. 1928, 37, and 4 Oct. 1929, 182. On the lengthened course, see Gidney and Millar, “Medical Students,” 41–42.

than limiting enrolments, but at the same time they also made the course more difficult to enter, and to complete.

The imposition of a numerical quota was consistently rejected in favour of such methods. There was one feeble, and temporary, attempt during the 1921/22 session: the University agreed to allow only 125 students into first-year medicine, but in the end admitted 140 because "it was found impossible . . . to adhere strictly to the number authorized without inflicting hardship upon a number of applicants who had fulfilled all the conditions and had applied for registration."⁴⁰ In the following year, the faculty reverted to the strategy of stiffening academic requirements for entry by requiring a pass in three subjects at the senior matriculation level, a feat usually entailing another year of high school work and traditionally performed by a very much smaller number of students than those acquiring junior matriculation. As the Secretary of the faculty put it, "raising . . . the standard of entrance to Honour [Senior] Matriculation . . . will reduce the number. . . ."⁴¹ The enrolment of only 92 first-year students that autumn appeared to justify such optimism. As in the past, boosting matriculation standards seemed to be a painless way of ensuring a supply of meritorious applicants while keeping their numbers within manageable bounds.⁴² Indeed, though complaints of overcrowding continued well into the decade, they were occasioned mainly by the post-war bulge of 1919–21 as it worked its way through the programme.

At the same time, however, the faculty deliberately set out to make the first year, including the final examinations, as difficult as possible:

[T]he instruction of the first year is heavy, and . . . the examination standards are high. The object of this is that the student at the very beginning of his six years of instruction in Medicine may come to realize that to be successful, not only as a student but in his profession, he must work hard and consistently. It is felt that in this way the Medical Faculty can best sort out those students who can most profitably proceed with the Medical course. It eliminates the weak student in this first year instead of carrying him

⁴⁰*President's Report, 1922*, Report of the Dean of the Faculty of Medicine, 13.

⁴¹UTA, Faculty of Medicine, Office of the Dean, A79-0023, Series 2, 1922–23, Box 7, "Vancouver Medical Association," Ryerson to L. Macmillan, 28 June 1922. He went on to state that "if it does not do so, academic standing will be the basis on which the limiting will be made."

⁴²The same expedient had resulted in a similar drop in enrolment several times in the history of medical schools at Toronto and elsewhere: see for example *President's Report, 1911*, 6; *University of Toronto Monthly* 14 [sic: 13], 5 (Mar. 1913): 213; UTA, Falconer Papers, A67-0007/042, Falconer to Hodgins, 15 Feb. 1916.

into later years when the hardship of dropping the student is often so evident that undesirable leniency is apt to be shown.⁴³

Or as J. J. R. MacLeod put it, “We endeavour in the Faculty to wield the pruning shears with great vigour in the first and second years. Our first year’s Curriculum is deliberately made a heavy one, with high examination standards. . . . so that we may weed out those students who are obviously unfitted for a career in medicine.”⁴⁴

This stringency was justified on the grounds of academic standards—the necessary sorting out of those not able to handle the demands of medical training. No doubt the faculty believed it was a sensible and humane way of avoiding individual disappointment and waste, while ensuring the maintenance of adequate standards. But it was also a policy that conveniently could be used to adjust the annual intake to more manageable proportions. The first-year failure rates tend to bear an uncanny correspondence to the size of the annual entry—and therefore to the potential size of the clinical classes. In other words, they rose or dipped according to the number of entrants (see Figure 1). A small entry class meant a low failure rate; a large one, a high failure rate. As a notation on the minutes of the committee on examinations put it, “limitation should be done by first year teachers in their marking.”⁴⁵ In lieu of control by limiting entry numbers, in other words, the faculty was attempting to use selection in the first year.

That attempt, however, was only modestly successful, and for a very practical reason. Before 1938, the only regulation about students repeating years was that they could not repeat a year more than once.⁴⁶ As a

⁴³UTA, Faculty of Medicine, A79-0023, Box 001 (1), Minutes of Rockefeller Committee, “General Statement of the Plan of Instruction of the New (6 Years) Course in Medicine of the University of Toronto,” 7. A strategy not limited to medicine: students in first-year arts at Toronto suffered high failure rates throughout the 1920s, which was one reason why Falconer, among others, wanted to require senior matriculation for arts, so that entrants would be better prepared for university work. See *President’s Report*, 1924, 7; UTA, Falconer Papers, A67-0007/090, “Taylor, C. B.,” Falconer to Taylor, 17 Dec. 1924. A similar problem in the United States at the same time is noted by Wechsler, *Qualified Student*, 244–45.

⁴⁴UTA, Faculty of Medicine, Office of the Dean, A79-0023, Series 13, Box 67 (4), Meeting of the Special Committee of the Ontario Medical Council on Curriculum and Matriculation with the Committee of Faculty of the Medical School of the University of Toronto, Nov. 1923, typescript, 20–21.

⁴⁵UTA, Faculty of Medicine, Office of the Dean, A86-0027/008, Committee on Curriculum and Examinations, 1922–32, 1 Feb. 1927, 187.

⁴⁶UTA, Faculty of Medicine Council Minutes, A86-0027/020, 5 Oct. 1928, 37. A regulation that could be circumvented: see *ibid.*, 4 Oct. 1929, 182.

consequence, something like 70 percent of all first-year failures re-applied for admission the following year. In 1932, the “highest figure in a decade” was reported in first year—167 students—with 19 of them being repeaters. This “serious overloading of a large class with such a high percentage of students having already manifested unsuitability for the medical course has evoked grave concern among the faculty,” reported the Dean in 1933, because it wasted the time and money of parents, students, and the state.⁴⁷ The faculty bent to their work. In the mid-1930s, when the numbers crunch was at its worst, they were failing 30 or 40 percent of first-year students. Even this outright massacre failed to do the job; as a frustrated Dean reported,

We were annoyed to find . . . that . . . most of those who had been ploughed returned to re-registration in the first year in spite of strong advice to the contrary and as there was no way of preventing this re-registration, the first year was larger than ever. As might be expected, these repeaters nearly all scraped through in the following spring examination, for only mental defectives could fail to pass this examination after two whole years of preparation for it.⁴⁸

First-year repeaters, moreover, were only the tip of a more general problem. Overall, 27 percent of all graduates in our sample—of all those who actually made it to the end of medical school—repeated at least one year.⁴⁹ A few were multiple repeaters, failing two, three, or, in a handful of cases, even four years and repeating each.⁵⁰ And this figure substantially underestimates the extent of the problem because it does not include those who repeated a year or two and then dropped out. Anywhere from a third to a half of all students who entered first year during the period failed to graduate, and many of these “wasted from one to seven years before finally withdrawing.”⁵¹ There was, then, a twofold and cumulative problem: too many students were entering

⁴⁷*President's Report*, 1933, Report of the Dean of the Faculty of Medicine, 18.

⁴⁸*President's Report*, 1938, Report of the Dean of the Faculty of Medicine, 32. A regulation was approved the following year forbidding first-year failures to repeat the year: UTA, Office of the Registrar, A65-0013/097, [Senate] Board of Medical Studies 1937–42, Acting Bursar to Registrar, 11 Mar. 1938; however, the name lists for first year, 1938/39 session, contain the names of several repeaters.

⁴⁹Calculated from four sample entry cohorts, for 1922/23, 1925/26, 1930/31, and 1932/33.

⁵⁰UTA, Faculty of Medicine Council Minutes, A86-0027/021, 15 Sept. 1933, 244; UTA, Faculty of Medicine, Faculty Secretary's Files, A86-0028/012, Memo, “Statistics re Repeaters 1st Year,” 3 Feb. 1938.

⁵¹Mary D. Salter, “A Method of Selection of Medical Students Based on Previous Academic Grades and Medical Aptitude Scores,” *Journal of the Association of American Medical Colleges* (Sept. 1942): 5.

first-year medicine every year, and too many students were failing and then repeating various years. They entered, failed, re-applied, and stayed in school, clogging classrooms and laboratories, clinics and operating rooms.

But if numbers continued to rise, why not change the nature of the entry standard? Why not move directly to selective admissions? That solution was not overlooked. In 1920 the medical faculty's first such proposal suggested that the criteria for selection should be "scholastic attainments, physical fitness, age, credentials from previous teachers, moral character, and, other things being equal, residence in the Province of Ontario."

Not surprisingly, in view of the close watch that educators kept on their colleagues, this plan resembled the kind of selective admissions policy then being implemented elsewhere. Toronto's version, however, was not an exact replica of that employed by Columbia College or its medical school, or introduced by other institutions. It lacked some of their criteria: at Columbia, an applicant's "leadership" at school and in the community, an essay on future plans and aspirations, a personal photograph and possibly an interview, and a psychological and/or aptitude test.⁵² Toronto's proposal was much more conservative; the requirements of "credentials from previous teachers" and "moral character" were not too far removed from the traditional certification by a high school principal of each application to medical school.

When the introduction in 1922 of a raised matriculation standard seemed to produce the desired results, the issue lay in abeyance for most of that decade.⁵³ But in the early thirties, as we have seen, it was renewed, though now in a different form. Instead of choosing among applicants for entry into medicine, the faculty proposed to institute selection at the second-year level on the basis of the final examinations of first year, which would now be termed "pre-medical" or "preliminary," on the grounds that

a suitable selection of students entering the second year can only be made after at least one year of University training. The selection would be based on the student's academic standing at the end of the first year *and on information gained in respect to (a) personality, aptitude and character (b) health and physical condition. The student's place of residence (in the order Ontario, Toronto, other provinces of Canada) might also be considered. . . .* This preliminary year might be passed in either of the Faculties of Medicine

⁵²See Wechsler, *Qualified Student*, 156–59, 169–73, 221–22.

⁵³Although questions about aptitude and fitness continued to be raised: see for example UTA, Faculty of Medicine, Office of the Dean, A86-0027/008, Committee on Curriculum and Examinations, 1922–32, 4 Feb. 1926, 150–51.

or of Arts. The Faculty of Medicine is in favour of the latter Faculty because it believes that the subsequent career of those students not taken into Medicine could be more easily arranged.⁵⁴

There were sound academic justifications for moving selection to the second year, said the Dean: "Experience has shown that the standing and marks obtained by students at matriculation do not form a satisfactory standard for the selection of medical students. A student may stand high at matriculation and fail hopelessly in his medical studies or vice versa." On the other hand, a very good correlation could be obtained between the first year's final marks and academic standing in later years.⁵⁵ It is also telling that the selection criteria which the faculty first proposed in 1932 and which they continued to urge throughout the decade had changed from those of 1920. Instead of academic work alone, they now included the factors of "personality, aptitude and character," much like those employed south of the border.

Nevertheless, there was to be no limitation on numbers at Toronto, and no selection mechanism beyond matriculation itself. The reason, we would suggest, has more to do with the politics of the provincial university than with academic rigour or the ambitions of medical professors. Obviously the First World War had a long-lasting effect in the period we are studying. Not only did the medical school take in a large number of students during the war itself, but it had to provide places for a huge number of veterans, as well as a larger-than-normal intake from the schools, in the immediate post-war years. This extraordinary enrolment began in 1919 and 1920, and thus did not graduate until 1925 or 1926 at the earliest. The wartime bulge, in other words, lasted for almost a decade and no public university could do anything else but accommodate it.

There were also pressures within the university to prevent any substantial reduction of entrants to medical school. Medical education was relatively

⁵⁴UTA, Faculty of Medicine Council Minutes, A86-0027/021, 7 Apr. 1933, 146 (italics added). This was a revised version of the plan first proposed in 1932 and rejected by the University: see *ibid.*, A86-0027/020, 5 Feb. 1932, 298-308.

⁵⁵*President's Report*, 1932, Report of the Dean of the Faculty of Medicine, 16. This statement was based on "a careful study" made by Professor E. A. Bott, head of the Department of Psychology and a leading figure in applied psychology and, in the Second World War, in the development of psychological tests for service personnel. See UTA, Faculty of Medicine Council Minutes, A86-0027/020, 5 Feb. 1932, 303; see also McKillop, *Matters of Mind*, 492-93 and 669 nn. 27, 29. Similar conclusions about the relationship between grades on college entrance examinations and future academic success had been drawn by E. L. Thorndike and C. C. Brigham in the United States; see Wechsler, *Qualified Student*, 246-47.

expensive compared to other faculties, and from the 1890s on, with increasing emphasis on laboratory work and small-group instruction, it was becoming more expensive still. As President Falconer put it on one occasion, “medical education today requires great outlay, both for the preliminary scientific education in the laboratories and for the clinical education in the hospitals. . . . Any modern medical school—and they are nearly all connected with great universities today—must be very expensive, and the reason for this is because the amount of instruction, preliminary and professional, that is required for the adequate training of a medical practitioner is so lengthy and so scientific that a long course, including instruction in the best-equipped laboratories at the hands of the most scientific men, is . . . necessary. . . .”⁵⁶ Given that fact, administrators were not keen to cut the numbers paying their fees to the Faculty of Medicine. In the 1930s the university’s precarious financial situation worsened when many students, especially in medical studies, fell behind on tuition payments.⁵⁷ To limit the number of fee-paying students at that point would have brought even greater financial pressures to bear on the institution. Indeed, this consideration probably accounts at least partially for the negative reaction of President Cody and the university leadership to the faculty’s proposal to transfer the first year of medicine, the “preliminary” year spent studying basic science, to the Faculty of Arts. Would such a transfer be acceptable, Dean Fitzgerald cautiously enquired, “if it should result in a diminution in the income from fees paid by students entering the medical course, or what in the future might be a premedical and medical course?”⁵⁸ Cody pointed out in response that “there were both financial and academic considerations entering into the problem,” and it was decided that “the transfer of the first year in Medicine to the Faculty of Arts was not a feasible proposition at the present time in this University.”⁵⁹

Above all, there was the ideal of the provincial university itself. Paid for from public funds, conceived of, for decades, as the crown of a public system of education that led from the most modest one-room rural elementary school to the doors of the university, the University of Toronto was accorded a special place in Ontario’s education system and was expected, in return, to admit any

⁵⁶Typescript evidence, Commission on Medical Education, 1915–1917, 23 October 1915, 140–41, 143.

⁵⁷UTA, Cody Papers, A68-0006/9, “Fennell, Arthur Bertram,” 1933–34, Fennell to Cody, 26 Jan. 1934; *ibid.*, 19, “Fees,” Fitzgerald to Cody, 4 Apr. 1935; UTA, Faculty of Medicine Council Minutes, A86-0027/021, 2 Feb. 1934.

⁵⁸UTA, Cody Papers, A68-0006/15, “Fitzgerald, J. G.,” Fitzgerald to Cody, 10 Jan. 1935.

⁵⁹UTA, Faculty of Medicine Council Minutes, A86-0027/021, 1 Feb. 1935, 150.

qualified citizen of Ontario who applied.⁶⁰ Every attempt to raise admission standards was seen, by many at least, as an attempt to cut off access and to limit equality of educational opportunity. A check on enrolments might be of critical importance, the dean of medicine remarked in 1920, but he wondered nonetheless how it could be done in “a Provincial University offering State education.”⁶¹ Writing to the Principal of Queen’s in 1924, Falconer noted that “as far as Ontario is concerned, I think that you will agree with me that political exigencies will not allow [entrance standards] to go higher at present.”⁶² “Political exigencies,” indeed, dictated a good part of university policy on this as on other matters. Falconer and the medical faculty suffered public scrutiny and condemnation in 1923 over the reorganization of the faculty and other matters including the conditions of the Rockefeller grant; the limitation of student numbers was mentioned by their opponents with appropriate relish and outrage.⁶³ Throughout the period, the university was always in straitened financial circumstances and had to depend on the good-will of politicians, and curry their favour. It was widely recognized, and repeatedly pointed out, sometimes in very forceful language, that Ontario’s universities were highly regional, that the University of Toronto drew disproportionately from Toronto and York County, and thus that it did not serve all Ontarians equally. “It is apparent,” declared a representative of the United Farmers in 1921,

that the situation of the State University excludes a large proportion of the people who are outside [Toronto] from its benefits. . . . there has been an obvious disregard to the real interest of the whole people in the devotion of the public moneys to . . . professional schools, such as medicine, dentistry, and the like. . . . in the University of Toronto culture education has been overcome and overborne by professional training at the public expense and immensely for the benefit of the City of Toronto.⁶⁴

⁶⁰Similar issues surrounded the question of admissions to state-funded universities in the United States; see Wechsler, *Qualified Student*, chapter 10. The Toronto Faculty of Medicine was in a different position from American medical schools, however, because it accepted high school graduates, whereas the latter could select from students already in a college course.

⁶¹*President's Report*, 1920, Report of the Dean of the Faculty of Medicine, 14.

⁶²UTA, Falconer Papers, A67-0007/090, Falconer to C. B. Taylor, 17 Dec. 1924.

⁶³See Greenlee, *Falconer*, 264–72; UTA, Special Committee . . . University of Toronto Finances, 1922–23, typescript, vol. 3, 401.

⁶⁴*Report of Royal Commission on University Finances* (Toronto, 1921), appendix 11, Statement of United Farmers’ Representative, 157–58, in Ontario, Sessional Papers, 1921, Part 8, #65.

Queen's and Western gleefully joined in that argument, as did some influential politicians, including Howard Ferguson. Thus it suited the university to move cautiously, and sometimes not to move at all, in the face of such antipathies.

As well, leading politicians (some of whom in the period combined the offices of premier and minister of education) *and* the Department of Education had another potent reason for objection to any limitation of access. During the first three decades of the twentieth century, small high schools—known as continuation schools—multiplied rapidly in the rural countryside and the smaller towns. By the 1920s, they outnumbered high schools and collegiate institutes. The curriculum which they offered, however, covered up to junior matriculation only. To raise standards above that was to exclude their students, or to force the young people of rural Ontario to incur extra costs of education by transferring to a high school in town. Moreover, many small high schools, even when they offered senior matriculation, lacked the facilities to teach Grade 13 science—which may have been why it was not required for entry into medicine until very late in the period.

Apart from that, the university set the standard for entry into its programmes at the level of senior high school work, and then allowed in every successful matriculant who applied. And in return, it was expected to honour its own matriculation requirements. As one Dean of Medicine conceded in the late 1930s, “we have a definite matriculation standard which gives any Ontario student who has it, no matter how long he took to obtain it, the right to register.”⁶⁵ When students met that standard, they were, in effect, guaranteed access to the programme of their choice.⁶⁶ Indeed, they were given not just the right of access to first year, but the right to fail and to repeat years with impunity. The bargain may even have extended to the question of whether the university had a legal right to limit numbers. At one point in the late 1920s, not only the medical faculty but others were exercised about excessive numbers of repeaters clogging up the programme; but many hours of discussion and recourse to legal advice brought no relief from the rule that students who failed a year could not be forbidden to repeat it. When in 1932 the medical faculty first seriously pressed for selective admissions, the Senate was

⁶⁵*President's Report*, 1938, Report of the Dean of the Faculty of Medicine, 32.

⁶⁶This policy was plainly set out on more than one occasion: see for example UTA, Office of the Registrar, A73-0051/021, “British Columbia,” Telegraph from Registrar, UBC, to Fennell, 23 Feb. 1931 (the University of Toronto Registrar's reply: “No fixed limit to registration [in medicine] has been determined.”); UTA, Faculty of Medicine, Office of the Dean, A86-0027/37 (1936-39), Committee on Applications and Memorials, Faculty of Medicine Council to Fennell, May 1937, p. 86: “the enrolment of students in the Faculty of Medicine is not limited in number . . .”

uncertain about whether the university could move in that direction and again sought legal advice.⁶⁷

Given that moral and political bargain, the university had only the most limited options. The medical school could, and did, raise its matriculation standard over the period. But it had to proceed cautiously, move only when the numbers crunch was most severe, and even then, compromise or ultimately back off in the face of pressure from the University governors or outside authorities. Limitation of numbers on the basis of high school examination marks was the best that could be achieved.

Beyond that, selective admissions—that is, drawing selectively from a pool of qualified candidates, all of whom met the minimum entrance requirements—was never implemented at Toronto before World War II. It was not that examples of such procedures were lacking. McGill was quite openly limiting the number of entrants to medicine by the mid-1920s, on the basis of previous academic record, a photograph or, preferably, personal interview, and a handwritten letter of application (to test for “qualities of heart and head and breeding,” according to its Dean).⁶⁸ The American model of selective admissions—a combination of high school marks, character and personality assessment, aptitude test, and interview—had been established at major medical schools since the 1920s. Beginning in 1929, the Association of American Medical Colleges instituted a Scholastic Aptitude Test for prospective medical students; by the mid-thirties, thousands of college students were taking it each year. Toronto’s faculty followed these developments closely and eventually, in 1937, won the agreement (and funding) of the Board of Governors for giving the American SAT to their own students. However, there was a serious problem with using it for selection at Toronto. Since the normal American pattern consisted of two premedical years of college studies followed by a four-year medical course, the scholastic aptitude test was administered to candidates during their second year of premedical work and tested their knowledge of the basic sciences gained through their college studies. But at Toronto, the majority of medical students came straight from high school into what was

⁶⁷UTA, Faculty of Medicine Council Minutes, A86-0027/020, 1 Apr. 1932, 326. We have been unable to find the record of that advice, but the evidence suggests that it was negative.

⁶⁸Dr. C. F. Martin, Dean of McGill Faculty of Medicine, quoted in discussion on paper by G. S. Young, “Post-Graduate Medical Education in Canada,” *Canadian Medical Association Journal* 15, no. 3 (Mar. 1925): 318. Free of the constraints of the provincial university, Queen’s and Western were also limiting enrolment in the 1920s: see *Report of Royal Commission on University Finances* (Toronto, 1921), appendix 6, Report of Trustees of Queen’s University, 101, in Ontario, Sessional Papers, 1921, Part 8, #65; and *Varsity*, 18 Oct. 1922, 4.

sometimes termed a preliminary year or premedical year which nevertheless was part of the medical course. They had, in other words, already gained access to the medical school. An aptitude test intended to serve as part of an admissions procedure was obviously not going to be of much use in that respect to the Toronto faculty, and indeed they were careful to stress that it was only an addition to the examination record, to indicate which students might be at risk of doing poorly in the medical course. There was also the fact that throughout the period, most of the evidence seemed to show that the best predictor of future success at medical school was not aptitude or other tests, but examination marks. Whether it was high school marks, or the results of the first year's work in medicine—and opinion was divided on that score—experts agreed that examination marks were on the whole an accurate predictor of later academic careers,⁶⁹ and the Ontario matriculation examinations retained a reputation for useful selection even as the numbers of those so selected rose.

But beyond these practical considerations, there was the moral and political pact between the university and the public to make higher education accessible to those who met the academic requirements, and that ruled out any form of limitation, whether a flat numerical quota or some more sophisticated selection process, on the university's part. For decades, any attempt to circumvent the bargain, even in the cause of adequate educational facilities or choosing the "best" students, was undercut by that understanding. Any attempt even to raise academic requirements had to meet the test of "fairness" to all of Ontario's citizens.

The Second World War finally brought an opportunity to renegotiate the bargain, as the nation, and its universities, geared up for the production of war *matériel*—including new doctors. In the fall of 1941, 210 students crowded into first-year medicine—a dramatic increase from the 140 or so new entrants of each of the preceding few years, and a cause of alarm among the medical professors.⁷⁰ A "new committee on limitation of students" recommended setting up selection procedures both to enforce a limit on future entrants and to make a cut of those already admitted. The latter request, in the view of the

⁶⁹For a summary treatment of this subject, see Woodside, *The University Question*, chapter 5 and esp. 55-57.

⁷⁰The record of proceedings through the session of 1941/42 can be followed in UTA, Faculty of Medicine, Office of the Dean, Faculty Council Minutes, A86-0027/23/1; *ibid.*, Special and other Committees, Minutes, A86-0027/12/2; UTA, Office of the Registrar, A65-0013/097, [Senate] Board on Medical Studies, 1937-42.

administration, was not possible or fair, and it took the rest of the academic session to work out a compromise; but many draft proposals and meetings later, the University finally endorsed measures to initiate limitation of first-year numbers, beginning in the fall of 1942, on the grounds that "owing to lack of facilities" the Faculty of Medicine could not continue to perform its task.⁷¹ The criteria by which a faculty admissions committee would judge candidates were also endorsed: these included, first and foremost, the student's matriculation record, but also the high school principal's recommendation, a medical aptitude test, the lack of any disability "which will prevent his [sic] becoming an efficient student of medicine," and perhaps a personal interview.⁷²

Thus, in what might seem an abrupt about-face, the University of Toronto agreed to a policy of selective admissions. The decision had been forced upon a reluctant administration by the pace of events, notably by the pressures of an extremely large class entering during war-time; even then, it moved cautiously until it found a legal loophole to its liking. However, attitudes about limitation were beginning to change as well; the President himself admitted that "in the past the difficulties had seemed too great, but he was now converted to the principle of selection of students on the basis of type suitable for the profession of medicine."⁷³ Although "amazed that there was no opposition" to the final plan, the Dean of Medicine exulted that "times have changed during the last 10 or 15 years. This marks a great advance in our efforts to limit the first year and to make it one which is composed of the best students we can possibly get."⁷⁴

Perhaps. But it was a less than optimal solution. Fearing the criticism of the press over whether "there were going to be enough doctors for the armed forces," the Board of Governors had *raised* the limit for first-year entry to 150 students—well above the 125 requested by the faculty, and even above the average of the last few years.⁷⁵ Two years later, Dean Gallie was still lamenting that that number was too large to permit adequate training.⁷⁶ And the Board insisted that this was a temporary wartime measure, requiring an annual re-affirmation.

Thus the faculty pressed on with renegotiation of the bargain. As medical professors worked overtime to hurry large classes through an accelerated

⁷¹UTA, Faculty of Medicine, Office of the Dean, Faculty Council Minutes, A86-0027/23/1, 2 Apr. 1942, 349.

⁷²Ibid., 13 Apr. 1942, 391.

⁷³Ibid., 24 Sept. 1941, 261.

⁷⁴Ibid., 13 Apr. 1942, 390.

⁷⁵Ibid., 30 Mar. 1942, 349, 351, 354; 13 Apr. 1942, 391 (report adopted by Senate).

⁷⁶*President's Report*, 1944, Report of the Dean of the Faculty of Medicine, 26.

course, they were also preparing a totally revised curriculum. Introduced in the 1945/46 session, the new structure of medical education at Toronto consisted of two pre-medical years "equivalent to an Honours Arts course," including heavy doses of science as well as a liberal arts component, followed by four years of medical studies proper.⁷⁷ This curriculum was carefully crafted to hold in delicate balance the various interests of professors, university administrators, and the public (and perhaps also the students). Pre-medical students registered in the Faculty of Medicine, but their courses were given at University College by the Arts faculty, which had insisted on a prominent role in drafting the content.⁷⁸ The medical faculty thus retained control over its entire programme at a cost, both to satisfy the arts professors over what they were to teach, and to meet the administration's demand that students who did not complete the pre-medical course successfully be allowed to transfer without penalty to some other course and degree in arts. The university authorities were also particularly concerned about potential loss of income from lower student fees in arts;⁷⁹ they were satisfied only by a carefully revamped fee structure ensuring that students in the pre-med course paid heftier fees than they would have in the equivalent course in arts, so that the total amount of medical school fees remained as high (in fact, somewhat higher).⁸⁰ To the satisfaction of the medical faculty, the principle of limitation of registration in the first year of pre-medical work remained as well; but it was to rest chiefly on the basis of high school matriculation marks, plus the principal's report if necessary. The aptitude test was quietly dropped, and the other criteria disappeared as well.⁸¹ The public was thus assured that the principle of open access

⁷⁷UTA, Cody Papers, A68-0006/066/08, "Subject: Medical Course": this file contains a great many of the records for this paragraph; see esp. Fennell to President, 10 Apr. 1945; President to Phillips, 10 Apr. 1945. For a succinct description of the new curriculum, see *President's Report*, 1945, 7, and Report of the Dean of the Faculty of Medicine, 27--29.

⁷⁸See for example UTA, Faculty of Medicine, Office of the Dean, A86-0027/009, Committee on Curriculum and Examinations, 1943-46, 24 Apr. 1944, 81 (meeting of Committee with Arts Faculty); UTA, Cody Papers, A68-0006/066/08, "Subject: Medical Course," Faculty of Medicine, 11 May 1944, Report of Proceedings (meeting of Arts Faculty with a representative from Medicine).

⁷⁹See UTA, Cody Papers, A68-0006/064/01, "Correspondence: F," Fennell to President, 18 Oct. 1944.

⁸⁰*Ibid.*, A68-0006/066/08, "Subject: Medical Course," Report of Special Committee [of Board of Governors] re Proposed Change in the Medical Course," 13 Feb. 1945.

⁸¹See University of Toronto Faculty of Medicine *Calendar*, 1946/47, 12-13; UTA, Faculty of Medicine, Office of the Dean, A86-0027/010, Committee on Curriculum and Examinations, 1946-55, 1 Oct. 1946, 16.

to a reasonably high number of qualified Ontario citizens was maintained. The one additional consideration, and one that spoke amply of the exigencies of university politics, was that rural candidates received special consideration. All in all, a fair bargain all around. And the Faculty of Medicine accepted it as a workable solution to their perennial problem: at last they had the means to exert some control over the size of the student body, without seeming to violate the principle of unimpeded access to the university on the grounds of academic standing. From now on, they could freely set their own academic standards for candidates to the core medical programme, after those students had already entered the university.

What were the consequences of an admissions policy based, as it was until the middle of the Second World War, on the matriculation certificate alone? For the University itself, they were mixed. By refusing to limit numbers, Toronto kept up its level of income from student fees; perhaps more important in principle, it also upheld a long-standing commitment to the right of access for Ontario's citizens. But such a policy incurred the undesirable consequence of less status in the eyes of medical pacesetters. Selection from a larger pool of qualified applicants was becoming standard procedure at the leading medical schools in North America. A student body of a manageable size (which depended not just on numbers but on able students) was a vital component in an era of increasing complexity and expense in medical education, and increasing emphasis on the research ideal, on small-group and laboratory instruction, full-time professors with small teaching loads, and all the other components of what was thought to exemplify a modern medical curriculum. Medical students themselves were expected to have high academic ability and to be "suitable" in other ways as well. Before 1945, Toronto's medical course, tied as it was to a high school system unique to North America, could not be assimilated to the new pattern in ways that satisfied the medical world—and especially the Toronto professors. Even after the war, to some extent Toronto remained out of step with the dominant North American model of medical education.

For the student, uncontrolled enrolments meant crowded classrooms and bedside clinics, and perhaps a less than ideal introduction to all the features of modern medicine. But there was also an opportunity inherent in that lack of selection. For everyone who met the minimum requirements, there was equality of access. For the rural and small-town applicant, there was the chance to attend the provincial university and to gain an education that might otherwise have been out of reach. And for disadvantaged groups—like women, and

Jewish students—Toronto's admissions policy opened its doors to those who might otherwise have been excluded.⁸²

Ironically, however, at the very moment that selective admissions was formally adopted, it ceased to be a pressing issue. At the end of the war, the flood of returning veterans swelled the pool of applicants to numbers far higher than any previously complained of, but it was politically impossible, even had it been desired, to turn the veterans away, or to make room for them by refusing all other qualified applicants. For several years, the post-war bulge fully occupied university authorities generally across Canada. At Toronto, thoughts of reducing the entering class in medicine to some ideal size were put aside.

Meanwhile, the demographics of the post-war era shaped a pattern of university enrolments that created a very different situation. By the early fifties, the largest portion of the enrolment boom had graduated, and those belonging to a much smaller age group, born in the thirties, were now coming up to university. The entering pre-medical class of 1951/52 dropped to 124 (from the 150 or so of the preceding few years), just as the first of the veterans were about to graduate.⁸³ And while the size of the first pre-med class in each ensuing year of the decade remained at that level, the last of the post-war bulge graduated. Total enrolments in medicine therefore dropped, while applications were also fewer. Indeed, as one ex-Dean of Medicine reminisced, "there was a falling-off in applications and we really would take everyone who was qualified and sometimes the Grade 13 averages were not so good."⁸⁴ Selective procedures were irrelevant at this point. Grade 13 marks provided the basic qualifying tool, interviewing was discarded, character and fitness recommendations rarely used, and the Dean's secretary efficiently saw to most of the necessary admissions paperwork.⁸⁵ It was only at the start of a very different era, when rising participation rates and the baby boom combined to create an enormous explosion of student numbers on university campuses across Canada, that the question of selective admissions, and the quest for the elusive balance between quantity and quality, became pressing issues once again.

⁸²See Gidney and Millar, "Medical Students," 37-41, 44; and Millar and Gidney, "Medettes."

⁸³*President's Report*, 1952, 203.

⁸⁴*Oral History Interviews*, University of Toronto, Faculty of Medicine (Hannah Institute for the History of Medicine), Dr. John D. Hamilton, vol. 19, typescript, 75.

⁸⁵For comments on the procedures used in the 1950s, see *ibid.*, Dr. Jan Steiner, vol. 43, typescript, 51 ff.; *ibid.*, Dr. A. L. Chute, vol. 7, typescript, 59-65; on the secretary's role, *ibid.*, Hamilton, 39-41.